Prudential

**Office of Servicemembers' Group Life Insurance**

# SERVICEMEMBERS' GROUP LIFE INSURANCE TRAUMATIC INJURY PROTECTION PROGRAM (TSGLI)

Administered by the Office of Servicemembers' Group Life Insurance

## Application for TSGLI Benefits

Please submit your completed claim to your branch of service below.

**TSGLI Branch of Service Contacts**

| Branch | Contact Information | Submit Claim by Fax | Submit Claim by Email | Submit Claim by Postal Mail |
|---|---|---|---|---|
| **Army**<br>All Components | Phone: (800) 237-1336 Option 4<br>Website:<br>www.hrc.army.mil/TAGD/TSGLI | (502) 613-4513 | usarmy.knox.hrc.mbx.tagd-tsgli-claims @mail.mil | US Army Human Resources Command<br>1600 Spearhead Division Avenue,<br>Dept 420 PDR-C (TSGLI)<br>Fort Knox, KY 40122-5402 |
| **Marine Corps**<br>All Components | Phone: (877) 216-0825 or 703-975-4069<br>Website:<br>www.woundedwarriorregiment.org | (800) 770-9968 | t-sgli@usmc.mil | HQ, Marine Corps<br>Attn: WWR-TSGLI<br>1998 Hill Street<br>Quantico, VA 22134 |
| **Navy**<br>All Components | Phone: 1-877-270-2162<br>Website: www.public.navy.mil/bupers-npc/support/casualty/Pages/TSGLI.aspx | (901) 874-2265 | MILL_TSGLI.FCT@navy.mil | Commander, Navy Personnel Command<br>Attn: PERS-00C<br>5720 Integrity Drive<br>Millington, TN 38055-1300 |
| **Air Force Active Duty** | Phone: (800) 433-0048 | | AFPC.DPFCS.PoI_Trng_CaseMgt@ us.af.mil | AFPC/DPFCS<br>550 C Street West, Suite 14<br>Randolph AFB, TX 78150-4716 |
| **Air Force Reserves and Air National Guard** | Phone: (800) 525-0102 | (720) 847-3887 | casualty.arpc1@us.af.mil | HQ, ARPC/DPTTB<br>18420 E. Silver Creek Ave.<br>Building 390 MS 68<br>Buckley AFB, CO 80011 |
| **Coast Guard** | Phone: (202) 795-6638<br>Website:<br>www.dcms.uscg.mil/PSD/fs/TSGLI | | ARL-PF-CGPSC-PSDFS-COMPENSATION@uscg.mil | Commander (CG)<br>Personnel Service Center (PSC)<br>Attn: TSGLI Case Manager,<br>PSC-PSD-FS-Casualty<br>U.S. Coast Guard STOP 7200<br>2703 Martin Luther King Jr Ave SE<br>Washington, DC 20593-7200 |
| **Public Health Service** | Phone: (240) 276-8799 | (240) 276-8817 or<br>(240) 453-6030 | compensationbranch@psc.hhs.gov | PHS Compensation Branch<br>1101 Wootton Parkway<br>Suite: 100<br>Rockville, MD 20852 |
| **NOAA Corps** | Phone: (301) 713-3444 | (301) 713-4140 | Director.cpc@noaa.gov | U.S. Dept. of Commerce<br>NOAA/OMAO/CPC<br>8403 Colesville Rd, Suite 500, 5th Floor<br>Silver Spring, MD 20910 |

# GENERAL INFORMATION

The Servicemembers' Group Life Insurance Traumatic Injury Protection (TSGLI) program provides for payment to service members who are severely injured (on or off duty) as the result of a traumatic event and suffer a loss that qualifies for payment under TSGLI. TSGLI is designed to help traumatically injured service members and their families with financial burdens associated with recovering from a severe injury. TSGLI payments range from $25,000 to $100,000, based on the qualifying loss suffered.

## WHO IS ELIGIBLE?

Effective December 1, 2005, all service members who are insured under SGLI and:

- experience a **traumatic event**
- that results in a **traumatic injury**
- which is listed as a **qualifying loss**

are eligible to receive a TSGLI payment. Service members who were severely injured between October 7, 2001 and November 30, 2005 may also be eligible for a TSGLI payment, regardless of where their injury occurred or whether they had SGLI coverage at the time of their injury. Members should contact their branch of service for more information.

**What is a Traumatic Event?**
A traumatic event is the application of external force, violence, chemical, biological, or radiological weapons, accidental ingestion of a contaminated substance, or exposure to the elements that causes damage to your body.

**What is a Traumatic Injury?**
A traumatic injury is the physical damage to your body that results from a traumatic event.

**What is a Qualifying Loss?**
A qualifying loss is a traumatic injury that is listed on the TSGLI Schedule of Losses, which lists all covered losses and payment amounts. You may view the complete Schedule of Losses and other TSGLI information at **http://www.benefits.va.gov/insurance/tsgli_schedule_Schedule.asp**. Your branch of service TSGLI office will determine whether your injury is a qualifying loss for TSGLI purposes.

## HOW TO FILE A TSGLI CLAIM

Filing a TSGLI claim is a three-step process in which the service member [or guardian, power of attorney or military trustee] and a medical professional must complete and submit the appropriate parts of the TSGLI Claim Form as follows:

| **Step 1** | **Step 2** | **Step 3** |
|---|---|---|
| The service member [or guardian, power of attorney or military trustee]… | The medical professional… | The medical professional OR the service member [or guardian, power of attorney or military trustee]… |
| must complete Part A (pages 3 through 7) of the form and give it to a medical professional to complete Part B. Note: If a guardian or power of attorney completes Part A, they must include copies of letters of guardianship, letters of conservatorship, power of attorney, or durable power of attorney (if appropriate). | must complete Part B. | must forward Parts A and B, along with medical records that document the member's injury and resulting loss, to the member's branch of service TSGLI office listed on the front cover of this form. |

# COMPLETING THE FORM

Instructions on completing the TSGLI Claim Form are included in each section. When completing the form, the service member, guardian, power of attorney or military trustee **must** complete the service member's Social Security number on each page of the form. If you have questions about completing the form or if the member is deceased, please contact the branch of service TSGLI office listed on the front cover of this form.

## CLAIM DECISION AND PAYMENT

**Who Makes the Decision on My Claim?**
Your branch of service TSGLI office will make the decision on your claim based upon the information in Parts A and B of the TSGLI Claim Form and any supporting medical documentation you provide. They will then forward their decision to the Office of Servicemembers' Group Life Insurance (OSGLI) for appropriate action.

**Who Will Receive the TSGLI Payment?**
Payment will be made directly to the member. If the member is unable, payment will be made under the appropriate letters of guardianship/conservatorship or a power of attorney to the guardian, power of attorney or military trustee on the member's behalf. If the member dies after qualifying for payment, the payment will be made to the member's current listed SGLI beneficiary(ies). The member must survive for seven days (168 hours) from the date of the traumatic event to be eligible for TSGLI.

**How the TSGLI Payment Will Be Made?**
If your branch of service TSGLI office approves your claim, OSGLI will make the TSGLI benefit payment. There are three payment methods used for TSGLI benefits: Prudential's Alliance Account®,* Electronic Funds Transfer (EFT), or check. If you do not choose a payment option, OSGLI will make the payment through Prudential's Alliance Account.

1. **Prudential's Alliance Account***

   1) 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.
   2) The interest rate credited to the Alliance Account is adjusted by Prudential at its discretion based on variable economic factors (including, but not limited to, prevailing market rates for short-term demand deposit accounts, bank money market rates and Federal Reserve Interest rates) and may be more or less than the rate Prudential earns on the funds in the account.
   3) An Alliance Account is an interest bearing draft account established in the beneficiary's name with a draft book. The beneficiary can write drafts for any amount up to the full amount of the proceeds. There are no monthly service fees or per draft charges and additional drafts can be ordered at no cost, but fees apply for some special services including returned drafts, stop payment orders and copies of statements/drafts.
   4) The funds in your Alliance Account are available immediately. Use the drafts to access the account anytime you wish. You can write a draft to yourself (which you can cash or deposit at your own bank) or write a draft to another person, or to any business as you need your funds.
   5) Alliance Account funds are part of Prudential's General Account and are backed by the financial strength of The Prudential Insurance Company of America which has been in business and serving its customers for over 140 years. The Alliance Account is not a bank account or a bank product, and therefore, is not FDIC insured.
   6) Account holders cannot make deposits into an Alliance Account. Only eligible payments from other Prudential insurance policies or contracts may be added to the Alliance Account.

   **Note:** A service member's legal guardian, military trustee, or power of attorney (POA) may choose the Alliance Account payment option as long as they submit proof of that appointment (i.e., the appropriate documentation) with the claim. The guardian, military trustee, or POA will not have their name added to the account, but will be able to sign Alliance Account drafts on behalf of the member.

2. **Electronic Funds Transfer (EFT)** — Your bank account will be electronically credited with the TSGLI payment amount. Depending on your bank, payments will be credited three to five days from the date the payment is authorized.
3. **Check Payment** — A check will be issued to the service member, guardian, power of attorney or military trustee on behalf of the member.

* The Bank of New York Mellon is the Administrator of the Prudential Alliance Account Settlement Option, a contractual obligation of The Prudential Insurance Company of America, located at 751 Broad Street, Newark, NJ 07102-3777. Draft clearing and processing support is provided by The Bank of New York Mellon. **Alliance Account balances are not insured by the Federal Deposit Insurance Corporation (FDIC).** The Bank of New York Mellon is not a Prudential Financial company.

## PART A - Member's Claim Information and Authorization - to be completed by the member, guardian, power of attorney or military trustee.

Service member's Social Security number

### 1 Service member Information

The service member, guardian, power of attorney or military trustee MUST fill in member's Social Security number at the top of each page.

**Important Note:** Contact information must be completed. Incomplete information will delay payment of your claim.

Service member's First Name | MI | Service member's Last Name

Date of Birth (mm/dd/yyyy)

Gender: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed

Branch of Service at time of injury: ☐ Army ☐ Navy ☐ PHS ☐ Air Force ☐ Marines ☐ NOAA ☐ Coast Guard

Rank/Grade

Address of Record (number and street) | Apt. (if any) | Telephone Number

City | State | ZIP Code

Email Address

Unit (at time of injury)

**Third Party Authorization** ☐ (Optional) I authorize the following person to speak with OSGLI or the Branch of Service about my claim (this can be a spouse, parent, friend or another person who is helping you with your claim).

First Name | MI | Last Name

### 2 Guardian, Power of Attorney or Military Trustee Information

**Important Note:** Please include copies of the letters of guardianship, conservatorship, or Power of Attorney, etc. with this form. Failure to include this documentation will delay processing of the claim.

Complete this section ONLY if a guardian, power of attorney or military trustee will receive payment on behalf of the member.

First Name | MI | Last Name

Mailing Address (number and street) | Apartment (if any)

City | State | ZIP Code

Telephone Number | Fax Number

### 3 Traumatic Injury Information

**Injuries that Qualify for TSGLI Payment**

To qualify for the TSGLI benefit, you must have experienced a **traumatic event** that resulted in a **traumatic injury** that is listed as a **qualifying loss** on the TSGLI Schedule of Losses.

**Definitions:**

**Traumatic Event** — A traumatic event is the application of external force, violence, chemical, biological, or radiological weapons, accidental ingestion of a contaminated substance, or exposure to the elements that causes damage to your body.

**Traumatic Injury** — A traumatic injury is the physical damage to your body that resulted from a traumatic event (illness or disease is not covered).

**Qualifying Loss** — A qualifying loss is a traumatic injury that is listed on the TSGLI Schedule of Losses. See the complete Schedule of Losses at **http://www.benefits.va.gov/insurance/tsgli_schedule_Schedule.asp**.

Service member's Social Security number

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |

## 3 Traumatic Injury Information

**Information About Your Loss**

Is the loss you are claiming the result of any of the following:

a. an intentionally self-inflicted injury or an attempt to inflict such injury? ☐ Yes ☐ No

b. use of an illegal or controlled substance that was not administered or consumed on the advice of a medical doctor? ☐ Yes ☐ No

c. the medical or surgical treatment of an illness or disease? ☐ Yes ☐ No

d. a traumatic injury sustained while committing or attempting to commit a felony? ☐ Yes ☐ No

e. a physical or mental illness or disease (not including illness or disease caused by a wound infection, a chemical, biological, or radiological weapon, or the accidental ingestion of a contaminated substance)? ☐ Yes ☐ No

**If you answered yes…**

to any of the questions above, you are not eligible for a TSGLI payment and should not file a claim.

**If you are not sure…**

whether your loss is a result of one of the items above, please contact your Branch of Service TSGLI Office to find out if you are eligible.

**Tell us about your traumatic Injury**

1. Were you covered under Servicemembers' Group Life Insurance (SGLI) at the time of the injury? ☐ Yes ☐ No
2. In the box below, please describe your injury and give the date, time and location where it occurred. **You must also submit medical records with this claim that document your injuries and resulting loss. (See Part B for qualifying losses.)**

**Traumatic Injury Information**

Service member's Social Security number

## 4 Payment Options

Please choose one of the three payment options by checking the appropriate box and filling in the requested information.

**Payment Option 1 – Prudential's Alliance Account**
An interest-bearing account will be established in the name of the member, who can access the money using the draft book. A guardian, power of attorney, or military trustee may sign Alliance Account drafts on behalf of the member if proof of appointment is submitted with the claim.

**Payment Option 2 – Electronic Funds Transfer**
This option can be selected by member or, if applicable, the guardian, power of attorney or military trustee. Payment will be made to the service member's bank account.

**Payment Option 3 – Check**
A check will be issued to the service member, guardian, power of attorney or military trustee on behalf of the service member.

**Please choose one of the three payment options below:**

☐ **Payment Option 1 - Prudential's Alliance Account**
Complete the mailing address below (street address only, no P.O. boxes).

Service member's Mailing Address for Payment - No P.O. Boxes

Apartment, Ward or Room (if any)

City

State

ZIP Code

☐ **Payment Option 2 - Electronic Funds Transfer (EFT)**
To have the payment made by EFT, fill in your banking information below.

Bank Routing Number

Bank Account Number

☐ Checking
☐ Savings

Bank Name

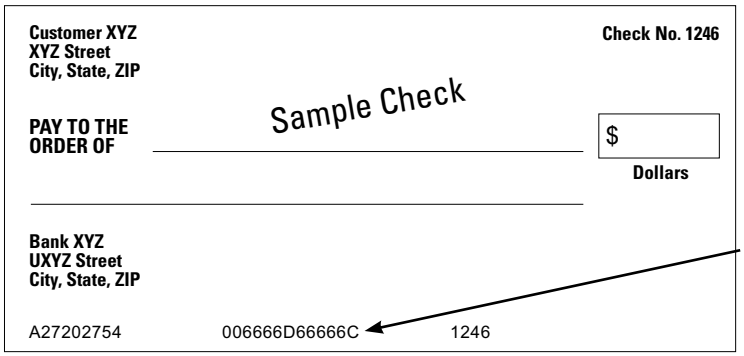
Bank Phone Number

First Name

MI

Last Name

The **bank routing number** is always 9 digits and appears between the ⑆ symbols




The **bank account number** varies in length and may contain dashes or spaces. The ⑈ symbol indicates the end of the account number.

☐ **Payment Option 3 - Check**
Important: If you are a guardian, power of attorney or military trustee you must complete the information below when requesting a check.

Mailing Address for Payment - No P.O. Boxes

Apartment (if any)

City

State

ZIP Code

## 5 Financial Counseling

VA sponsors financial counseling for TSGLI recipients.

To receive this counseling, check the box below.

☐ **I would like to receive financial counseling with my TSGLI benefit.**

You should get financial counseling as soon as possible after receiving your insurance money and before making any major financial decisions. For more information on this benefit, visit **http://www.benefits.va.gov/insurance/bfcs.asp**.

**PART A - Member's Claim Information and Authorization (cont'd)** - to be completed by the member, guardian, power of attorney or military trustee.

Service member's Social Security number

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |

**6** **Signature**

X

Signature of service member, guardian, power of attorney or military trustee  Date Signed (mm/dd/yyyy)

**WARNING:** Any intentional false statement in this claim or willful misrepresentation relative thereto is subject to punishment by a fine of not more than $10,000 or imprisonment of not more than five years, or both. (18 U.S.C. 1001)

Description of Authority to act on behalf of the member (Guardian, POA, etc.)

Description of Authority: If the guardian, power of attorney or military trustee completes this section, they must also indicate their authority to act on behalf of the member (e.g., guardian, conservator, etc.).

## Member must complete and sign the HIPAA release on page 7

**PART A - Member's Claim Information and Authorization (cont'd)** - to be completed by the member, guardian, power of attorney or military trustee.

Service member's Social Security number

**7**

**Authorization for Release of Information to Branch of Service and Office of Servicemembers' Group Life Insurance**

The member, guardian, power of attorney, or military trustee **must** complete and sign this section.

**Failure to complete this section will delay payment of claim.**

This Authorization is intended to comply with the HIPAA Privacy Rule.

**Member must complete and sign the HIPAA release below:**

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, medical examiner or other health care provider that has provided treatment, payment or services pertaining to:

First Name MI Last Name

Date of Birth (mm/dd/yyyy)

or on my behalf ("My Providers") to disclose my entire medical record for me or my dependents and any other health information concerning me to the Branch of Service and Office of Servicemembers' Group Life Insurance (OSGLI) and its agents, employees, and representatives. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes. OSGLI is an administrative unit created by Prudential to administer the Servicemembers' Group Life Insurance Program. OSGLI administers the TSGLI program on behalf of the Department of Veterans Affairs.

I authorize all non-health organizations, any insurance company, employer, or other person or institutions to provide any information, data or records relating to credit, financial, earnings, travel, activities or employment history to OSGLI.

Unless limits* are shown below, this form pertains to all of the records listed above.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization and I instruct My Providers to release and disclose my entire medical record without restriction.

This information is to be disclosed under this Authorization so that my Branch of Service and OSGLI may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits, 2) administer coverage, and 3) conduct other legally permissible activities that relate to any coverage I have applied for with OSGLI.

This Authorization shall remain in force for 24 months following the date of my signature below, while the coverage is in force, except to the extent that state law imposes a shorter duration. A copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to OSGLI at: 80 Livingston Avenue, Roseland, NJ 07068. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that OSGLI has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this Authorization to release my complete medical record, OSGLI may not be able to process my claim for benefits and may not be able to make any benefit payments. I understand that I have the right to request and receive a copy of this Authorization.

*Limits, if any:

NOTE: This release authorizes the branch of service and OSGLI to look at medical records. You may also be asked to provide these documents.

**Signature**

The member, guardian, power of attorney or military trustee must sign here.

X

Signature of service member, guardian, power of attorney or military trustee

Date Signed (mm/dd/yyyy)

Description of Authority to act on behalf of the member (Guardian, POA, etc.)

**PART B - Medical Professional's Statement -** to be completed by a medical professional who is a licensed practitioner of the healing arts acting within the scope of his/her practice.

Service member's Social Security number

## 1 Patient Information

Patient's First Name | MI | Patient's Last Name

Date of Injury (mm/dd/yyyy)

**If patient is deceased, please provide:**

Date of Death (mm/dd/yyyy) | Time of Death ☐ a.m. ☐ p.m.

Cause of Death

## 2 Qualifying Losses Suffered by Patient

**Instructions:** Please check the box next to each loss the patient has experienced and fill in any additional information requested. Omitted information, such as sight or hearing measurements, will delay processing of the claim.

**Patient's loss MUST meet the definition of loss given.**

**Inpatient hospitalization is defined as: "Being hospitalized as an inpatient for 15 consecutive days as the result of a traumatic injury"**

**Definition of a hospital** – A hospital that is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Healthcare Organizations. This includes Combat Support Hospitals, Air Force Theater Hospitals and Navy Hospital Ships.

Hospital does not include a nursing home. Neither does it include an institution, or part of one, which: (1) is used mainly as a place for convalescence, rest, nursing care or for the aged; or (2) furnishes mainly homelike or Custodial Care, or training in the routines of daily living; or (3) is for residential or domiciliary living; or (4) is mainly a school.

Was the member hospitalized as an inpatient for at least 15 consecutive days? ☐ Yes ☐ No

**Reason for Inpatient Hospitalization –** Please give the predominant reason the patient was hospitalized.

☐ Traumatic Brain Injury ☐ Other Traumatic Injury

**Longest Period of Inpatient Hospitalization –** Please give the beginning and ending dates for the longest period of consecutive days the patient was hospitalized as an inpatient. The count of consecutive inpatient hospitalization days begins when the injured member is transported to the hospital (if applicable), includes the day of admission, continues through subsequent transfers from one hospital to another, and includes the day of discharge.

Date of transport (mm/dd/yyyy) | Date of Admission (mm/dd/yyyy) | Date of discharge (mm/dd/yyyy) | **OR** ☐ Check here if still hospitalized

**Name and location of hospital** (if more than one hospital, list all)

**Loss of Sight is defined as:**

- Visual acuity in at least one eye of 20/200 or less (worse) with corrective lenses, OR
- Visual acuity in at least one eye of greater (better) than 20/200 with corrective lenses and a visual field of 20 degrees or less, OR
- Anatomical loss of eye. Loss of sight must be expected to be permanent OR must have lasted at least 120 days.

**Loss of Sight** | Date of onset/loss (mm/dd/yyyy)

☐ Loss of sight in left eye or anatomical loss of left eye

☐ Loss of sight in right eye or anatomical loss of right eye

**Visual Acuity and Field**

| | Left Eye | Right Eye |
|---|---|---|
| Best corrected visual acuity | | |
| Visual Field (degrees) | | |

**Loss of Speech is defined as:**

An organic loss of speech (lost the ability to express oneself, both by voice and by whisper, through normal organs for speech). If a member uses an artificial appliance, such as a voice box, to simulate speech, he/she is still considered to have suffered an organic loss of speech and is eligible for a TSGLI benefit.

**Loss of Speech** | Date of onset (mm/dd/yyyy)

☐ Loss of speech

**PART B - Medical Professional's Statement (cont'd) -** to be completed by a medical professional who is a licensed practitioner of the healing arts acting within the scope of his/her practice.

Service member's Social Security number

## 2 Qualifying Losses Suffered by Patient (cont'd)

**Loss of hearing is defined as:**

Average hearing threshold sensitivity for air conduction of at least 80 decibels. Hearing Acuity must be measured at 500 Hz, 1000 Hz and 2000 Hz to calculate the average hearing threshold. Loss of hearing must be clinically stable and unlikely to improve.

**Loss of Hearing**

Date of onset (mm/dd/yyyy)

☐ Loss of hearing in left ear

☐ Loss of hearing in right ear

**Hearing Acuity**

Average Hearing Acuity (measured without amplification device)

Left Ear _____ db

Right Ear _____ db

**Burns are defined as:**

2nd degree (partial thickness) or worse burns over 20% of the body including the face and head OR 20% of the face only.

Note: Percentage may be measured using the Rule of Nines or any other acceptable alternative.

**Burns**

☐ 2nd degree or worse burns to the body including face and head

☐ 2nd degree or worse burns to the face only

Percentage of body affected ___ %

Percentage of face affected ___ %

**Coma is defined as:**

Coma with brain injury measured at a Glasgow Coma Score of 8 or less that lasts for 15, 30, 60 or 90 consecutive days.

Number of days includes the date the coma began and the date the member recovered from the coma.

**Coma**

☐ Coma

Date of onset (mm/dd/yyyy)

Date of recovery (mm/dd/yyyy)

**OR** ☐ Check here if coma is ongoing

Glasgow score at 15 days ___ Glasgow score at 30 days ___ Glasgow score at 60 days ___ Glasgow score at 90 days ___

**Important:**

**Facial Reconstruction:** If the patient is undergoing facial reconstruction, a surgeon MUST certify this section by checking the box, printing his/her name and signing on the appropriate line.

**Facial Reconstruction is defined as:**

Reconstructive surgery to correct traumatic avulsions of the face or jaw that cause discontinuity defects, specifically surgery to correct discontinuity loss of the following:

- upper or lower jaw
- 50% or more of the cartilaginous nose
- 50% or more of the upper or lower lip
- 30% or more of the periorbital
- tissue in 50% or more of any of the following facial subunits: forehead, temple, zygomatic, mandibular, infraorbital or chin

**Facial Reconstruction**

☐ Upper or lower jaw
☐ 50% of cartilaginous nose
☐ 50% of upper lip
☐ 50% of lower lip
☐ 30% of left periorbital
☐ 30% of right periorbital
☐ 50% of left temple
☐ 50% of right temple
☐ 50% of left zygomatic
☐ 50% of right zygomatic
☐ 50% of left mandibular
☐ 50% of right mandibular
☐ 50% of left infraorbital
☐ 50% of right infraorbital
☐ 50% of chin
☐ 50% of forehead

**Certification of Surgeon**

Date of first surgery (mm/dd/yyyy)

First Name of Surgeon

Last Name of Surgeon

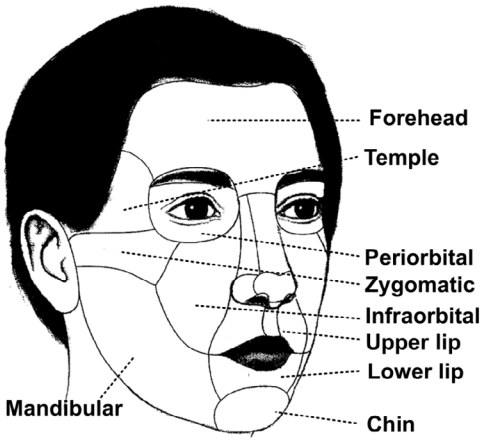
Specialty

Date Signed (mm/dd/yyyy)

X

Signature of Surgeon

Telephone Number



**PART B - Medical Professional's Statement (cont'd) -** to be completed by a medical professional who is a licensed practitioner of the healing arts acting within the scope of his/her practice.

Service member's Social Security number

## 2 Qualifying Losses Suffered by Patient (cont'd)

**Amputation is:** the severance or removal of a limb or genital organ or part of a limb or genital organ, including both severance due to a traumatic injury, or surgical removal that is required for the treatment of a traumatic injury.

**Amputation of Hand is defined as:**

Amputation of hand at or above the wrist.

Above the wrist means closer to the body.

| Amputation of Hand | Date of amputation (mm/dd/yyyy) |
|---|---|
| ☐ Amputation of left hand | |
| ☐ Amputation of right hand | |

**Amputation of Fingers is defined as:**

- Amputation of four fingers on the same hand (not including the thumb) at or above the metacarpophalangeal joint, OR
- Amputation of thumb at or above the metacarpophalangeal joint.

Above the metacarpophalangeal joint means closer to the body.

| Amputation of Fingers | Date of amputation (mm/dd/yyyy) |
|---|---|
| ☐ Amputation of 4 fingers/ left hand | |
| ☐ Amputation of 4 fingers/ right hand | |
| ☐ Amputation of left thumb | |
| ☐ Amputation of right thumb | |

**Amputation of Foot is defined as:**

- Amputation of foot at or above the ankle, OR
- Amputation of all toes (including the big toe) on the same foot at or above the metatarsophalangeal joint.

Above the ankle and above the metatarsophalangeal joint means closer to the body.

| Amputation of Foot | Date of amputation (mm/dd/yyyy) |
|---|---|
| ☐ Amputation of left foot | |
| ☐ Amputation of right foot | |

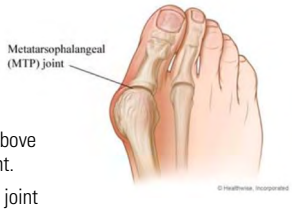
**Amputation of Toes is defined as:**

- Amputation of four toes on one foot at or above the metatarsophalangeal joint (not including the big toe),

OR

- Amputation of big toe at or above the metatarsophalangeal joint.

Above the metatarsophalangeal joint means closer to the body.




| Amputation of Toes | Date of amputation (mm/dd/yyyy) |
|---|---|
| ☐ Amputation of 4 toes/ left foot | |
| ☐ Amputation of 4 toes/ right foot | |
| ☐ Amputation of big toe/ left foot | |
| ☐ Amputation of big toe/ right foot | |

**Important:**

**Limb Salvage:** If the patient is undergoing limb salvage, a surgeon MUST certify this section by printing his/her name and signing on the appropriate line.

**Limb Salvage is defined as:**

A series of operations designed to avoid amputation of an arm or a leg while at the same time maximizing the limb's functionality. The surgeries typically involve bone and skin grafts, bone resection, reconstructive, and plastic surgeries and often occur over a period of months or years.

**Submit operative report for each surgery.**

| Limb Salvage | Date of first surgery (mm/dd/yyyy) |
|---|---|
| ☐ Salvage of left arm | |
| ☐ Salvage of left leg | |
| ☐ Salvage of right arm | |
| ☐ Salvage of right leg | |

**Certification of Surgeon**

I certify that the patient is undergoing limb salvage surgery as defined in the column to the right.

First Name of Surgeon

Last Name of Surgeon

Specialty

Additional Comments

X

Signature of Surgeon

Date Signed (mm/dd/yyyy)

Telephone Number

**PART B - Medical Professional's Statement (cont'd) -** to be completed by a medical professional who is a licensed practitioner of the healing arts acting within the scope of his/her practice.

Service member's Social Security number

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## 2 Qualifying Losses Suffered by Patient (cont'd)

**Paralysis is defined as:**

Complete paralysis due to damage to the spinal cord or associated nerves, or to the brain. A limb is defined as an arm or a leg with all its parts. Paralysis must fall into one of the four categories listed below:

- Quadriplegia - paralysis of all four limbs
- Paraplegia - paralysis of both lower limbs
- Hemiplegia - paralysis of the upper and lower limbs on one side of the body
- Uniplegia - paralysis of one limb

| **Paralysis** | Date of onset (mm/dd/yyyy) |
|---|---|
| ☐ Quadriplegia | |
| ☐ Paraplegia | |
| ☐ Hemiplegia | |
| ☐ Uniplegia | |

**Genitourinary System Losses**

**Anatomical loss of the penis is defined as:**

Amputation of the glans penis or any portion of the shaft of the penis above the glans penis or damage to the glans penis or shaft of the penis that requires reconstructive surgery.

Above the glans penis means closer to the body.

☐ Anatomical loss of the penis — Date of loss or amputation (mm/dd/yyyy)

**Permanent loss of use of the penis is defined as:**

Damage to the glans penis or shaft of the penis that results in complete loss of the ability to perform sexual intercourse that is reasonably certain to continue throughout the lifetime of the member.

☐ Permanent loss of use of the penis — Date of loss (mm/dd/yyyy)

**Anatomical loss of one testicle is defined as:**

The amputation of, or damage to, one testicle that requires testicular salvage, reconstructive surgery, or both.

☐ Anatomical loss of one testicle — Date of loss or amputation (mm/dd/yyyy)

**Anatomical loss of both testicle(s) is defined as:**

The amputation of, or damage to, both testicles that requires testicular salvage, reconstructive surgery, or both.

☐ Anatomical loss of both testicles — Date of loss or amputation (mm/dd/yyyy)

**Permanent loss of use of both testicles is defined as:**

Damage to both testicles resulting in the need for hormonal replacement therapy that is medically required and reasonably certain to continue throughout the lifetime of the member.

☐ Permanent loss of use of both testicles — Date of loss (mm/dd/yyyy)

**Anatomical loss of the vulva is defined as:**

The complete or partial amputation of the vulva or damage to the vulva that requires reconstructive surgery.

☐ Anatomical loss of the vulva — Date of loss or amputation (mm/dd/yyyy)

**Anatomical loss of the uterus is defined as:**

The complete or partial amputation of the uterus or damage to the uterus that requires reconstructive surgery.

☐ Anatomical loss of the uterus — Date of loss or amputation (mm/dd/yyyy)

**Anatomical loss of the vaginal canal is defined as:**

The complete or partial amputation of the vaginal canal or damage to the vaginal canal that requires reconstructive surgery.

☐ Anatomical loss of the vaginal canal — Date of loss or amputation (mm/dd/yyyy)

**Permanent loss of use of the vulva is defined as:**

Damage to the vulva that results in complete loss of the ability to perform sexual intercourse that is reasonably certain to continue throughout the lifetime of the member.

☐ Permanent loss of use of the vulva — Date of loss (mm/dd/yyyy)

**Permanent loss of use of the vaginal canal is defined as:**

Damage to the vaginal canal that results in complete loss of the ability to perform sexual intercourse that is reasonably certain to continue throughout the lifetime of the member.

☐ Permanent loss of use of the vaginal canal — Date of loss (mm/dd/yyyy)

**PART B - Medical Professional's Statement (cont'd) -** to be completed by a medical professional who is a licensed practitioner of the healing arts acting within the scope of his/her practice.

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**2 Qualifying Losses Suffered by Patient (cont'd)**

**Anatomical loss of the ovary is defined as:**
The amputation of one ovary or damage to one ovary that requires ovarian salvage, reconstructive surgery, or both.

☐ Anatomical loss of one ovary — Date of loss or amputation (mm/dd/yyyy)

**Anatomical loss of both ovaries is defined as:**
The amputation of both ovaries or damage to both ovaries that requires ovarian salvage, reconstructive surgery, or both.

☐ Anatomical loss of both ovaries — Date of loss or amputation (mm/dd/yyyy)

**Permanent loss of use of both ovaries is defined as:**
Damage to both ovaries resulting in the need for hormonal replacement therapy that is medically required and reasonably certain to continue throughout the lifetime of the member.

☐ Permanent loss of use of both ovaries — Date of loss (mm/dd/yyyy)

**Total and permanent loss of urinary system function is defined as:**
Damage to the urethra, ureter(s), both kidneys, bladder, or urethral sphincter muscle(s) that requires urinary diversion and/or hemodialysis, either of which is reasonably certain to continue throughout the lifetime of the member.

☐ Total and permanent loss of urinary system function — Date of loss (mm/dd/yyyy)

**Description of Injury/ Assistance Needed**
Please provide a description of the injury and descriptions of the assistance needed to perform each ADL. Failure to provide this information may delay processing of claim.

**What is the predominant reason the patient is/was unable to independently perform ADL?**
Check the predominant reason the patient cannot independently perform ADL and describe the injury in the box provided.

## Inability to Independently Perform Activities of Daily Living (ADL)

**Inability to Independently Perform ADL is defined as:**
Inability to independently perform at least two of six ADL (bathing, continence, dressing, eating, toileting and transferring). Inability must last for at least 15 consecutive days for traumatic brain injury and at least 30 consecutive days for any other traumatic injury.

The patient is considered unable to perform an activity independently only if he or she **REQUIRES** assistance to perform the activity. If the patient is able to perform the activity by using accommodating equipment, such as a cane, walker, commode, etc., the patient is considered able to independently perform the activity without requiring assistance.

**Requires Assistance** is defined as:

- physical assistance (hands-on),
- standby assistance (within arm's reach),
- verbal assistance (must be instructed because of cognitive impairment), without which the patient would be **INCAPABLE** of performing the task.

**What is the predominant reason the patient is/was unable to independently perform ADL?**

☐ Traumatic Brain Injury ☐ Other Traumatic Injury

(Please describe injury and give reason(s) it resulted in inability to perform activities of daily living.)

**PART B - Medical Professional's Statement (cont'd) -** to be completed by a medical professional who is a licensed practitioner of the healing arts acting within the scope of his/her practice.

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**2** **Qualifying Losses Suffered by Patient (cont'd)**

**Which ADL is the patient unable to perform?**
Check each ADL the patient cannot perform;
AND
Fill in the dates inability began and ended or indicate inability is ongoing.

**Require Assistance** is defined as:
- physical assistance (hands-on),
- standby assistance (within arm's reach),
- verbal assistance (must be instructed because of cognitive impairment),

**without which the patient would be INCAPABLE of performing the task.**

## Inability to Independently Perform Activities of Daily Living (ADL) (cont'd)

**Patient is UNABLE to bathe independently if…**

He/she **requires** assistance from another person to bathe (including sponge bath) more than one part of the body or get in or out of the tub or shower.

Describe assistance needed:

☐ **Unable to bathe independently**

Start date (mm/dd/yyyy) | End date (mm/dd/yyyy)

**OR** ☐ Check here if inability is ongoing

**Type of assistance required** (check all that apply)

☐ physical assistance (hands-on) ☐ verbal assistance (must be instructed because of cognitive impairment)

☐ standby assistance (within arm's reach)

**Patient is UNABLE to maintain continence independently if…**

He/she is partially or totally unable to control bowel and bladder function or **requires** assistance from another person to manage catheter or colostomy bag.

Describe assistance needed:

☐ **Unable to maintain continence independently**

Start date (mm/dd/yyyy) | End date (mm/dd/yyyy)

**OR** ☐ Check here if inability is ongoing

**Type of assistance required** (check all that apply)

☐ physical assistance (hands-on) ☐ verbal assistance (must be instructed because of cognitive impairment)

☐ standby assistance (within arm's reach)

**Patient is UNABLE to dress independently if…**

He/she **requires** assistance from another person to get and put on clothing, socks or shoes.

Describe assistance needed:

☐ **Unable to dress independently**

Start date (mm/dd/yyyy) | End date (mm/dd/yyyy)

**OR** ☐ Check here if inability is ongoing

**Type of assistance required** (check all that apply)

☐ physical assistance (hands-on) ☐ verbal assistance (must be instructed because of cognitive impairment)

☐ standby assistance (within arm's reach)

**Patient is UNABLE to eat independently if…**

He/she **requires** assistance from another person to:
- get food from plate to mouth, OR
- take liquid nourishment from a straw or cup, OR

he/she is fed intravenously or by a feeding tube.

Describe assistance needed:

☐ **Unable to eat independently**

Start date (mm/dd/yyyy) | End date (mm/dd/yyyy)

**OR** ☐ Check here if inability is ongoing

**Type of assistance required** (check all that apply)

☐ physical assistance (hands-on) ☐ verbal assistance (must be instructed because of cognitive impairment)

☐ standby assistance (within arm's reach)

**PART B - Medical Professional's Statement (cont'd) -** to be completed by a medical professional who is a licensed practitioner of the healing arts acting within the scope of his/her practice.

Service member's Social Security number

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## 2 Qualifying Losses Suffered by Patient (cont'd)

### Inability to Independently Perform Activities of Daily Living (ADL) (cont'd)

**Patient is UNABLE to toilet independently if…**

He/she must use a bedpan or urinal to toilet, OR

he/she **requires** assistance from another person with any of the following: going to and from the toilet, getting on and off the toilet, cleaning self after toileting, getting clothing off and on.

Describe assistance needed:

☐ **Unable to toilet independently**

Start date (mm/dd/yyyy) | End date (mm/dd/yyyy)

**OR** ☐ Check here if inability is ongoing

**Type of assistance required** (check all that apply)

☐ physical assistance (hands-on)

☐ verbal assistance (must be instructed because of cognitive impairment)

☐ standby assistance (within arm's reach)

**Patient is UNABLE to transfer independently if…**

He/she **requires** assistance from another person to move into or out of a bed or chair.

Describe assistance needed:

☐ **Unable to transfer independently**

Start date (mm/dd/yyyy) | End date (mm/dd/yyyy)

**OR** ☐ Check here if inability is ongoing

**Type of assistance required** (check all that apply)

☐ physical assistance (hands-on)

☐ verbal assistance (must be instructed because of cognitive impairment)

☐ standby assistance (within arm's reach)

## 3 Other Information

**To your knowledge, were any of the losses indicated in Part B due to:**

a. an intentionally self-inflicted injury or an attempt to inflict such injury,
b. use of an illegal or controlled substance that was not administered or consumed on the advice of a medical doctor,
c. the medical or surgical treatment of an illness or disease,
d. a physical or mental illness or disease (not including illness or disease caused by a pyogenic infection, a chemical, biological, or radiological weapon, or the accidental ingestion of a contaminated substance).

**If yes**, please explain below:

## 4 Medical Professional's Comments

Use this block to provide any additional information about the patient's injuries. When a narrative description is required, please be complete and concise.

**PART B - Medical Professional's Statement (cont'd) -** to be completed by a medical professional who is a licensed practitioner of the healing arts acting within the scope of his/her practice.

Service member's Social Security number

## 5 Medical Professional's Information

**Name of Medical Professional**

First Name

MI

Last Name

Medical Professional's Address (number and street)

Suite

City

State

ZIP Code

Telephone Number

Fax Number

Email Address

Specialty

Medical Degree

Medical Professional's License number

## 6 Medical Professional's Signature

☐ I have been directly involved in the patient's care for his/her loss.

☐ I have not treated the patient for his/her loss but I have reviewed the patient's medical records.

**Do you feel the claimant is competent to endorse checks and direct the use of the proceeds?** ☐ Yes ☐ No

This Medical Professional's Statement is based upon my examination of the patient, and/or, a review of pertinent medical evidence. I understand the patient and/or I may be asked to provide supporting documentation to validate eligibility under the law.

X

Signature

Date (mm/dd/yyyy)

**WARNING**: Any intentionally false statement in this claim or willful misrepresentation relative thereto is subject to punishment by a fine of not more than $10,000 or imprisonment of not more than five years, or both. (18 U.S.C. 1001)