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**Chapter 31. Disability Benefits on National Service Life Insurance**

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**31.01 TOTAL DISABILITY**

Total disability is defined as any impairment of mind or body which continuously renders it impossible for the insured to follow any substantially gainful occupation. Continuous, as referred to above, means with reasonable regularity or continuity. It should not be restricted or interpreted in its absolute sense. Substantially gainful occupation is any kind of work for which the insured may be fitted, trained, or qualified mentally and physically. The occasion, source, or cause of the insured's disability (physical or mental due to injury or illness/disease) is immaterial. The fact that the disability resulted from the insured's misconduct is immaterial.

**31.02 STATUTORY DISABILITY**

Statutory disability is defined, without prejudice to any other cause of disability, as the permanent loss of the use of both feet, of both hands, or of both eyes, or of one foot and one hand, or of one foot and one eye, or of one hand and one eye, or the total loss of hearing of both ears, or the organic loss of speech, shall be deemed to be total disability for insurance purposes.

1. The loss of use of a foot or hand shall be deemed to exist when no effective function remains other than that which would be equally well served by an amputation stump with use of suitable prosthetic appliance; i.e., when the member is impaired in effectiveness to a degree where there is loss for all practical purposes of those functions for which the member is normally used.
2. The loss of use of an eye shall be deemed to exist when the disabled person has impairment of central visual acuity in such eye to 5/200 or less after correction, or where the visual field of such eye has been reduced by concentric contraction to within 5 degrees or less of point of fixation. This is based on the VA Rating Schedule of Disability for Organs of Special Sense that grants a 100% rating for loss of use of eye based on visual acuity or visual field.
3. Total loss of hearing shall be deemed to exist where the disabled person has sustained the total loss of bone and air conduction in both ears under current testing criteria after an audiology examination.
4. Organic loss of speech shall be deemed to exist where the disabled person has lost the ability to express himself either by voice or whisper through the normal organs of speech by reason of organic changes in such organs. Where such loss exists, the fact that some speech can be produced through the use of artificial appliance or other organs of the body will be disregarded.

**31.03 PRIMARY REQUIREMENTS**

Disease or injury per se, unless statutory, is insufficient to support an affirmative finding of total disability, no matter how severe. Such finding must be based upon disease or injury with unemployment resulting therefrom. Similarly, such finding may not be based upon unemployment in conjunction with disease or injury in the absence of evidence establishing that such unemployment is the reasonable consequence of the disease or injury.

1. It must be established that the existing disease or injury is sufficient to lay the foundation for the claim for insurance benefits. It is then a question of the extent of impairment. The extent of the injury or disease as reflected in his/her unemployability must be considered. It should be borne in mind that under existing criteria it is not necessary that an insured establish complete helplessness and unemployability in order to persuade the VA to acquiesce in totality. It is sufficient that, by reason of his/her physical or mental condition, the insured has been deprived of ability to perform a substantial amount of work performed by others engaged in the same occupation. One must avoid the danger of projecting him/herself into the insured's shoes. To say that one would not consider him/herself totally disabled under the same circumstances is merely to beg the question unless one has first satisfied him/herself that, except for the insured's impairment he/she and one's self are equal. Such a comparison would very likely not properly evaluate the difference in will power, in tenacity of purpose to overcome the handicap, and in resistance between the insured and one's self. As a proper approach to a sound determination, consideration must be given to the effect of special factors, such as convalescence, apparent arrest, remission, anatomical losses, and certain diseases, such as epilepsy, leprosy and mental diseases, which are frequently prone to render the insured an industrial outcast.
2. The questions to be determined are: Does the insured have an impairment? Does the impairment in fact prevent him from continuously following substantially gainful employment? Is the disability (for total and permanent insurance benefits) founded upon conditions which render it reasonably certain that the disability will continue throughout the life of the disabled person?

**31.04 DISTINCTION BETWEEN COMPENSATION OR PENSION AND INSURANCE**

**ADJUDICATION**

The standards for determining the degree of disability for pension or compensation purposes and insurance are distinctly dissimilar. The extent of disability for pension or compensation purposes is determined on the basis of a rating schedule founded on average-person impairment. In contrast, since the rights to insurance benefits are founded on contract, the extent of disability must be measured by its effect on the insured in the individual case. The former cannot be determinative for insurance purposes and the latter cannot be determinative for pension or compensation purposes. Accordingly, consideration must be given to the particular facts in each case, such as age, type of work the individual is trained for, his/her mental capacity, his/her mental attitude, and his/her educational background.

**Note**: The definition of “average-person impairment” is a test the courts use to evaluate ratings for compensation and pension purposes. The test gets its name from its use in the statutes, as follows, “the ratings shall be based, as far as practicable, upon the average impairments of earning capacity resulting from such injuries in civil occupations.” 38 USC 1155; “Any disability which is sufficient to render it impossible for the average person to follow a substantially gainful occupation.” 38 USC 1502(a)(4)(A); Brown v. Derwinski 2 Vet. App. 444 (1992).

**31.05 HOSPITALIZATION**

Based on the fact that an individual cannot work and be an inpatient in a hospital at the same time, an insured undergoing hospitalization for treatment of disease or injury is considered totally disabled. This rule does not apply where the insured is hospitalized solely for purpose of quarantine or observation.

**31.06 CONVALESCENCE**

Though an insured's injuries may have healed, or the disease from which he/she has suffered is no longer active, if it is prudent and sound medically for him/her to remain in convalescence for a further period to recoup his/her strength, such further period will be considered as one of total disability. The length of periods of convalescence which will be so considered varies with the individual case, with relatively short periods being adequate generally in cases of acute disease or injury which are not extensive and considerably longer periods in cases of chronic disease or injury of extensive nature. Some diseases require prolonged convalescence. Because of difficulty in determining when the disease has ceased to be active, and proneness to reactivation, definite arrest is often times not determined until a relatively long period of restricted activity coupled with a regimen of rest has expired. During such period the insured must demonstrate a favorable response to graduated exercise. Accordingly, in the absence of affirmative evidence to the contrary, the insured during such period may be considered as totally disabled.

**31.07 EPISODIC/REMISSION**

1. Physical Illness/Diseases or Injuries - Many physical illness/diseases or injuries, such as multiple sclerosis, Hodgkin’s disease, cancer, and seizures are prone to periods of remission. This means that the condition may be temporarily inactive and have a lesser impact on the Veteran’s ability to work.
2. Mental Illness/Diseases - Many mental illness/diseases, such as schizophrenia, anxiety, depression, PTSD, or bipolar disorder are episodic in nature (when on or off medication). This means that the condition may improve during certain periods while the Veteran is on medication or in therapy.
3. In all such instances related to a and b above, the Veteran should not be considered as recovered following a period of active symptoms unless it is found that the episode/remission is definite and complete. Where there is a period of relative good health intervening between two periods of active symptoms, a finding of total disability with respect to the intervening period would depend upon the length and extent of this period. If it was so brief as to raise a doubt as to its being a period of relative good health or so limited that there was no opportunity to demonstrate ability to work, an affirmative finding in this connection may be made. Also, even though the period extended over several months, if the period of relative good health was only partial, the insured would be considered as totally disabled. The latter conclusion would not be reached, however, in the presence of an affirmative record of continuous and substantially gainful employment during such period.

**31.08 MEDICAL CONDITIONS THAT LEGALLY BAR EMPLOYMENT**

An individual's medical condition may legally prevent them from being employed in certain types of occupations (e.g. epileptics operating heavy machinery or driving). This is not in and of itself sufficient to support a finding of total disability; but it must be given consideration in cases where other pertinent factors are not sufficiently persuasive for an affirmative finding in this connection.

**31.09 AGE**

Age is an important factor in determining whether an individual is capable of following an occupation efficiently; not because age itself is a deterrent to, or a criterion for one's ability to work, but rather because of the body changes accompanying the aging process. Because of the principle of making total disability findings on the basis of individual impairment, we must consider the debilitating effect of age upon the particular individual concerned and not upon the average person. Accordingly, retirement, irrespective of the category of employment involved, is not persuasive in determining whether one has become totally disabled. The determination must be based on the degree of impairment of mind and body due to disease or injury and the degenerative effects of aging. These must be evaluated in the light of the vocational experience of the individual concerned. However, while the degree of impairment must be considered in relation to the physical and mental rather than the chronological age of the individual affected, it is still to be remembered generally that the same degree of impairment may be more limiting for an older employee than for a younger one.

**31.10 EXTENT AND NATURE OF WORK**

Total disability as defined above does not mean the insured is unable to perform a particular occupation, but rather means the insured is unable to perform any continuous and substantially gainful occupation. However, the rule must be applied reasonably with relationship to those occupations for which the insured's prior vocational or professional experience and background equip him/her. If the insured’s education, experience, or background would allow for substantially gainful employment in other occupations, he/she would not necessarily be considered totally disabled. However, in the face of facts demonstrating his/her inability to perform his/her previous or similar occupations, mere speculation as to what work he/she might be able to perform should be avoided.

**31.11 AVERAGE HOURS AND WAGES**

The words continuously and substantially gainful in the definition of total disability relate to the particular work or position in which the insured has been customarily employed. It is not necessary that he/she work the maximum number of hours or receive the maximum rate of pay for the job. If he/she works an extensive period without excessive loss of time due to illness and receives income within the range usually paid for similar work, the employment should be considered continuous and substantially gainful. A brief period of employment, however, should not be too readily accepted as proof of continuous and substantially gainful work, for an unsuccessful work attempt is indicative of continuing disability. See 31.25.b. Marginal employment shall not be considered substantially gainful employment. For purposes of this section, marginal employment generally shall be deemed to exist when an insured’s earned annual income does not exceed the amount established by the U.S. Department of Commerce, Bureau of the Census, as the poverty threshold for one person. Marginal employment may also be held to exist, on a facts found basis (includes but is not limited to employment in a protected environment such as a family business or sheltered workshop (See 31.13 through 31.15)), when earned annual income exceeds the poverty threshold. Consideration shall be given in all claims to the nature of the employment and the reason for termination. (See 38 CFR 4.16)

**31.12 SPORADIC AND PART-TIME EMPLOYMENT**

If it is found that the work record of an insured reflects only part-time employment; or, if full time, that such work was of a sporadic nature, the medical aspects of the case must be carefully considered to ascertain if the insured is able to carry on steadily on a full-time basis. If not, the work record should be disregarded.

1. Part-time employment is 20 hours or less per week.
2. Sporadic employment can be full or part-time; however, it occurs infrequently, irregularly, or in scattered instances rather than on a continuous or regular basis.

**31.13 SHELTERED EMPLOYMENT AND WORKING TO ONE'S DETRIMENT**

1. Sheltered employment is not a substantially gainful occupation because the insured cannot work in a competitive environment. For instance, if the insured requires a considerably higher degree of supervision than his/her fellow workers, or if there is always someone present to fill in for him/her, the insured is working in a sheltered employment setting and is not substantially gainfully employed. A decision that the insured is working in sheltered employments should only be made on the basis of evidence reflecting the day-to-day details of the work.
2. There are cases where an insured is continuously following a substantially gainful occupation, but is injuring his/her physical or mental health by so doing. In such cases, the insured is considered to be totally disabled despite the work record, because he/she is working to the detriment of his/her health. The test to be used in such cases is whether the insured has the ability to work without serious peril to his/her life or health, or without the risk of substantially aggravating the ailment with which he/she is afflicted. However, this principle cannot be used to grant benefits indefinitely. If the insured, does in fact, continuously follow a substantially gainful occupation for an extended period of time, and if there is no evidence that his/her physical or mental health has been impaired, disability benefits should be stopped because the evidence shows in fact that the insured was not working to his/her detriment.

**31.14 COMPENSATED WORK THERAPY**

VA’s Compensated Work Therapy Program aims to provide veterans an opportunity to gain valuable long term employment skills and also give them the resources they need for a hopeful future. Insureds who are part of this program or who are residents of a VA Domiciliary and can perform some degree of work under close supervision as a form of rehabilitation therapy, not in competition with able bodied persons, are not substantially gainfully employed. Pay in association with these programs is a gratuity or an award payable by VA to the patient or member as a part of the expense of the therapeutic and rehabilitative program as distinguished from salary or wages, earnings or an additional monetary benefit to the Veteran. Such employment will be not considered in determining the total disability of the insured.

**31.15 SELF-EMPLOYMENT**

Where the insured is engaged in the operation of his/her own business, care must be taken in determining whether the operation is in fact substantially gainful for purposes of granting total disability insurance benefits. The important factors to be considered in these cases are those related to physical and mental participation in the business; the number of hours worked per day, the number of days per week the insured is so engaged, and the nature of the duties performed, etc.

**31.16 REQUIREMENTS**

The insured or a person acting on his/her behalf must submit written application, as follows:

1. For V, J, JR, JS, RS, or W policies, either:
2. Proof of statutory disability, or
3. Proof of total disability of six or more consecutive months, which commenced on or subsequent to the effective date of insurance or date of application, whichever is later, while the insurance was inforce on a premium paying basis, prior to age 65.
4. For SDVI policies, either:
5. Proof of statutory disability, or
6. Proof of total disability of six or more consecutive months prior to age 65.

**NOTE**: If the evidence on file is sufficient to prove total disability for six or more consecutive months prior to age 65 at the time of application for Basic S-DVI, waiver of premium may be processed without a formal application for waiver.

1. In the event of the death of an insured who did not file an application for waiver, an application may be filed by the beneficiary, with evidence of the insured's right to waiver, within 1 year after the death of the insured; or, if the beneficiary is incompetent or a minor, such beneficiary may file application, with evidence of insured's right to waiver, within 1 year after removal of the legal disability or proof of age of majority. This provision does not grant any rights to Supplemental S-DVI after death, even if such waiver is granted. (See Chapter 15)

**31.17 INSURANCE DEEMED IN FORCE (PREMIUM-PAYING BASIS)**

1. The term premium-paying basis applies to all insurance programs. However, as noted in 31.16b, waiver of premiums can be issued on S-DVI, even if the total disability began prior to the policy issuance/effective date.
2. Insurance will be deemed to be in force on a premium-paying basis in any instance where information from the service department shows that an allotment for payment of premiums was established for the contract, even though deductions from pay for such purpose were not made.
3. Extended insurance will not be considered as insurance in force on a premium-paying basis as the wording of the contract of insurance itself provides for extended insurance only after the policy has lapsed.

**31.18 NECESSITY FOR A CLAIM**

An NSLI policy is a contract between the U.S. Government and the insured. It sets the rights, responsibilities, and liabilities of both under the contract. In the event of disagreement as to claim, an action on the claim may be brought against the United States under the provisions of 38 U.S.C. 1984. The purpose of requiring the filing of a claim as prerequisite to suit on the policy is to give the Government notice that claim is being made so it may make investigation and award any benefits due without being subjected to the expense of litigation. A claim after death for insurance benefits is a claim for waiver of premiums. Should the waiver of premium not be considered at point of claim, it can still be applied for if necessary, to mature the insurance under 31.16c.

**31.19 DEFINITION OF CLAIM**

1. A claim is any correspondence from the insured or any person acting on his/her behalf which indicates an intent or desire to file claim for disability insurance benefits under NSLI. The date of this correspondence will be used to determine the timeliness of the claim. However, the claimant may be required to furnish a formal claim for the pertinent information needed.

**NOTE**: The submission of an online application through the VA Insurance website by the insured is considered a valid claim for insurance benefits. Additionally, emailed applications from the insured or any person acting on his/her behalf will be considered a valid claim for insurance benefits.

1. The signature of the insured or any person acting on his/her behalf is not required on the claim, if the intent to apply is clear. If there is doubt as to the insured's authorization of the paper, appropriate inquiry should be made of him/her to learn whether he/she did authorize the action.

**NOTE**: The submission of an online application through the VA Insurance website by the insured will be considered a valid, signed application due to the online credentialing required as part of the application process.

1. An inquiry as to the status of insurance will not be considered a claim for disability insurance benefits. In instances where a claim is filed by someone on behalf of the insured, and it appears that the insured may be incompetent or otherwise incapable of filing on his/her own behalf, the claim will be accepted for purposes of establishing a claim date. Claims for compensation, pension, or educational benefits are not considered claims for disability insurance benefits.
2. If the insured dies without filing a claim for waiver, such claim may be filed by the beneficiary within l year after the death of the insured. If the beneficiary be incompetent or a minor, claim may be filed within l year after removal of legal disability.
3. When an insured files a claim for total or total and permanent disability insurance benefits, it will apply to all basic insurance contracts in effect. This does not include Supplemental S-DVI plans of insurance. For example, if the insured has a V policy and an RH policy and the claim only indicates the V policy, approved disability insurance benefits would apply to both the V and RH policies.

**31.20 TIMELINESS OF FILING A CLAIM**

1. The maximum amount of premiums eligible to be refunded cannot exceed more than one year of back premiums from the date of application for waiver in the absence of satisfactory evidence of circumstances beyond the insured's control which prevented his or her making timely claim. The one-year maximum premium refund rule applies regardless of whether the insured is living or deceased. See 31.20b for handling of waiver in case of deceased insured.
2. Similarly, with timely applications filed by beneficiaries after the death of an insured, waiver of premiums becoming due more than l year prior to death may not be waived unless the insured's failure to timely file claim was due to circumstances beyond his or her control. Circumstances or conditions which may permit, although not necessarily require, a finding that the insured was prevented by circumstances beyond his or her control from filing a timely claim, may include mental or physical disability of such severe degree as to render the insured incapable of taking care of his or her affairs within a reasonable timeframe, or when there are other unusual and extenuating circumstances which are a reasonable cause of the insured's failure to make timely application. Generally, the lack of knowledge of the nature of his or her disability is not a circumstance beyond the insured's control. However, there are exceptions to this general rule. If the insured did not know that he or she was suffering from a terminal illness until death became imminent, the failure to timely file claim will be excused. If the insured lacks knowledge of the nature of his or her disability and does not realize how disabled he or she is, but tries unsuccessfully to work, or, if he or she lacks knowledge of the nature of his or her disability and continues in substantially gainful work at a detriment to his or her health, the failure to timely file claim will be excused. If any VA office or system receives information in writing that discloses the existence of severe disabilities and potential entitlement to disability insurance benefits and fails to apprise the insured of his or her probable rights to the benefits, such failure is deemed an incomplete action by VA and, as such, constitutes extenuating circumstances that will excuse the failure to timely file claim. When circumstances beyond the control of the insured excusing the failure to file timely are found, waiver of premiums will be effective during the one-year period prior to the filing date plus the period during which he or she was prevented from filing.
3. The appointment of a guardian does not change the requirement for timely filing of claim. Even though the guardian may neglect for years to file a claim on behalf of the insured, the test remains whether or not the insured was prevented from filing claim on time due to circumstances beyond his or her control.

**31.21 DEFINITION OF EVIDENCE**

1. Evidence is any proof that:
2. establishes or helps to establish a fact or the truth of a statement,
3. makes clear an issue or question, or
4. tends to prove or disprove any matter in question, or to influence the belief respecting it.

1. Proof is a type of evidence that provides legally sufficient reasoning to establish the claim of the insured, a person acting on his/her behalf, or his/her beneficiary. Testimony is a still more restricted form of evidence that is delivered by a witness in a legal action, either orally or in the form of affidavits or depositions.

**31.22 EVIDENCE IN SUPPORT OF CLAIM**

1. All pertinent evidence to substantiate the eligibility and timeliness of a claim must be filed before any final action may be taken. Such evidence may include:

1. detailed medical and occupational records,
2. Such evidence may include a complete report of the insured's employment status, indicating the manner in which he or she performs his or her work (if any) notwithstanding his or her impaired condition.
3. Medical diagnoses must be supported by appropriate findings set forth in the records; and such findings must indicate the degree of severity of the impairment.
4. Employment evidence should include the exact dates of employment; the nature of the work involved; the amount of time lost from work on account of illness or injury; the insured's reason for terminating his or her employment; and all other facts necessary in determining the scope of employment and the duties and responsibilities of the insured.
5. The educational and vocational background of the claimant should be ascertained.
6. proof that the insured failed to file a timely claim due to circumstances beyond his or her control, or
7. documentation that indicates potential fraud in obtaining or reinstating the insurance,
8. information that suggests a possibility of incompetency, (An independent determination of incompetency is not necessary if the insured has been determined incompetent by a court or has been rated incompetent by VA.)
9. proof of entitlement under 38 USC 1914
10. Pertinent evidence is evidence that is relevant or applicable to the matter at issue.
11. Lay evidence may be submitted when private medical statements or employer statements are not available or to supplement such statements. The weight to be given the lay evidence must depend entirely on facts and circumstances in the individual case. In each case, the merits of the claim must be determined on the basis of the nature and extent of disability in official clinical records, VA medical reports, statements of reputable private physicians, and the official report of the employer. Lay evidence in conflict with such records cannot as a general rule be accorded substantial weight. On the other hand, if such records are not obtainable, lay evidence should be considered as it may be the only evidence obtainable.

**31.23 PERIODS OF TOTAL DISABILITY**

To establish total disability for insurance purposes, the claimant must prove based on evidence of record that they were unable to perform substantially gainful employment for a period of six or more consecutive months. The six-month criteria does not apply when a statutory disability exists.

**31.24 BEGINNING AND ENDING DATES OF TOTAL DISABILITY**

The beginning date of total disability will be that date on which, according to the evidence of record, the insured was first shown to be suffering from an impairment of mind or body which continuously thereafter rendered it impossible for him or her to follow any substantially gainful occupation. When the beginning date is based on some event, such as medical treatment or cessation of employment, which occurred in a certain month, but the exact date is not known, the last day of the month will be presumed to be the date in question. If the period of total disability has ended because of the insured's return to work or because of evidence showing his or her ability to again engage in continuous and substantially gainful employment, the ending date of the period of total disability will be either the date prior to the date of return to work or the date on which the medical evidence first showed that the insured's disability was no longer total in degree.

**31.25 MULTIPLE PERIODS OF TOTAL DISABILITY**

1. When the evidence reflects a period of six months total disability for both service-connected (SC) and non-service connected (NSC) conditions, the follow rules will apply:
2. If total disability is due to a NSC condition occurring after the insurance is in effect, waiver can be granted. Example: Application for S-DVI is received and approved from a Veteran who is 35 years old. He/She is paying premiums. At 50 years old, he/she is involved in a car accident and becomes totally disabled due to NSC conditions. Waiver can be granted in this scenario because total disability, regardless of whether due to SC or NSC, began after the insurance was in effect.
3. If total disability is due to a NSC condition occurring before the insurance is in effect, waiver cannot be granted. Example: Veteran is involved in a car accident and becomes totally disabled due to NSC conditions. Veteran also has SC conditions. Veteran applies for S-DVI and is approved as NSC from car accident does not cause him to exceed the allowable debits for health. Veteran cannot be granted waiver in this scenario as total disability due to an NSC began before the insurance was in effect.

See 39 USC 1912(a)

1. When the evidence reflects two or more periods of total disability for an existing insured, claims should be handled as follows:
2. If the insured was totally disabled for six consecutive months, followed by a period of substantially gainful employment, before again becoming totally disabled, the claim for total disability cannot be approved until a new six consecutive month period of total disability has been reached.
3. If the insured was totally disabled for six consecutive months, followed by a period of substantially gainful employment, before again becoming totally disabled, and the second period of total disability started after age 65, the claim for total disability cannot be approved.
4. If the insured was totally disabled for less than six consecutive months, followed by a period of substantially gainful employment, before again becoming totally disabled for less than six consecutive months, the claim for total disability cannot be approved until a full six consecutive month period of total disability has been reached.
5. If the insured was totally disabled for less than six consecutive months, followed by a period of substantially gainful employment, before again becoming totally disabled for less than six consecutive months, and the second period of total disability started after age 65, the claim for total disability cannot be approved.
6. Determining periods of employment should take into consideration unsuccessful work attempts. An unsuccessful work attempt is any employment in which the insured worked for less than six months and left employment due to his/her disabilities or hours are so limited due to medical issues as to result in part-time or sporadic employment.

**31.26 EFFECTIVE DATES**

1. The beginning date for total disability awards is the first premium due after the date of determination of total disability. In instances where failure to file timely claim partially limits the premium refund, the premium refund will be computed by determining the date which was up to l year prior to that on which claim was filed.
2. Where the insurance has been converted or changed to a permanent plan during the period in which the insured was totally disabled, the award will show waiver under the plan in effect prior to conversion or change terminating as of the date prior to the date of conversion or change and waiver on the converted or changed policy from the date of conversion or change.
3. Waiver of premiums on permanent plans of insurance issued or reinstated under 38 U.S.C. 1981 will be effective as of the premium due date in the month in which application for insurance is made, or commencing with the effective date of issue or reinstatement, whichever is later.
4. Waiver of premiums on insurance issued under 38 U.S.C. 1922(a) may be granted pursuant to the provisions of 38 U.S.C. 19 l 2 and such waiver may not be denied on the grounds that the service-connected disability became total prior to the effective date of the insurance. However, in order that there may be entitlement to waiver of premiums under 38 U.S.C. 1912, total disability must be found to exist for 6 or more consecutive months before the date of application for, or the effective date of the insurance whichever is later. Waiver of premiums on statutory awards are exempt from this 6-month rule. Where the insurance under this section is granted with a retroactive effective date, the total disability must exist for 6 or more months from the premium due date in the month in which application is made.
5. Where RH insurance is issued with an effective date subsequent to the insured's 65th birthday, waiver of premiums under 38 U.S.C. 1912 can be granted as of the effective date of the policy so long as his total disability commenced prior to his 65th birthday and has continued for 6 or more consecutive months.

**31.27 ENDING DATES OF AWARDS**

1. Where total disability is found to have existed for a limited period only, the ending date of waiver will be the last day of the premium month in which total disability ceases.
2. When a decision is made to terminate a waiver of premium on the basis of evidence showing insured is no longer totally disabled, waiver will be discontinued as of the ending date of the premium month in which total disability no longer exists. In multiple policy cases the premium end date may not be the same due to premium month cycling.
3. If the insurance effective date is the last day of a month, the last day of each succeeding month is the premium due date for such month. Accordingly, if it is found that the insured's final day of total disability in such instance is the last day of a month, the final day of waiver of premiums will be the last day of the month.
4. Where waiver of premiums is discontinued on insurance issued under 38 U.S.C. 1922(a) because of severance of service-connection of a total disability, the waiver will be discontinued as of the current effective date, and the insured given the opportunity to pay future premiums.

**31.28 FAILURE TO COOPERATE ON NEW CLAIMS**

Any competent claimant who, has failed without reasonable explanation to return necessary information within 30 days of the second of two follow-up requests, will be considered as having failed to cooperate. If a request for evidence from the insured is returned as undeliverable, every effort will be made to determine the correct address. Nevertheless, the insured's failure to keep the VA advised of his/her correct address will be sufficient basis for denying the claim on grounds of failure to cooperate. Final action in this respect, however, will not be taken until the end of 60 days from the date of the original request or upon the receipt of replies to all inquiries regarding correct address, whichever is later.

**31.29 FAILURE TO COOPERATE ON REVIEW ACTIONS**

1. The rules stated above with respect to an insured's failure to cooperate on a new claim for disability insurance benefits, apply generally to the failure of an insured to cooperate with VA on requests for evidence in connection with necessary periodic reviews of continuing awards. However, such an award may not be terminated solely because of an insured's failure to comply with two requests for evidence. In such case, refer to 31.29b.
2. In the event an insured does not comply with the two requests for evidence, the total disability waiver will remain in effect only in the following situations:
3. If evidence in VA systems indicates the insured is incompetent or proposed incompetent;
4. If the evidence in VA systems indicates the insured is unemployable;
5. If the evidence in VA systems indicates the insured has a statutory condition; or
6. If the evidence in VA systems clearly indicates the member continues to be unable to maintain substantially gainful employment.
7. If the insured indicates there were extenuating circumstances as to why they did not respond (e.g. in the hospital) and provides the required evidence within 30 days of notification of the circumstance.
8. If an insured’s disability waiver is terminated because they did not respond to requests for evidence and they later submit the required evidence, a supplemental decision will be prepared. Should this supplemental decision result in a continuing termination of the award, it will not extend the appeal period allowed the insured.

**31.30 SUPPLEMENTAL ACTIONS AND REVIEWS**

1. Adverse actions where new and relevant evidence is submitted will be reconsidered as follows:
2. Submit new and relevant evidence within the appeal period: The evidence will be reviewed and a determination will be made as to eligibility for total disability waiver. If the waiver cannot be approved, the insured will be provided the right to appeal the decision.
3. Submit new and relevant evidence after the appeal period: The evidence will be reviewed and a determination will be made as to eligibility for total disability waiver. If the waiver cannot be approved, the insured will be provided the right to appeal the decision.
4. In any case in which clear and unmistakable error appears in a decision, a review will be made at any time, and corrective action taken by supplemental decision.

**31.31 ROUTINE REVIEWS**

1. Except in statutory total disability cases, if an insured has recovered the ability to continuously follow substantially gainful employment, the waiver will be discontinued. Evidence may be medical in nature and/or relate to employment. If there is current evidence showing continuous and substantially gainful employment, the waiver may be terminated, except where there is evidence the employment is detrimental to the insured's health or under sheltered conditions. In weighing the evidence every reasonable doubt should be resolved in favor of the insured. If the medical evidence of record, even though not current, would under sound medical judgment indicate the continued existence of total disability, there is no need to update or obtain new medical evidence.
2. If the insured is receiving vocational rehabilitation under the provisions of 38 U.S.C. 3102, his/her waiver of premiums may be continued so long as he remains in training even though his disabilities have improved. Upon his rehabilitation or termination of training, his/her entitlement to continuation of waiver of premiums will be determined on the basis of the facts of his/her individual case.
3. In all routine reviews all available VA systems and evidence will be reviewed prior to a decision on continuation of total disability. Additional evidence will only be requested from the insured when all available evidence is insufficient to make a determination.

**31.32 TWENTY-YEAR CASES (38 CFR 8.31)**

Waiver of premiums for total disability which have been continuously in force for 20 or more years may not, in accordance with 38 CFR 8.31, be terminated except upon evidence showing that the waiver decision resulted from fraud. The 20-year period of disability will commence on such date as is determined by the VA Compensation and/or Pension, Federal court, or VA Insurance (based upon the laws as set forth under 38 USC 1912). Where all the evidence in a given case reflects more than 1 period of total disability, the 20 years referred to will commence as of the beginning date of the current period of such disability.

**31.33 ENDING DATE OF TDIP AWARDS**

1. The date of discontinuance of monthly installments will be the day prior to the due date of the next monthly installment following the action of discontinuance. The date of discontinuance of waiver of premiums on the total disability income provision will be the same as for the premiums on basic policy (the day prior to the due date of the next premium following the day discontinuance action is taken).
2. The criteria for determining entitlement or termination of waiver of premiums shall be applicable to findings for determining entitlement or cessation of monthly disability income benefits.
3. When the disability insurance benefits are effective on the 31st day of the month, the last day of each succeeding month will be the due date of the installment for that month.

**31.34 DECISIONS AS TO COMPETENCY**

All decisions on claims for total disability insurance benefits where a mental disability is involved will include a determination as to whether the insured is competent or incompetent.

1. Incompetency is a financial determination rather than a medical determination and indicates a disorder resulting in an inability to manage one's affairs, including disbursement of funds.
2. Previous determinations of incompetency by VA or a court of law will be followed in absence of satisfactory evidence the insured has recovered.

**31.35 STATUTORY PROVISIONS FOR INCONTESTABILITY**

Title 38 U.S.C. 1910 provides that all contracts or policies of insurance shall be incontestable from the date of issue, reinstatement, or conversion except for fraud, nonpayment of premium, or on the grounds that the applicant was not a member of the military or naval forces of the United States.

**31.36 DEFINITION OF FRAUD**

A false representation of fact with intent to deceive; upon which action was taken based on the misrepresentation.

**31.37 THE GOVERNMENT'S ROLE**

The Government in asserting fraud must do more than establish that the policy was issued, reinstated or converted because of false representations. It must establish that the fraud was present by clear and convincing evidence.

**31.38 APPLICABLE CRITERIA**

1. **Misrepresentation** - Fraud consists in the misrepresentation of a material fact by one who, knowing the falsity of his/her statement, intends to induce the person with whom he/she is dealing to act in reliance thereon, if by so doing the second person suffers a detriment.
2. **Material Fact** - To make an affirmative finding of fraud, it must be established that the misrepresentation was of material fact; not of a trivial matter although factual. The fact in question must have been sufficiently material to have induced the VA to act favorably on the applicant's request for issue or reinstatement of insurance.
3. **Knowledge** - The perpetration of fraud consists of a willful act. Accordingly, where the applicant has made a false statement of a material fact in connection with his/her application, or has failed to disclose certain material information relative to his/her health at such time, no fraud may be found where the circumstances disclose that the applicant was without knowledge of the falsity of his/her statement or of the true facts with respect to which he/she failed to make disclosure.
4. **Intent** - It must be clear that the applicant knew the VA needed the specific information requested on the form, and that he/she either furnished misleading information or withheld the truth knowing, or at least suspecting, that if the true information were brought out his/her application would have been denied.

**31.39 DOCTRINES OF NOTICE AND WAIVER**

1. Once a final decision is made on any insurance matter, VA is on notice of all information either expressly given or implied, in the record. Some specific examples of notice are listed below:
   1. If a physician provides evidence on a waiver application that the insured is totally disabled as of the date of application; but there is information on other VA systems indicating that the insured is currently working or is able to work but is not currently working, due to the condition(s) being claimed as disabling, VA is on notice of all work history.
   2. If an applicant has applied for compensation or pension and states that he/she has not received benefits, VA is on notice that he/she once suffered from a disability and development should precede acceptance.
2. The general administrative policy regarding fraud determinations is based largely upon well-settled principles of insurance law. These principles state that if an insurer is aware of facts which constitute fraud, but maintains the policy, thus leading the insured to believe they are still covered, the insurer waives the right to forfeiture.
   1. **CLEAR AND UNMISTAKABLE ERROR, EQUITABLE RELIEF, AND BENEFIT OF THE DOUBT**
3. Clear and Unmistakable Error (CUE)– 38 U.S.C. 5109A
   1. A clear and unmistakable error (CUE) exists if all three of the following requirements are met:
      1. either the correct facts were not known to VA Insurance or the statutory or regulatory provisions were incorrectly applied,
      2. the error, had it not been made, would have changed the outcome at the time it was made, and
      3. the determination must be based on the record and the law that existed at the time of the decision.
   2. The statute allows for Insurance to make an adjustment on a case based on a CUE without having to submit a request to the Secretary.
   3. Insurance employees should raise cases of CUE through their supervisory chain of command. The Assistant Director for Operations has the delegated authority to make adjustments due to clear and unmistakable error.
4. Equitable Relief – 38 U.S.C. 503
   1. Equitable relief is defined as is a remedy for an injustice done to a claimant resulting from mistakes made in applying rules and regulations that either:
      1. deprived the claimant of benefits, or
      2. caused the claimant to suffer a loss because he/she relied on an erroneous decision.
5. The statute vests sole decision-making authority for granting relief with the Secretary.
6. Insurance employees should raise cases of equitable relief through their supervisory chain of command. Any requests for equitable relief from Insurance require the approval of the Director for submission through VA Central Office.
7. Benefit of the Doubt -38 U.S.C. 5107(b)
8. The statute requires Insurance employees to consider all information and lay and medical evidence of record. When there is an approximate balance of positive and negative evidence, Insurance shall give the benefit of the doubt to the claimant/insured on the matter.

**31.41 SUBMISSION OF CASES FOR POSSIBLE PROSECUTION**

1. Generally, if a contract of insurance, including a disability rider, has been canceled due to fraud, the case will be referred to VA’s Office of Inspector General as appropriate.
2. Exceptions to the general rule:
3. Cases in which the statute of limitations (5 years) has run since filing of fraudulent document.
4. Cases involving incompetent veterans.
5. Cases involving veterans with terminal illnesses.
6. Cases where the veteran directly disclosed his/her fraudulent action.

**31.42 NECESSITY FOR DECISION**

1. Whenever benefits under insurance become payable because of the death of the insured as the result of disease or injury traceable to the extra hazard of military service, the liability for payment of such benefits shall be borne by the United States in an amount which, when added to the policy reserve at maturity, will equal the then value of such benefits. The amount shall be transferred from the NSLI appropriation to the NSLI fund.
2. Whenever insurance premiums are waived because of the total disability of the insured as the result of disease or injury traceable to the extra hazard of military service, there shall be transferred from time to time an amount equal to the amount of such premiums from the NSLI appropriation to the NSLI fund. VA is transferring a small amount of appropriated funds to NSLI from VII. The amount is determined by reducing the total transfers in the previous year by a calculated percentage from the NSLI appropriations to the NSLI fund. Fund transfers are applied to total collections of the NSLI fund.
3. Whenever benefits under TDIP become payable because of total disability of the insured as a result of disease or injury traceable to the extra hazard of military service, there shall be transferred from the NSLI appropriation to the NSLI fund from time to time any amounts which become, or have become, payable to the insured on account of such total disability. There shall be transferred from the NSLI fund to the NSLI appropriation the amount of the reserve held on account of the total disability benefit. In 2005, VA calculated the present value of the remaining TDIP extra hazard awards and had this amount transferred from NSLI fund to the NSLI appropriation. This ended the requirement for ongoing transfers needed for TDIP extra hazards.
4. When insurance benefits are awarded for death of the insured, or a waiver of premiums is granted, or TDIP benefits are awarded because of total disability of the insured, a determination must be made as to whether the injury or disease is traceable to the extra hazard of military service. In the NSLI program, determination of extra hazard is applicable to V policies only. There have not been any extra hazard claims since the NSLI program closed to new insureds. However, lifetime annuity payments for beneficiaries of prior extra hazard claims are still being paid. Annual transfers of NSLI appropriations to the NSLI fund for these annuity payments are calculated as part of the transfer noted in (b). In the unlikely event an extra hazard claim is identified in the future, NSLI appropriations will be used to settle an extra hazard death benefit. This will not impact the NSLI fund.
5. Extra Hazard Criteria
6. General. An affirmative finding of fact as to the extra hazard of military service in a given case requires that there be a reasonably clear showing that the insured would not have been exposed to the particular hazard involved but for his/her military service. It was not intended that there be charged to the extra hazard of service the cost of any claim arising from disease or injury to which the insured would ordinarily have been exposed in civilian life.
7. Effect of Line of Duty or Service Connection. A finding as to the extra hazard of service is not the same as either line of duty or service-connected findings. All affirmative findings as to extra hazard have to be based on injury or disease incurred in service and in line of duty; however, the reverse is not true. The test, with respect to extra hazard findings, is whether or not the particular disease or injury involved is traceable to the performance of duty.
8. Determining the Facts of the Particular Case. No claim will be found due to the extra hazard of service on the basis of speculation or in the absence of affirmative evidence; and all evidence must be carefully weighed. If any fact or circumstance creates a reasonable doubt that the disease or injury is traceable to the performance of duty, the loss involved will not be held due to the extra hazard of service.
9. Matters of Common Knowledge. Although exhaustive efforts must be made to obtain all necessary evidence, it must be remembered that in reaching decisions it will be necessary to take into consideration matters of common knowledge regarding which little, if any, information will be available.
10. Circumstances Usually Indicating Extra Hazard. Injuries sustained as the result of enemy action, as well as conditions which result from such injuries, will be deemed to be due to the extra hazard of military service. Likewise, death or injury suffered as the result of the performance of military duty will be so held; as will injury or death suffered as the result of airplane crash or motor vehicle accident while performing official duty, in the absence of willful misconduct or substantial negligence. In this last-mentioned respect, however, there will be excepted those instances where injury or death results from travel as a passenger on a regular flight of a scheduled airline in the United States or as the result of motor vehicle travel in vehicles substantially similar to ordinary passenger and commercial vehicles under conditions usually experienced in civilian travel. Death or disability resulting from tropical or oriental diseases or conditions which arise as the result of confinement as a prisoner of war will likewise be generally held to be due to the extra hazard of service. So, also, will diseases originating or aggravated as the result of exposure to the elements or adverse climatic conditions.
11. Circumstances Usually Precluding Extra Hazard. Disease or injury arising while the insured is on leave, furlough, liberty pass, or is absent without leave, is not held due to the extra hazard of military service. So, it is, also, with diseases or injuries resulting from the insured's willful misconduct or substantial negligence. Congenital defects and certain organic diseases, although they may arise during military service, cannot, under sound medical judgment, be held to have been caused by such service. However, if it is quite clear from the record, the latter conditions may be held due to extra hazard on the basis of aggravation.
12. Skin Conditions. Many skin conditions are the result of insect bites or irritation through contact with vegetation, particularly in tropical areas, and existing skin conditions are aggravated by heat and dampness of the tropics. Under either circumstance, it is proper to hold the condition due to the extra hazard of military service.
13. Accidents. Injury resulting from accident while performing military duty is traceable to the extra hazard of service in the absence of willful misconduct or substantial negligence. This rule also applies to accidents occurring while one is traveling under orders, except in instances cited in subparagraph (5) above. In cases of insured's traveling under orders and voluntarily using civilian motor vehicles, injury arising from accident should not be held due to extra hazard of service unless military urgency or similar circumstance contributed to the accident. Injury from aircraft accident is not due to extra hazard of service if the insured voluntarily participates as passenger or otherwise in a flight in a privately owned or rented airplane. Other accidents may, under some circumstances, be held to be due to the extra hazard of service if the insured, although not performing official duty, was present at his/her post, ship, or station and available for duty. Death or disability from recreational activity should not be considered as traceable to the extra hazard of service unless such activity was compulsory or was a part of the military training.
14. Contagious or Infectious Diseases. Although contagious and infectious diseases are contact diseases, the mere fact that such a disease is contracted while in the military service is not of itself sufficient to warrant a finding that it is due to the extra hazard of service. Such diseases contracted in the continental United States should be held to be due to the extra hazard of service only if it is shown that the insured was stationed in an area where the disease was epidemic. When such a disability is contracted outside the continental limits of the United States, it should be taken into consideration that the insured is exposed because the performance of his/her military duties requires his/her presence in that locality. Under such circumstances it is reasonable to hold that a disability so contracted is traceable to the performance of duty.
15. Pulmonary Tuberculosis. Pulmonary tuberculosis may be held to be traceable to the performance of duty when it is shown that the insured was exposed to gas while performing duty through contact with persons suffering from the disease or when his/her duties were of such an arduous nature that it may be presumed that the onset of the disability was due to the resulting lowering of his/her vitality. In determining whether disability or death from tuberculosis is based on contact with the disease is due to the extra hazards of service, consideration should be given to service in certain overseas areas where the incidence of the disease was markedly higher among certain types of troops. For instance, the incidence of tuberculosis in port areas of North Africa, Italy, France, the Islands of the Pacific, Philippine Islands and Japan during World War II, was such as to afford a basis for presuming that the disease was due to extra hazards of military service. Also, duties involving attendance of those who were ill give rise to a similar presumption. In determining whether the disability or death from tuberculosis to be deemed to have arisen from the arduous nature of the insured's duties, consideration should be given to long periods of imprisonment by the enemy as well as to sustained periods of exposure to the elements or service of considerable duration under combat conditions.
16. Mental Health. In considering mental health conditions consideration must be given to the history of mental health issues prior to service; the length of service prior to the onset of the condition; the degree of adjustment to military life following induction; the kind of service, that is, whether the insured was subject to any unusual stress such as combat, trauma, bombing, isolation, protracted stay in jungle; also, if he/she had a preexisting disability, whether this service was such as to aggravate it beyond its natural progress.
17. Suicide. Suicide will be held due to extra hazard of service if it is done while in a severe mental episode resulting from the pressures of military service, and there are not apparent any other reasons.
18. Age and Time. Insureds whose injury or disease was at one time due to the extra hazard of service and who subsequently regained the ability to engage in substantially gainful employment. Care should be exercised in holding the second claim due to the extra hazard of service. Where long periods of time intervene, the insured has engaged in or had the ability to engage in employment, the insured has reached the later years of life and incurred additional disabilities due to age, the second claim should not ordinarily be held due to the extra hazard of service unless the evidence clearly shows that the disease or injury which was due to the extra hazards of service is also the principal cause of the present period of total disability.
19. Disease or injury preexisting the issue of TDIP will not bar extra hazard determination. The Government shall bear the cost of the benefits under the total disability income provision whenever such benefits become payable because total disability of the insured resulted from disease or injury traceable to the extra hazard of the military service. The law does not limit such liability to diseases or injuries which occur after the issuance of the total disability provision. There will be cases in which health conditions originating in earlier military service are not present at the time of application. In other cases, even though detected and disclosed, the disease or injury will not be considered serious enough at the time of application to warrant rejection under the good health criteria.
20. Determinations concerning the extra hazards of military service will not be reversed except on the basis that such determination was a clear and unmistakable error.