Prudential

Office of Servicemembers' Group Life Insurance

Application Instructions for Veterans' Group Life Insurance (VGLI)

To apply for VGLI, complete the attached application and return it with your first premium payment to the Office of Servicemembers' Group Life Insurance (OSGLI) or visit **www.benefits.va.gov/insurance**. You have one year and 120 days from your date of separation to apply for VGLI.

1. Service Member Information

Complete all personal information fields on the application.

2. Coverage Amount and Premium

The chart below shows the most frequently requested coverage amounts and the monthly premium. Coverage is available in $10,000 increments. The maximum amount of coverage cannot be more than the amount of SGLI you had upon separation from service. For coverage amounts not shown below, please see the rate chart at www.benefits.va.gov/insurance or call 800-419-1473. If you elect less coverage than your SGLI amount, you will only have one year and 120 days from your separation date to apply for an increase up to your SGLI amount.

Amount of Coverage	Age 29 & Under	Age 30-34	Age 35-39	Age 40-44	Age 45-49	Age 50-54	Age 55-59	Age 60-64	Age 65-69	Age 70-74	Age 75 & Over
$400,000	$32.00	$40.00	$52.00	$68.00	$88.00	$144.00	$268.00	$432.00	$600.00	$900.00	$1,800.00
$350,000	$28.00	$35.00	$45.50	$59.50	$77.00	$126.00	$234.50	$378.00	$525.00	$787.50	$1,575.00
$300,000	$24.00	$30.00	$39.00	$51.00	$66.00	$108.00	$201.00	$324.00	$450.00	$675.00	$1,350.00
$250,000	$20.00	$25.00	$32.50	$42.50	$55.00	$90.00	$167.50	$270.00	$375.00	$562.50	$1,125.00
$200,000	$16.00	$20.00	$26.00	$34.00	$44.00	$72.00	$134.00	$216.00	$300.00	$450.00	$900.00
$150,000	$12.00	$15.00	$19.50	$25.50	$33.00	$54.00	$100.50	$162.00	$225.00	$337.50	$675.00
$100,000	$8.00	$10.00	$13.00	$17.00	$22.00	$36.00	$67.00	$108.00	$150.00	$225.00	$450.00
$50,000	$4.00	$5.00	$6.50	$8.50	$11.00	$18.00	$33.50	$54.00	$75.00	$112.50	$225.00
$10,000	$0.80	$1.00	$1.30	$1.70	$2.20	$3.60	$6.70	$10.80	$15.00	$22.50	$45.00

3. Preferred Payment Method and Frequency

You have the option of paying your VGLI premium monthly, quarterly, semi-annually, or annually. You can save up to 5% depending on how often you pay. For additional information on premium discounts, please visit www.benefits.va.gov/insurance. If you receive military retirement pay or VA compensation, your monthly premium can be automatically deducted from your payment. Please continue to send in your premium until automatic deductions begin.

4. Is a Health Statement Required?

If...	Then...
Your separation date was before November 1, 2012...	You have 120 days from your separation date to apply for VGLI without answering health questions. After which, you must provide proof of good health.
Your separation date was November 1, 2012 or later...	You have 240 days from your separation date to apply for VGLI without answering health questions. After which, you must provide proof of good health.

5. Beneficiaries

You have the right to name anyone as your beneficiary. To name more beneficiaries than the application allows, please list them on a separate sheet of paper along with your name, Social Security Number, signature, and date. Your beneficiary designation is not valid unless it is signed, dated, and received by OSGLI prior to your death.

6. Include These Items with Your Application

- Proof of your SGLI coverage (e.g., copies of your DD214 or orders and your most recent leave and earnings statement).
- First premium payment payable to "OSGLI." Please write the full name of the Veteran applying for VGLI in the memo section of the check if someone other than the Veteran is paying the premium.

Please make a copy of your completed application for your records.

Questions? Visit the VA insurance website at www.benefits.va.gov/insurance or call 800-419-1473 (Monday to Friday, 8:00 a.m. to 5:00 p.m. Eastern Time).

Application For

Veterans' Group Life Insurance

Return completed application to:
OSGLI
PO Box 41618, Philadelphia, PA 19176-9913
Or fax to: 800-236-6142

IMPORTANT: No insurance may be granted unless a completed application has been received (38 U.S.C. 1977) and premium has been paid.

1. Service Member Information

First Name | Middle Initial | Last Name

No. | Street

City | State | ZIP

Social Security Number | Date of Birth | Gender

Branch of Service | Date of Separation

Home Phone | Cell Phone

Email Address

Please use email address to send me: ☐ Newsletters and general information

2. Coverage Amount and Premium

I understand that my VGLI coverage cannot exceed the amount of SGLI I had upon separation from service. I also understand that I cannot have combined SGLI and VGLI coverage in excess of $400,000.

I elect the following amount of VGLI coverage:

☐ $400,000 ☐ $350,000 ☐ $300,000 ☐ $250,000 ☐ $200,000 ☐ $150,000 ☐ $100,000 ☐ $50,000 ☐ $10,000
☐ Other $ _____ (must be a multiple of $10,000)

Enclosed is my first premium payment of: $ _____ (Please make check payable to "OSGLI.")

Important: You have 1 year and 120 days from your date of separation to apply for a coverage increase up to the amount of SGLI you had at separation. Evidence of good health will be required.

3. Preferred Payment Method and Frequency

Important: You must submit your first month's premium with your application even if you choose the automatic monthly deduction option. Please continue to mail in payments on a monthly basis until automatic deductions begin. Deductions should begin by the time your third month's premium is due.

My preferred payment method is:

☐ Mail – Please select your preferred payment frequency: ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually
☐ Online via my VGLI Online Account. You can set up your online account at www.benefits.va.gov/insurance.
☐ Automatic monthly deductions* from military retirement pay
☐ Automatic monthly deductions* from VA compensation
My VA claim file number is _____

*In order to set up monthly deductions you must currently be receiving military retirement pay or VA compensation pay and those payments must be sufficient to cover your premium.

Applicant's Social Security Number ___ ___ ___ – ___ ___ – ___ ___ ___ ___

4. Health Statement

Please see page 1, item 4 (Is a Health Statement Required?) to determine whether you need to complete this section. Attach a separate sheet of paper with complete details for any question answered "Yes." Be sure to include your name, Social Security Number, and signature on any additional sheets of paper.

Height _____ Weight _____

Have you had or been treated for or had known indications of:

	Y	N
A. A heart condition?	☐	☐
B. High blood pressure?	☐	☐
C. Lung or respiratory disorders?	☐	☐
D. Diabetes?	☐	☐
E. Cancer or tumors?	☐	☐
F. Disorders of kidney, bladder or urinary system?	☐	☐
G. Liver or gall bladder disorder?	☐	☐
H. Stomach or intestinal disorder?	☐	☐
I. Arthritis?	☐	☐

Have you within the past five years:	Y	N
J. Been declined or postponed for any form of life or health insurance or offered a policy with a higher premium because of health reasons only?	☐	☐
K. Been absent from work for more than five continuous days because of sickness or injury?	☐	☐
L. Been advised to have a surgical procedure?	☐	☐
M. Been a patient or been advised to enter a hospital or health care facility?	☐	☐
N. Consulted, been attended, or examined by a doctor or other practitioner exclusive of annual or periodic physicals?	☐	☐
O. Used barbiturates, heroin, opiates, or other narcotics, or been treated for alcoholism?	☐	☐
P. Been diagnosed as having acquired immunodeficiency syndrome (AIDS) or AIDS-related complex (ARC) or any disease of the immune system?	☐	☐
Do you have any known physical impairments, deformities, or ill health not covered above?	☐	☐
Do you have a service-connected disability?	☐	☐

If yes, what is the VA claim file number? _____

_____

Signature of Applicant (Do not print. Sign in ink.) Date

5. Beneficiaries

I designate the following beneficiaries to receive my insurance proceeds. I understand that the primary beneficiaries will receive payment upon my death. The share of any primary beneficiary who dies before me will be distributed equally among the remaining primary beneficiaries. If all primary beneficiaries die before me, the insurance will be paid to the secondary beneficiaries. I understand that unless I have named beneficiaries below, my insurance will be paid under the provisions of the law (38 U.S.C. 1970). The designation below cancels any prior SGLI or VGLI beneficiary designation or payment instruction.

Primary Beneficiaries (The total for all primary beneficiaries must equal 100%.)

First Name	MI	Last Name	Social Security Number (if known)	Relationship To You	Share to Beneficiary (Use % or $ amount)	Payment Option (Lump sum or 36 equal monthly installments*)
Street	City, State ZIP		Date of Birth			
First Name	MI	Last Name	Social Security Number (if known)	Relationship To You	Share to Beneficiary (Use % or $ amount)	Payment Option (Lump sum or 36 equal monthly installments*)
Street	City, State ZIP		Date of Birth			

Secondary Beneficiaries (The total for all secondary beneficiaries must equal 100%.)

First Name	MI	Last Name	Social Security Number (if known)	Relationship To You	Share to Beneficiary (Use % or $ amount)	Payment Option (Lump sum or 36 equal monthly installments*)
Street	City, State ZIP		Date of Birth			
First Name	MI	Last Name	Social Security Number (if known)	Relationship To You	Share to Beneficiary (Use % or $ amount)	Payment Option (Lump sum or 36 equal monthly installments*)
Street	City, State ZIP		Date of Birth			

Applicant Signature

I certify that the information provided on this form is true and correct to the best of my knowledge and belief. Any deceptions or knowingly false statement either by inference or omission may result in cancellation of the insurance or in the refusal to pay a claim.

Print Name of Applicant — Social Security Number of Applicant

Signature of Applicant (Do not print. Sign in ink.) — Date

PENALTY: The law provides that whoever makes any statement of a material fact knowing it to be false shall be punished by fine, imprisonment, or both.

*If you elect a lump sum payment, the beneficiary(ies) will be given the option of receiving the lump sum payment through the Prudential Alliance Account ®, by check, or Electronic Funds Transfer (EFT). Alliance is not available for payments less than $5,000, payments to individuals residing outside the United States and its territories, and certain other payments. These will be paid by check.

The funds in an Alliance Account begin earning interest immediately and will continue to earn interest until all funds are withdrawn. Interest is accrued daily, compounded daily and credited every month. The interest rate may change and will vary over time subject to a minimum rate that will not change more than once every 90 days. You will be advised in advance of any change to the minimum interest rate via your quarterly Alliance Account statement or by calling Customer Support at (877) 255-4262.

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