Form Approved
OMB No. 2900-0015

Department of Veterans Affairs

(FOR USE OF VA INDEX)

GOVERNMENT LIFE INSURANCE

APPLICATION FOR TOTAL DISABILITY INCOME PROVISION

(Medical)

NATIONAL SERVICE LIFE INSURANCE - This application should be used by applicant whose insurance age is 41 or over. Insurance age is the applicant's age on the birthday nearest the effective date of the provision applied for *(See paragraph 2 of Instructions).* Application for total disability income provision must be made before the insured's 55th birthday.

UNITED STATES GOVERNMENT LIFE INSURANCE - All applicants for the total disability income provision should use this form.

The United States is not liable if total disability occurs prior to the effective date of this provision or the date of this application, whichever is later.

NOTE: Please read Part IV, Important Information and Instructions, before completing this form. Type or use ink.

PART I - INFORMATION

1. FIRST NAME - MIDDLE NAME - LAST NAME OF INSURED

2. INSURANCE FILE NO. *(Include letter prefix)*

F

3. MAILING ADDRESS FOR INSURANCE PURPOSES *(No. and street or rural route, city or P.O. , Stae and ZIP Code)*

4. SOCIAL SECURITY NO.

5. TELEPHONE NO. OF INSURED *(Include Area Code)*

6. VA CLAIM NO. *(If any)*

C

7. POLICY NUMBER(S) AND AMOUNT OF INSURANCE FOR EACH POLICY TO WHICH TOTAL DISABILITY INCOME PROVISION IS TO BE ADDED.

POLICY NUMBER *(Include letter prefix V, K, J, RS, H or W)*	AMOUNT OF POLICY	POLICY NUMBER *(Include letter prefix V, K, J, RS, H or W)*	AMOUNT OF POLICY

NOTICE TO NATIONAL SERVICE LIFE INSURANCE POLICYHOLDERS WHO ALREADY HAVE A TOTAL DISABILITY INCOME PROVISION. If this application is approved, I hereby surrender the existing Total Disability Income Provision attached to my National Service Life Insurance policy or policies shown above. (DO NOT RETURN POLICY OR RIDER FORM).

NOTE: If the applicant has a Total Disability Income Provision attached to his/her National Service Life Insurance policy, the law requires that such provision must be surrendered as one of the conditions to issuing the Total Disability Income Provision applied for by this application.

8. METHOD AND MODE OF PAYMENT OF PREMIUMS *(See Instruction 3, Part IV)*

A. METHOD OF PAYMENT *(Check appropriate box and complete item indicated)*

- ☐ DIRECT REMITTANCE TO VA *(Complete Item 8B)*
- ☐ MONTHLY ALLOTMENT FROM ACTIVE SERVICE PAY *(Complete Item 8D)*
- ☐ MONTHLY DEDUCTIONS FROM VA COMPENSATION OR PENSION *(Complete Item 8C)*
- ☐ MONTHLY ALLOTMENT FROM SVC. DEPT. RETIREMENT PAY *(Complete Item 8D)*

B. MODE FOR DIRECT REMITTANCE

- ☐ MONTHLY
- ☐ QUARTERLY
- ☐ SEMI-ANNUALLY
- ☐ ANNUALLY

C. AMOUNT OF MONTHLY VA COMPENSATION OR PENSION RECEIVED

$

D. MONTH ALLOTMENT EFFECTIVE

E. AMOUNT OF FIRST PREMIUM ON TOTAL DISABILITY INCOME PROVISION

$

9. PLEASE HAVE THE EXAMINING PHYSICIAN MAIL THIS APPLICATION TO THE FOLLOWING ADDRESS:

DEPARTMENT OF VETERANS AFFAIRS
P.O. BOX 7208
PHILADELPHIA, PA 19101

PART II - STATEMENT OF APPLICANT *(Every question must be answered. Type or use ink. Date and sign statement at bottom of page.)*

The purpose of questions contained in STATEMENT OF APPLICANT is to secure complete information regarding the condition of the applicant's health. All diseases, injuries, abnormalities, deformities, infirmities, or the results thereof in impairment of bodily functions must be stated and fully described. Statements made by the applicant in this application are relied upon in granting this provision. Consequently, any deception or knowingly false statement either by inference, omission, or otherwise may result in cancellation of this provision or in the refusal to pay a claim on the policy.

Complete the following employment questions. If additional space is required, attach separate sheet and key answers to item number.

1A. ARE YOU NOW WORKING? ☐ YES ☐ NO	1B. DO YOU WORK FULL TIME? ☐ YES ☐ NO	1C. NO. OF HOURS WORKED PER DAY

1D. TYPE OF BUSINESS AND NATURE OF DUTIES	1E. IF NOT WORKING OR WORKING PART-TIME, EXPLAIN WHY

In completing Items 2A through 16 show all disabilities whether service-connected or nonservice-connected. Give full details to "Yes" answers in Item 17.

HAVE YOU EVER HAD OR BEEN TREATED FOR ANY OF THE FOLLOWING:	YES	NO		
2A. HEART TROUBLE OR MURMUR, CHEST PAIN, HIGH BLOOD PRESSURE OR ABNORMAL PULSE?				
2B. NERVOUS OR MENTAL DISORDER, PARALYSIS, SEVERE OR FREQUENT HEADACHES?				
2C. EPILEPSY, CONVULSIONS, DIZZY SPELLS OR LOSS OF CONSCIOUSNESS?				
2D. NEURITIS OR SCIATICA?				
2E. PLEURISY, ASTHMA, CHRONIC COUGH OR SPITTING OF BLOOD?				
2F. DISEASE OR ULCER OF STOMACH, INTESTINES OR RECTUM?				
2G. LIVER OR GALLBLADDER DISORDER, CHRONIC INDIGESTION OR CHRONIC DIARRHEA?				
2H. STONES IN KIDNEY OR URINARY TRACT OR PROSTATIC DISORDER?				
2I. ALBUMIN, BLOOD, PUS OR SUGAR IN THE URINE?				
2J. DIABETES, CANCER, SYPHILIS OR TUBERCULOSIS?				
2K. GOUT, ARTHRITIS, RHEUMATISM OR RHEUMATIC FEVER?				
2L. BACK OR SPINAL DISORDER?				
2M. GOITER OR THYROID DISORDER?				
2N. APPENDICITIS?				
2O. HERNIA, HEMORRHOIDS, VARICOSE VEINS OR VARICOSE ULCERS?				
2P. TUMOR, ABCESS, CYST OR GROWTH OF ANY KIND? *(Show type or location below)*				
2Q. IMPAIRED VISION OR HEARING OR EAR DISCHARGE?				
2R. HARDENING OF ARTERIES OR PHLEBITIS?				
2S. ACCIDENT, INJURY OR SURGICAL OPERATION?				

17. REMARKS (Give complete details to any "Yes" answer and Key answers to Item number. Include dates, physicians or hospitals and names and addresses. Indicate after explanation of each disability whether service-connected or nonservice-connected, and give date of last VA physical examination for compensation or pension and VA office which requested this examination. If additional space required, attach separate signed sheets.)

I consent that any hospital, physician or surgeon who has treated or examined me for any purpose, or whom I have consulted professionally, any insurance company or organization to which I have applied for insurance, or to any person, firm or corporation to whom or to which I have applied for employment may divulge to the Department of Veterans Affairs or in any suit against the United States by reason of the foregoing testify as to, or produce in court any information obtained by them, or it, concerning myself. I understand that the Government will rely on the truth of these answers. I HAVE READ ALL THE FOREGOING ANSWERS AND SAME ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

I am obliged to advise the Department of Veterans Affairs of any change of health condition arising after the signing and prior to delivery of this form to the Department of Veterans Affairs.

18. DATE	19. SIGNATURE OF APPLICANT (Do not print) (Sign in ink)

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