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 E-mail	Submit Claim by Postal Mail	
Army All Components	Phone: (800) 237-1336 Website: www.tsgli.army.mil	(866) 275-0684	tsgli@conus.army.mil	Army Human Resources Command Traumatic SGLI (TSGLI) 200 Stovall Street Alexandria, VA 22332-0470	
Marine Corps All Components	Phone: (877) 216-0825 or (703) 432-9277 Website: https://www.manpower.usmc. mil/pls/ portal/url/page/m_ra_home/wwr/ wwr_a_command_element/wwr_d_regi- mental_staff/3_s3/wwr_tsgli	(888) 858-2315	t-sgli@usmc.mil	HQ, Marine Corps Attn: WWR-TSGLI 3280 Russell Road Quantico, VA 22134	
Navy All Components	Phone: (800) 368-3202 / 901-874-2501 DSN 882 Website: www.npc.navy.mil/Command Support/ CasualtyAssistance/TSGLI	(901) 874-2265	MILL_TSGLI@navy.mil	Navy Personnel Command Attn: PERS-62 5720 Integrity Drive Millington, TN 38055-6200	
Air Force Active Duty	Phone: (800) 433-0048 Website: ask.afpc.randolph.af.mil	(210) 565-2348	afpc.casualty@randolph.af.mil	AFPC/DPWC 550 C Street West, Suite 14 Randolph AFB, TX 78150-4716	
Air Force Reserves	Phone: (800) 525-0102	(303) 676-6255	arpc.dippedl@arpc.denver.af.mil	HQ, ARPC/DPPE 6760 E Irvington Place, #4000 Denver, CO 80280-4000	
Air National Guard	Phone: (703) 607-0901	(703) 607-0033	tsgliclaims@ngb.ang.af.mil	NCOIC, Customer Operations Air National Guard Bureau 1411 Jefferson Davis Hwy Suite 10718 Arlington, VA 22202	
Coast Guard	Phone: (202) 475-5391	(202) 475-5927	compensation@comdt.uscg.mil	COMDT (CG-1222) 2100 2nd Street SW Washington, DC 20593-0001	
Public Health Services	Phone: (301) 594-2963	(301) 594-2973 or (800) 733-1303	compensationbranch@psc.hhs.gov	PHS Compensation Branch Parklawn Building 5600 Fishers Lane, Rm 4-50 Rockville, MD 20857	
NOAA Corps	Phone: (301) 713-3444	(301) 713-4140	Director.cpc@noaa.gov	U.S. Dept. of Commerce, NOAA 8403 Colesville Rd, Suite 500 Silver Spring, MD 20910	

OMB Control Number: 2900-0671 Re

Respondent Burden: 45 minutes

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GENERAL INFORMATION

The Servicemembers' Group Life Insurance Traumatic Injury Protection (TSGLI) program is a rider to Service member's Group Life Insurance (SGLI). The TSGLI rider 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

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 in the theaters of operation for Operation Enduring Freedom or Operation Iraqi Freedom may also be eligible for TSGLI payment. 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 www.insurance.va.gov/sgliSite/TSGLI.htm 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 or 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 or power of attorney or military trustee]	The medical professional	The medical professional OR the service member [or guardian or power of attorney or military trustee]
must complete Part A (pages 3 through 6) 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 (pages 7 through 12).	must forward Parts A & B to the member's branch of service TSGLI office listed on the front cover of this form.



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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. 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 incompetent, payment will be made under the appropriate letters of guardianship/conservatorship or a power of attorney to the guardian or power of attorney 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.

- 1. **Prudential's Alliance Account**®* (for member only) An interest-bearing account will be established in the name of the member. The member can access the money immediately using the draft book ("checkbook"). There are no monthly service fees or per-check charges and additional checks can be ordered at no additional cost. If you have any questions about Alliance, please call Alliance Customer Service toll free at 877-255-4262 or the OSGLI Claim Department toll free at 800-419-1473.
- 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.
 - **Note**: If the member does not choose EFT and there is no guardian or power of attorney, the payment will be made through Prudential's Alliance Account.
- Check Payment (for guardian or power of attorney only) A check will be issued to the guardian or power of attorney or military trustee on behalf of the member.

RESPONDENT BURDEN: We need this information to allow service members who are insured under Servicemembers Group Life Insurance and suffer a loss from a traumatic injury to receive monetary compensation. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 45 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.whitehouse.gov/omb/library/OMBINV.html#VA. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this survey.

PRIVACY ACT NOTICE: VA will not disclose information collected on this survey to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses identified in the VA system of records, 36VA00, Veterans and Armed Forces Personnel U.S. Government Life Insurance Records-VA, and published in the Federal Register. Your obligation to respond is voluntary. Giving us your Social Security number account information is mandatory. Applicants are required to provide their Social Security number under Title 38 USC

1980A. VA will not deny an individual benefits for refusing to provide his or her Social Security number unless the disclosure is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect.

* Open Solutions BIS, Inc. 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. Check clearing is provided by JPMorgan Chase Bank, N.A. and processing support is provided by Integrated Payment Systems, Inc. Alliance Account balances are not insured by the Federal Deposit Insurance Corporation (FDIC). Open Solutions BIS, Inc., JPMorgan Chase Bank, N.A., and Integrated Payment Systems, Inc. are not Prudential Financial companies.

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e member's Social Secu	
Service member	Service member's First Name MI Service member's Last Name
Information	
The service member, guardian or power of	Date of Birth (MM DD YYYY) Gender Marital Status
attorney MUST fill in member's Social	Male Married Divorced Single Widowed
Security number at the	Branch of Service Rank/Grade
top of pages 3 through 13 of this form.	Army PHS Marines Active Duty Reserves
Important Notes	Address of Record (number and street) NoAA
Important Note: Contact information	Apt. (ii ally letephole Number
must be completed. Incomplete information	City State ZIP Code
will delay payment of	City State ZIP Code
your claim.	
	E-mail Address
	Unit (at time of injury)
Guardian,	Complete this section ONLY if a guardian, power of attorney or military trustee will receive payment on behalf of the member
Power of Attorney or	First Name MI Last Name
Military Trustee	
Information	Mailing Address (number and street) Apartment (if any)
Important Note: Please include	
copies of the letters	City State ZIP Code
of guardianship, conservatorship, or	
Power of Attorney, etc. with this form.	Telephone Number Fax Number
Failure to include this	
documentation will delay payment of the	
claim.	
Traumatic	Injuries that Qualify for TSGLI Payment
Injury	In order to qualify for the TSGLI benefit, you must have experienced a traumatic event that resulted in a traumatic injury
Information	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. You may view the
	complete Schedule of Losses at www.insurance.va.gov/sgliSite/TSGLI.htm.

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
inioimation	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 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 C are eligible.	Office to find	dout if you
	Tell us about your traumatic Injury In the box below, please describe your injury and give the date, time and location where it occurred.		

ce member's Social Secu	Tty Number	
Payment Options	Please choose one of the three payment options below: Payment Option 1 - Prudential's Alliance Account®	(for member ONLY) To have the payment made through
Please choose one of the three payment options by checking the appropriate	Prudential's Alliance Account, fill in the mailing address be Service member's Mailing Address for Payment - No P.O. Boxes	
box and filling in the requested information.	City	tate ZIP Code
Payment Option 1 — Prudential's Alliance Account		To have the payment made by EFT, fill in your banking inform pank routing and bank account numbers. Please print clea
An interest-bearing account will be established in the	Built reduing Number	Cher
name of the member, who can access the money using the draft	Bank Name	Bank Phone Number
book ("checkbook").	First Name 1	//I Last Name
Payment Option 2 – Electronic		
Funds Transfer Payment will be made to the bank account indicated. This option can be selected by member	Customer's Name Street Address City, State, Zip The bank routing number is always Customer's Name Street Address City, State, Zip PAY TO THE ORDER OF	spaces. The
or, if applicable, the guardian or power of attorney.	9 digits and appears between the is symbols Street Address City, State, Zip	Dollars symbol indicate the end of the account numb
	Bank Routing Number Bank Accou	
Payment Option 3 – Check A check will be issued to the guardian or power of attorney on behalf of the service member.	Payment Option 3 - Check (for guardian, power of a To have the payment made by check, fill in the guardian o Mailing Address for Payment - No P.O. Boxes City	
Member, guardian, or power of attorney Authorization claim (this can be a spouse, parent, friend or another p		on to speak with OSGLI or the Branch of Service about my ad or another person who is helping you with your claim). Il Last Name
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	X Signature of service member, guardian, or power of attorney WARNING: Any intentional false statement in this claim or willful misrepresent	Date (MM DD YYYY) Description of Authoration relative thereto is subject to act on behalf of the

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Authorization for Release of Information	Member must complete and sign the HIPAA release, below: I authorize any health plan, physician, health care professional, hospital, clinic, laboratory,	
to Branch of Service and Office of Servicemembers' Group Life	examiner or other health care provider that has provided treatment, payment or services provided treatment, payment or service	ertaining to:
The member, guardian, power	Date of Birth (MM DD YYYY) or on my behalf ("My Providers") to disclose my entire medical record for me or my depend	lants and any other health informati
of attorney, or military trustee must complete and sign this section.	concerning me to the Branch of Service and Office of Servicemembers' Group Life Insurance and representatives. This also includes information on the diagnosis and treatment of medrugs, and tobacco, but excludes psychotherapy notes. OSGLI, an administrative unit creat Servicemembers' Group Life Insurance Program and OSGLI administers the TSGLI program	te (OSGLI) and its agents, employee intal illness and the use of alcohol, ted by Prudential to administer the
Failure to complete this section will delay payment of claim	Affairs. I authorize all non-health organizations, any insurance company, employer, or other person information, data or records relating to credit, financial, earnings, travel, activities or empl Unless limits* are shown below, this form pertains to all of the records listed above.	·
This authorization is intended to	By my signature below, I acknowledge that any agreements I have made to restrict my prothis authorization and I instruct My Providers to release and disclose my entire medical red	
comply with the HIPAA Privacy Rule.	This information is to be disclosed under this Authorization so that my Branch of Service an and determine or fulfill responsibility for coverage and provision of benefits, 2) administer 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 be except to the extent that state law imposes a shorter duration. A copy of this authorization that I have the right to revoke this authorization in writing, at any time, by sending a writte Livingston Avenue, Roseland, NJ 07068. I understand that a revocation is not effective to relied on this Authorization or to the extent that OSGLI has a legal right to contest a claim the policy itself. I understand that any information that is disclosed pursuant to this author covered by federal rules governing privacy and confidentiality of health information.	n is as valid as the original. I underst en request for revocation to OSGLI a the extent that any of My Providers under an insurance policy or to cont
	I understand that if I refuse to sign this authorization to release my complete medical recoclaim for benefits and may not be able to make any benefit payments. I understand that I h copy of this authorization.	
	*Limits, if any:	
	NOTE: This release authorizes the branch of service and OSGLI to look at medical records documents.	You may also be asked to provide t
Signature The member, guardian, power of	X Signature of service member, guardian, power of attorney or military trustee Date (MM DD YYYY)	Description of Authority to act on behalf of the member
attorney or military trustee must sign here.		(Guardian, POA, etc.)

ART B - Medical Pro ting within the scope	ofessional's Statement - to be completed by a medical profession of his/her practice.	Service member's Social Security Number al who is a licensed practitioner of the healing arts
Patient Information	Date of Injury (MM DD YYYY) Is the patient capable of handling his/her own affairs? Yes N If patient is deceased, please provide: Date of Death (MM DD YYYY) Time of Death	atient's Last Name
Hospitalization Information Please complete this section for ALL patients.	Cause of Death Cause of Death Reason for Hospitalization — Please give the predominant reason the Traumatic Brain Injury Other Traumatic Injury Longest Period of Hospitalization — Please give the beginning and ending date hospitalized. The count of consecutive hospitalization days begins when the injure the day of admission, continues through subsequent transfers from one hospital to	es for the longest period of consecutive days the patient was and member is transported to the hospital (if applicable), includes
	Date of admittance to first hospital Name and location of hospital (if more than one hospital, list all) Definition of a hospital — A hospital that is accredited as a hospital under the Accreditation of Healthcare Organizations. This includes Combat Support Hospital Hospital does not include a nursing home. Neither does it include an institution, convalescence, rest, nursing care or for the aged; or (2) furnishes mainly homelike.	Date of discharge from last hospital OR Check here if still hospitalized Hospital Accreditation Program of the Joint Commission on als, Air Force Theater Hospitals and Navy Hospital Ships. or part of one, which: (1) is used mainly as a place for
Qualifying Losses Suffered	or (3) is for residential or domiciliary living; or (4) is mainly a school Hospitalization Hospitalization for at least 15 consecutive days	Hospitalization of at least 15 consecutive days as defined above.
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	Loss of Sight 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 Best corrected visual acuity Visual Field (degrees)	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
delay payment of the claim. Patient's loss MUST meet the definition of loss given.	Loss of Speech Loss of speech Date of onset	Loss of Speech is defined as: Organic loss of speech (lost the ability to express oneself, both by voice and whisper, through normal organs for speech), even if member uses an artificial appliance, such as a voice box, to simulate speech. Loss of speech must be clinically stable and unlikely to improve.

	ope of his/her practice.	t) to be completed by a medical prof	fessional who is a licensed practitioner of the healin
Qualifying	Loss of Hearing	Date of onset	Loss of hearing is defined as:
Losses Suffered by	Loss of hearing in left ear		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 hear-
Patient (cont'd)	Loss of hearing in right ear		ing threshold. Loss of hearing must be clinically stable and unlikely to improve.
	Hearing Activity	Left Ear Right Ear	
	Average Hearing Acuity (measured without amplification device)	db db	
	Burns		Burns are defined as:
	2nd degree or worse burns to 2nd degree or worse burns to 3	the body including face and head	2nd degree (partial thickness) or worse burns over 20% of the body including the face and head OR 20% of the face only.
	Percentage of body affected %%	Percentage of face affected %	Note: Percentage may be measured using the Rule of Nines or any other acceptable alternative
	Coma		Coma is defined as:
	Coma Date of onset	Date of recovery	Coma with brain injury measured at a Glasgow Coma Score of 8 or less that lasts for 15, 30, 60 or 90 consecutive days.
	Date of offset	Date of recovery	Number of days includes the date the coma began and the date the member recovered from the coma.
	OR Check here if coma is ongo	ing	
	Glasgow score at 15 days	Glasgow score at 30 days Glasg	jow score at 60 days Glasgow score at 90 days
Important:	Facial Reconstruction		Facial Reconstruction is defined as:
Facial Reconstruction:	Upper or lower jaw 50% of cartilaginous nose	50% of left zygomatic 50% of right zygomatic	Reconstructive surgery to correct traumatic avulsions of the face or jaw that cause discontinuity defects, specifically surgery to correct discontinuity loss of the following:
If the patient is undergoing facial	50% of upper lip	50% of left mandibular	■ upper or lower jaw
reconstruction, a		_	■ 50% or more of the cartilaginous nose
surgeon MUST certify this section	50% of lower lip	50% of right mandibular	■ 50% or more of the upper or lower lip
by checking the box,	30% of left periorbita	50% of left infraorbita	■ 30% or more of the periorbita
printing his/her name and signing on the appropriate line.	30% of right periorbita 50% of left temple	50% of right infraorbita 50% of chin	 tissue in 50% or more of any of the following facial subunits: forehead, temple, zygomatic, mandibular, infraorbital or chin.
	50% of right temple	50% of forehead	
	Certification of Surgeon		
	Date of first surgery		Forehead
	Name of Surgeon		
			Periorbita Zygomati
	X Cinnature of Courses		Infraorbit
	Signature of Surgeon		Upper lip Lower lip
	Date (MM DD YYYY)]	Mandibular Chin

Service member's Social Security Number

	cope of his/her practice.	or removal of a limb or part of a limb, includi	ofessional who is a licensed practitioner of the healing
Suffered by	Amputation of Hand	Date of amputation	Amputation of Hand is defined as:
Patient (cont'd)	Amputation of left hand		Amputation of hand at or above* the wrist
			*at or above: closer to the body
	Amputation of right hand		
	Amputation of Fingers	Date of amputation	Amputation of Fingers is defined as:
	Amputation of 4 fingers/ left hand		■ Amputation of four fingers on the same hand (not including the thumb) at or above* the
	Amputation of 4 fingers/ right hand		metacarpophalangeal joint OR, Amputation of thumb at or above the metacarpophalangeal joint.
	Amputation of left thumb		*at or above: closer to the body
	Amputation of right thumb		
	Amputation of Foot	Date of amputation	Amputation of Foot is defined as:
	Amputation of left foot		■ Amputation of foot at or above the ankle OR,
	Amputation of right foot		 Amputation of all toes (including the big toe) on the san foot at or above the metatarsophalangeal joint. *at or above: closer to the body
	Amputation of Toes	Date of amputation	Amputation of Toes is defined as:
	Amputation of 4 toes/ left foot		 Amputation of four toes on one foot at or above the metatarsophalangeal joint (not including the big toe)
	Amputation of 4 toes/ right foot		OR, ■ Amputation of big toe at or above the metatarsop
	Amputation of big toe/ left foot		geal joint. *at or above: closer to the body
	Amputation of big toe/ right foot		
Important:	Limb Salvage	Date of first surgery	Limb Salvage is defined as:
Limb Salvage:	Salvage of left arm		A series of operations designed to save an arm or leg rather than amputate.
If the patient is undergoing limb salvage, a surgeon	Salvage of left leg		A surgeon must certify that: The option of amputation of limb(s) was offered to
MUST certify this section by checking	Salvage of right arm		the patient as a medically justified alternative to limb salvage and
the box, printing his/ her name and signing on the	Salvage of right leg		■ The patient has chosen to pursue limb salvage.
appropriate line.	Certification of Surgeon		Additional Comments
	The option of amputation was chosen to pursue limb salvag	s offered to the patient and the patient has e.	
	Name of Surgeon		
	X Signature of Surgeon		_
	Signature of Surgeon Date (мм dd yyyy)		
	Succession of the succession o		

) to be completed by a medical profe	Service member's Social Security Number ssional who is a licensed practitioner of the healing
Qualifying	ope of his/her practice. Paralysis	Date of onset	Paralysis is defined as:
Losses Suffered by Patient (cont'd)	Quadriplegia Paraplegia		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:
Description	Hemiplegia		Quadriplegia - paralysis of all four limbs
of Injury/ Assistance Needed	rieinipiegia		 Paraplegia - paralysis of both lower limbs Hemiplegia - paralysis of the upper and lower limbs on
Please provide a description of the	Uniplegia		one side of the body
injury and descriptions of the		Perform Activities of Daily Living (■ Uniplegia- paralysis of one limb
perform each ADL. Failure to provide this information may delay payment of claim.	for at least 15 consecutive days for tr The patient is considered unable to p	least two of six ADL (bathing, continence, dre aumatic brain injury and at least 30 consecuti erform an activity independently only if he or by using accommodating equipment, such as tivity without requiring assistance.	ssing, eating, toileting and transferring). Inability must last ve days for any other traumatic injury. she REQUIRES assistance to perform the activity. If the a cane, walker, commode, etc., the patient is considered
	■ physical assistance (hands-on),		
	stand-by assistance (within arm	's reach),	
	■ verbal assistance (must be instr	ucted because of cognitive impairment),	
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	Traumatic Brain Injury	the patient is/was unable to independent Other Traumatic Injury on(s) it resulted in inability to perform activitie	
describe the injury in the box provided.	Unable to bathe independentl	v	Patient is UNABLE to bathe independently if
Which ADL is the patient unable to perform? Check each ADL	Start date OR Check here if inability is ong	End date	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:
the patient cannot perform; AND; Fill in the dates inability began and	Type of assistance required (chec physical assistance (hands-on) stand-by assistance (within arm's reach)	-	
ended or indicate inability is ongoing	Unable to maintain continent	ce independently End date	Patient is UNABLE to maintain continence independently if
	OR Check here if inability is ong	oing	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:
	Type of assistance required (check physical assistance (hands-on) stand-by assistance (within arm's reach)	c all that apply) verbal assistance (must be instructed because of cognitive impairment)	Describe destinative needed.



Qualifying	Inability to Independently Perform Activities of Daily Living	(ADL) (cont'd)
Losses Suffered by Patient (cont'd) Require Assistance is defined as: physical assistance	Unable to dress independently Start date End date 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)	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:
(hands-on), ■ stand-by 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.	(within arm's reach) Unable to eat independently Start date End date 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)	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 toilet independently Start date End date 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)	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 transfer independently Start date End date 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	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:

Service member's Social Security Number

	rofessional's Statement (con't) to be completed by a medical professional who is a licensed practitioner of the healicope of his/her practice.			
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 If yes, please explain below:			
Medical	Use this block to provide any additional information about the patient's injuries. When a narrative description is required, please be			
Professional's Comments	complete and concise.			
Medical Professional's	Name of Medical Professional First Name MI Last Name			
Information	Medical Professional's Address (number and street) City State ZIP Code Telephone Number Fax Number E-mail Address			
	Specialty Medical Degree			
Medical Professional's Signature	I have observed the patient's loss. I have not observed the patient's loss, but I have reviewed the patient's medical recommendation 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 Date (MM DD YYYY) X Signature			