

Office of Servicemembers'

Group Life Insurance

Office of Servicemembers' Group Life Insurance

P.O. Box 41618 Philadelphia, PA 19176-1618

800-419-1473 Contact Center Toll free, worldwide

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.

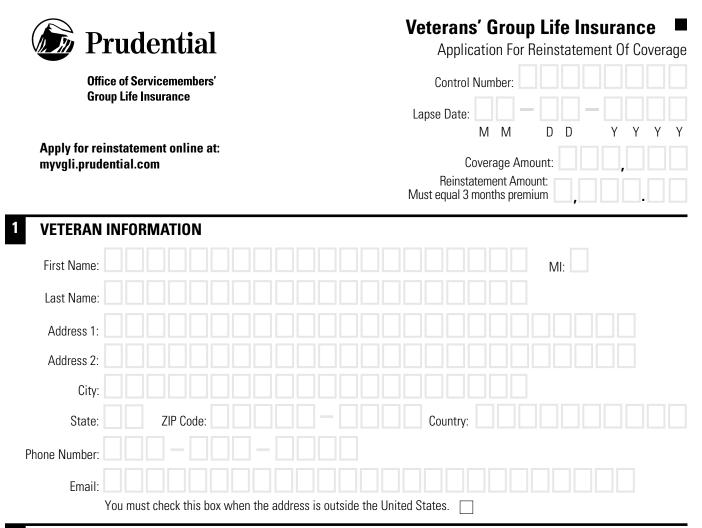
You can also determine your premium online with the "premium calculator" at:

- 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



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.

Χ	Date	:		_			_					
Veteran's Signature:		М	М		D	D		Y	Y	Y	Y	

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.





Veterans' Group Life Insurance

Application For Reinstatement Of Coverage

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

Office	of Servicemembers'
Group	Life Insurance

Control Number:		

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CERTIFICATION OF HEALTH

3

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			Ý	IN
Α.	Heart trouble or abnormal pulse?		F.	Disorders of kidney, bladder or urinary system?		\square
Β.	High blood pressure?		G.	Disorders of the liver or gall bladder?		
C.	Diabetes or sugar in urine?		Η.	Disorders of stomach or intestines?		
D.	Cancer or tumors?		Ι.	Arthritis?		
E.	Lung or respiratory disorders?					
In	the past 5 years have you:					
	-	Y N			Y	Ν
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?		0.	Used barbiturates, heroin, opiates, or other narcotics, or been treated for alcoholism?		
			P.	Been diagnosed as having Acquired		
K	Been absent from work for more than 5 continuous days because of sickness or injury?			Immunodeficiency Syndrome (AIDS) or AIDS related Complex (ARC)?		
L.	Been advised to have a surgical procedure?		Q.	Had any known physical impairments,		
M.	Been a patient or been advised to enter a		u .	deformities, or ill health not covered above?		
	hospital or health care facility?		R.	Do you have a service-connected disability?		\square
N.	Consulted, been attended, or examined by a					
	doctor or other practitioner other than annual or periodic physicals?			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	IIIness 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	Date:			_			_				
Veteran's Signature:		Μ	М		D	D		Y	Y	Y	Y

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