Office of Servicemembers' Group Life Insurance
P.O. Box 41618
Philadelphia, PA
19176-1618

800-419-1473
Contact Center
Toll free, worldwide

Prudential

Office of Servicemembers' Group Life Insurance

Apply Online at **myvgli.prudential.com**

DEAR VETERAN,

PLEASE FOLLOW THE INSTRUCTIONS BELOW TO APPLY FOR REINSTATEMENT OF YOUR VETERANS' GROUP LIFE INSURANCE (VGLI) COVERAGE.

Application for Reinstatement of Veterans' Group Life Insurance

SECTION 1 – VETERAN INFORMATION
Please provide all requested information.

SECTION 2 – CERTIFICATION OF HEALTH
Complete Section 2 if your lapse date is **less than 6 months ago** and **your health has not changed** since the lapse date. **NO NEED TO COMPLETE SECTION 3.**

SECTION 3 – CERTIFICATION OF HEALTH
Complete Section 3 if your lapse date **more than 6 months ago or** your **health has changed** since the lapse date.

SEND YOUR COMPLETED APPLICATION TO:
Office of Servicemembers' Group Life Insurance
P.O. Box 41618
Philadelphia, PA
19176-1618

REINSTATEMENT AMOUNT
The reinstatement amount is equal to three (3) times your monthly premium (based on the insured's current age). For questions, please call the contact center at 800-419-1473, Monday through Friday from 8:00 a.m. to 5:00 p.m. Eastern Time, Toll Free, Worldwide.

You can also determine your premium online with the "premium calculator" at:

- myvgli.prudential.com
- If you do not have an online account, select 'learn more about VGLI Coverage' and then select the Premium Calculator Tab
- If you have an account, log into your VGLI account and click on the coverage information tab.

Thank you for your service.

Office of Servicemembers' Group Life Insurance

Ed. 06/2022

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Office of Servicemembers' Group Life Insurance

Apply for reinstatement online at: myvgli.prudential.com

Veterans' Group Life Insurance

Application For Reinstatement Of Coverage

Control Number:

Lapse Date: MM-DD-YYYY

Coverage Amount: ___,___

Reinstatement Amount: Must equal 3 months premium _,___.__

1 VETERAN INFORMATION

First Name:

MI:

Last Name:

Address 1:

Address 2:

City:

State:

ZIP Code:

Country:

Phone Number:

Email:

You must check this box when the address is outside the United States. ☐

2 CERTIFICATION OF HEALTH

- **Complete Section 2: ONLY if your lapse date is less than 6 months AND your health has not changed since the lapse date.**
- **DO NOT COMPLETE SECTION 3.**

I am applying for reinstatement of my insurance in the amount shown above. As a condition to the reinstatement of this insurance, I certify that to the best of my knowledge and belief, I am now in as good health as I was on the date of the insurance lapse.

SINCE THAT DATE, I have not been ill or suffered or contracted any disease, infirmity, or any injury, nor have I been prevented by reason thereof from attending to my usual occupation, nor have I consulted a physician, surgeon, or other practitioner for medical advice or treatment at home, hospital, or elsewhere in regard to my health, except as shown below. This statement refers to all disabilities including any service-connected disabilities.

I declare that, to the best of my knowledge and belief, the above statements are complete and true. Any deception or false statement, either by reference, omission, or otherwise can result in loss of coverage or denial of a claim for benefits.

X

Veteran's Signature:

Date: MM-DD-YYYY

The Office of Servicemembers' Group Life Insurance (OSGLI) administers Servicemembers' Group Life Insurance and Veterans' Group Life Insurance under the supervision of the Department of Veterans Affairs. OSGLI is a division of the Prudential Insurance Company of America.

Prudential

Office of Servicemembers' Group Life Insurance

Veterans' Group Life Insurance

Application For Reinstatement Of Coverage

Apply for reinstatement online at: www.insurance.va.gov

Control Number: ☐☐☐☐☐☐☐☐

Last Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

3 CERTIFICATION OF HEALTH

Complete Section 3 only if your Lapse Date is more than 6 months ago OR your health has changed since the lapse date.

Have you had or been treated for or had known indications of:

		Y	N
A.	Heart trouble or abnormal pulse?	☐	☐
B.	High blood pressure?	☐	☐
C.	Diabetes or sugar in urine?	☐	☐
D.	Cancer or tumors?	☐	☐
E.	Lung or respiratory disorders?	☐	☐
F.	Disorders of kidney, bladder or urinary system?	☐	☐
G.	Disorders of the liver or gall bladder?	☐	☐
H.	Disorders of stomach or intestines?	☐	☐
I.	Arthritis?	☐	☐

In the past 5 years have you:

		Y	N
J.	Been declined or postponed for any form of life or health insurance or offered a policy with a higher premium because of health reasons only?	☐	☐
K	Been absent from work for more than 5 continuous days because of sickness or injury?	☐	☐
L.	Been advised to have a surgical procedure?	☐	☐
M.	Been a patient or been advised to enter a hospital or health care facility?	☐	☐
N.	Consulted, been attended, or examined by a doctor or other practitioner other than annual or periodic physicals?	☐	☐
O.	Used barbiturates, heroin, opiates, or other narcotics, or been treated for alcoholism?	☐	☐
P.	Been diagnosed as having Acquired Immunodeficiency Syndrome (AIDS) or AIDS related Complex (ARC)?	☐	☐
Q.	Had any known physical impairments, deformities, or ill health not covered above?	☐	☐
R.	Do you have a service-connected disability?	☐	☐

If yes, what is the VA claim file number? ____________

Please provide details for all questions answered "yes." Use additional paper if necessary.

Question Number	Nature of Illness	Illness began Month/Year	Time lost from Normal Activities	Full Recovery Month/Year	Treating Physician's Name & Address

(Please attach a separate sheet with details for any question answered "yes")

I declare that, to the best of my knowledge and belief, the above statements are complete and true. Any deception or false statement, either by reference, omission, or otherwise can result in loss of coverage or denial of a claim for benefits.

X

Veteran's Signature:

Date: ☐☐ – ☐☐ – ☐☐☐☐
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