Servicemembers' and Veterans' Group Life Insurance Accelerated Benefits Option



Administered by the Office of Servicemembers' Group Life Insurance 80 Livingston Avenue Roseland, NJ 07068-1733

Toll-Free: 1-800-419-1473

Fax: (800) 236-6142

Instructions For Submitting a Claim for Accelerated Benefits

About The Accelerated Benefit

The accelerated benefit allows you to receive up to 50% of your Servicemembers' or Veterans' Group Life Insurance if you have been diagnosed by your physician as being terminally ill (as defined in Public Law 105-368) with nine (9) months or less to live. Only *you* (the insured) can apply for this benefit.

The amount of insurance proceeds payable to your beneficiary(ies) at the time of your death will be reduced by the amount of accelerated benefit you choose to receive now. Your premium will be lowered to reflect the reduced amount of your coverage.

How To Claim This Benefit

To submit a claim for accelerated benefits, you, your physician and, if you're covered under SGLI, your branch of service must complete the attached forms as indicated at the top of each form. Once all forms are completed, you should send the forms to:

OSGLI ABO Claim Processing 80 Livingston Avenue Roseland, NJ 07068-1733

What You Should Know About Your Claim

You should be aware of the following before submitting your claim:

- Once we process your claim for accelerated benefits, we will send you a check for the amount you request* and an explanation of the amount.
- Once you cash the payment, the accelerated benefit cannot be revoked.
- You can receive this benefit only once during your lifetime.
- You may use this benefit for any purpose you choose. Its use is not limited to medical expenses.
- If you're covered under SGLI, OSGLI will notify your branch of service to reduce the face amount of your coverage and your premium rate.
- If you die before cashing the accelerated benefit check, someone should return the check to OSGLI.
- If your claim is not approved, we will notify you. You will then have the chance to submit additional medical information. You can also reapply at a later date if you believe your condition will qualify you for this benefit.
- * The amount you request will be reduced by the amount of interest that would have been earned on it (over nine months) had you not claimed it. Therefore, the check you receive will be less than the amount you claim.

If you have any questions, please call us toll-free at 1-800-419-1473. A customer service representative will assist you.

PRIVACY ACT STATEMENT - Title 38 U.S Code, Chapter 19, Subchapter III, Servicemembers' Group Life Insurance, authorizes solicitation of this information. This information is needed to determine your eligibility for an "Accelerated Benefit Option" payment. Section 7701(c) of Title 31, requires that any person doing business with the Federal Government furnish a Social Security Number or tax identification number. An accelerated benefit will not be paid to you unless a completed application has been received by the Office of Servicemembers' Group Life Insurance (Title 38, Section 1980).

RESPONDENT BURDEN - VA may not conduct or sponsor, and respondent is not required to respond to this collection of information unless it displays a valid OMB Control Number. Public reporting burden for this collection of information is estimated to average 12 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have comments regarding this burden estimate or any other aspect of this collection of information, call 1-800-419-1473 for mailing information on where to send your comments.

OMB Control No.: 2900-0618 Respondent Burden: 12 minutes

To Be Completed By Insured

a) Claim For Accelerated Benefits

Your Name		Social Security Number	Social Security Number		
Your home add	ress		Date of birth	Branch of Service (if covered under SGLI)	
Your mailing a	ddress (if differen	t from above)	Amount of SGLI Coverage	Amount of Claim (can be no more than one-half of coverage)	
			\$	\$	
Type of coverage: (check one) SGLI (circle one of the following) Active Duty Ready Reserve Army or Air National Guard Separated or Discharged VGLI					
No.	e: If you checked	SGLI, you must also have yo	our military unit complete the	attached form.	
I acknowledge that I have read all of the attached information about the accelerated benefit. I understand that I can get this benefit only once during my lifetime and that I can use it for any purpose I choose. I further understand that the face amount of my coverage will reduce by the amount of accelerated benefit I choose to receive now. Your Signature Date					
b) Authori	zation to Rel	ease Medical Reco	rds	1	
To all physicians, hospitals, medical service providers, pharmacists, employers, other insurance companies, and all other agencies and organizations:					
			ecords, including examination if the Insurance (OSGLI) or it	ons, treatments, history, and is representatives.	
Printed Name					
Signature			Date		
			sidered as effective and valid a	ns the original.	

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To Be Completed By Physician

Attending Physician's Certification

Patient's Name	Patient's Social Security Numb	ber			
Diagnosis	ICD-9-CM Disease Code*				
Description of Present Medical Condition (please attach results of x-rays, E.K.G. or other tests)					
Is the patient capable of handling his/her own affairs? YES □ NO □					
The patient applied for an accelerated benefit under his/her government life insurance coverage. To qualify, the patient must have a life expectancy of nine (9) months or less. Does your patient meet this requirement? YES \square NO \square					
Attending Physician's Name (please print)	State in which you are licensed to practice	Specialty			
Mailing address	Telephone Number	<u> </u>			
	Fax Number				
Signature	Date				

^{*}ICD-9-CM is an acronym for International Classification of Diseases, 9th revision, Clinical Modification

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To Be Completed By Personnel Office of Servicemember's Unit

(Complete this form only if the applicant for Accelerated Benefits is covered under SGLI.)

Branch of Service Statement

Servicemember's Name	Social Security Number	Branch of Service		
Amount of SGLI Coverage	Monthly Premium Amoun	t t		
\$	\$			
Name of Person Completing This Form	Telephone Number	Fax Number		
Title of Person Completing This Form	Duty Station and Address	•		
Signature	Date			
of person completing this form				

Notice: It is fraudulent to complete these forms with information you know to be false or to omit important facts. Criminal and/or civil penalties can result from such acts.