

Office of Servicemembers' Group Life Insurance

Please send the completed form and all attachments to:

OSGLI PO Box 41618 Philadelphia, PA 19176

SGLI Disability Extension Application and Instructions

IMPORTANT INFORMATION ABOUT THE SERVICEMEMBERS' GROUP LIFE INSURANCE (SGLI) DISABILITY EXTENSION

The SGLI Disability Extension provides coverage for up to two years from your date of separation at no cost to you. The SGLI Disability Extension is available to Veterans who are totally disabled and had SGLI coverage at the time of their separation from service. To be considered totally disabled, you must have any impairment of mind or body which continuously renders it impossible for you to follow any substantially gainful occupation, OR have one of the following conditions, regardless of employment status:

- 1. Permanent loss of use of any of the following:
 - both hands

both feet

both eyes

- one foot and one eye
- one hand and one foot
- one hand and one eye

- 2. Total loss of hearing in both ears
- 3. Organic loss of speech (lost ability to express oneself, both by voice and whisper, through normal organs for speech. Note: Being able to speak with an artificial appliance is still considered a loss of speech.)

For more information about the SGLI Disability Extension, please visit: https://www.va.gov/life-insurance/options-eligibility/sgli/#can-i-get-a-free-extension-of-

HOW TO APPLY FOR THE SGLI DISABILITY EXTENSION

- Review and follow the applicable instructions within each section.
- Mail your completed application and required documentation OSGLI PO Box 41618 Philadelphia, PA 19176 or fax to 800-236-6142.

Important: You must include a copy of your most recent separation orders and your most recent **Leave and Earnings Statement (LES)** with your application. You may also send in a copy of your **DD-214** or **NGB22** in lieu of your **separation orders** and LES. You must also provide a copy of your completed VA rating decision (not a summary). This is the document that provides all medical and employment criteria used by the VA to determine your percentages related to each.

If your application is approved:

- You will receive written notification of your approval from the Office of Servicemembers' Group Life Insurance (OSGLI).
- Your SGLI coverage will be extended for a maximum of two years from your date of separation or until you are able to work, whichever comes first.
- Around 60 days prior to the end of your SGLI Disability Extension, you will receive a billing statement for Veterans' Group
 Life Insurance (VGLI). Your VGLI coverage will begin the day after your SGLI Disability Extension ends, provided we've
 received your first VGLI premium payment. If you do not receive a billing statement at this time, please contact OSGLI
 immediately. If you don't pay the initial premium, you won't have the coverage. If you do not want VGLI, simply disregard the
 billing statement and you will not be enrolled for coverage. It is important that you provide OSGLI with up-to-date contact
 information to ensure you receive the billing statement.
- If your application is not approved, you will receive written notification of your denial. If you applied for the SGLI-DE within 1 year and 120 days from separation, you will also receive instructions on additional steps you can take to have your application considered for VGLI coverage.

QUESTIONS?

If you have any questions, please send an email to sgli.extension@prudential.com or call 800-419-1473, Monday through Friday, between 8:00 a.m. and 5:00 p.m. Eastern Time.





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SGLI Disability Extension Application

veteran 5 Stat	eilleilt Pi	lease read the instructions on page 1 before completing this forn
1 Veteran	First Name	MI Last Name
Information		
	Social Security Number Date	e of Birth (MM DD YYYY)
		Gender
	Address Line 1	Male Female
	Address Line 1	
	Address Line 2	
	City	State ZIP Code
	Country	Phone Number
	Email Address	
	Enter Address	
	Date of Separation (MM DD YYYY) Bran	nch of Service SGLI Coverage Amount
	Date of Separation (wind buttin)	Soci coverage Amount
		\$,
	*Unemployability means that VA has determined due to your disability. Please be advised, a disability rating of 100% does	that you are incapable of obtaining or maintaining gainful employment es not necessarily equate to unemployability.
Veteran's Impairment Statement	Note: Being able to speak with an artificial app • Important: You must include a com the VA with your application. A 'pr	Yes No Yes No Yes No one foot Yes No one eye Yes No one eye Yes No Yes No One eye No Yes No Yes No Yes No Yes No Yes No Oress oneself, both by voice and whisper, through normal organs for speech. Oliance is still considered a loss of speech. Inplete copy of the final VA rating decision document from roposed' rating cannot be accepted.
		s" to any of the permanent conditions above, you do not need an exam. Ir VA or Military rating decision that documents this loss to complete your

	☐ I am currently workin	☐ I am currently working more than 20 hours per week. ☐ I am currently working 20 hours per week or less.													
	☐ I am not currently working, but have worked since I separated from service. ☐ I have not worked since my separation from service due to my disability.														
	Are you currently working with special conditions or accommodations? Yes No														
		If yes, you must provide evidence of condition or accommodation. Satisfactory evidence may include a letter from your employer on company letterhead.													
	A special condition or accommodation is any condition or accommodation without which an individual would be unable to work without more supervision or assistance than required by other workers performing similar work.														
	If you need more space t	since your separation from se han is allowed, use a separa eparating from service, do no	ate sheet of paper ar												
Name, add	dress, and phone number	Type of work (e.g.,	Average number of hours worked	Dates of	employment										
	of employer	seasonal, occasional, or year-round)	per week	From (mm/dd/yyyy)	To (mm/dd/yyyy										
				1											
Veteran's Signature	I declare that, to the best of my knowledge and belief, the above statements are complete and true.														
งเรเเสเนเห	Any deception or false statement, either my reference, omission, or otherwise can result in loss of coverage or denial of a claims for benefits.														
	-			Date of S	Signature (MM DD YYYY)										
	x														

Veteran's Last Name

Last 4 digits of Social Security Number



Office of Servicemembers' Group Life Insurance

Authorization Form

Authorization				Claimant's Social Security Number											
for Release of Information	Name of Insured:														
to the Office	First Name	MI	Last Name												
of Service- members'															
Group Life	Date of Birth (MM DD YYYY)														
Insurance															
This Authorization is intended to	I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility or other health care provider that has provided treatment, payment, or services pertaining to:														
comply with the HIPAA	First Name MI Last Name														
Privacy Rule															
	Print Name of Deceased or Patient														
	or on my (his/her) behalf ("My Providers") to disclose my (his/her) entire medical record for me or my dependents and any other health information concerning me (him/her) to the Office of Servicemembers' Group Life Insurance (OSG and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy note														
	I authorize all non-health organizations, any insurance company, employer or other person, or institutions to provide a 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 (he/she) have made to restrict my (his/her) protected health information do not apply to this authorization and I instruct My Providers to release and disclose my (his/her entire medical record without restriction.														
	This information is to be disclosed under this Authorization so that OSGLI may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits, 2) obtain reinsurance, 3) administer coverage, and 4) conduction other legally permissible activities that relate to any coverage I (he/she) have (has) or have (has) applied for with OSGLI.														
	This authorization shall remain in force for 24 mor is in force. A copy of this authorization is as valid authorization in writing, at any time, by sending a Philadelphia, PA 19176. I understand that a revoca relied on this Authorization or to the extent that O or to contest the policy itself. I understand that any redisclosed and no longer covered by federal rules	as the origi written req ation is not SGLI has a information	nal. I understand that uest for revocation to effective to the exte legal right to contes in that is disclosed p	at I have the right to revoke this to OSGLI at: P.O. Box 41618, ent that any of My Providers has st a claim under an insurance polic oursuant to this authorization may											
	I understand that if I refuse to sign this authorization to release my (his/her) 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:														
		Date of Sig	nature (мм dd үүүү)												
Χ															
	atient or Personal Representative			Description of Personal Representativ Authority or Relationship to Patient											

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SGLI Disability Extension Application Physician's Statement

(This is not required if you are including a complete copy of your VA rating. We will follow up if IMPORTANT additional information is required.) 7 Instructions This section must be completed by your physician if you are not sending in your VA rating for the decision. IMPORTANT Physician: Your patient has requested coverage under the Servicemembers' Group Life Insurance (SGLI) Disability Extension program. Answer all applicable parts of this form completely. Your answers should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Please be as specific as you can. Patient's First Name ΜI Last Name Patient's Social Security Number Does the patient have an impairment of mind or body that continuously renders it impossible for him/her to follow any substantially gainful occupation? \square Yes \square No If you answered yes above, please provide details below. Include the date the impairment began and date the impairment prevented the patient from gainful employment. What is the patient's clinical diagnosis? ICD Code is Required Diagnosis Date (MM DD YYYY) Primary:___ Secondary: _____ Secondary: Please describe any relevant test procedures performed. Please describe any relevant surgical procedures performed. Please list any medications the patient is currently taking. Was the patient hospitalized? \square Yes \square No If yes, provide dates of hospitalization:

TO (MM DD YYYY)

From (MM DD YYYY)

	Patie	ent's l	Last I	Nam	9											L	ast	4 d	igits	of S	ocia	ıl Se	curit	y Nu	ımber
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Is the patient capable	of l	han	dlin	g h	is/l	her	0W	/n a	ffai	irs?	' [Yes			No									
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Physician's Specialty																DI	L	nian	'o Dh	lono	Nur	mber			
Physician's Specialty	Τ																iyai	Ciaii	311	one	INUI				Т
Physician's Address										_								_							
City	1				_		Т		1					Sta	ate	7	[ZIP (Code			_			
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statement is true.								•										J				•			
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X																									
Physician's Signature																									

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