MANUAL: Personnel
Chapter Series CC--Commissioned Corps Personnel Manual
Part 2--Commissioned Corps Personnel Administration

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service

Chapter CC29--Officers' Relations, Services and Benefits
Subchapter CC29.4--Insurance
Personnel INSTRUCTION 1--Servicemens' Group Life Insurance and Veterans' Group Life Insurance

CONTENTS

CONTENTS (Continued)

Section A. Purpose and Scope

This INSTRUCTION describes insurance available to PHS commissioned officers under the Servicemens' Group Life Insurance (SGLI) and Veterans' Group Life Insurance (VGLI) programs. This INSTRUCTION also contains information on procedures by which PHS commissioned officers may participate in the SGLI or VGLI programs (including designation of beneficiaries, conversion of SGLI to VGLI upon separation or retirement, and collection by beneficiaries of insurance proceeds upon the death of the insured individual.

Section B. Authority

The SGLI program is authorized by Public Law 89-214, as amended (38 U.S.C. 765-776). The VGLI program is authorized by Public Law 93-289, as amended (38 U.S.C. 777-779). Pertinent regulations are contained in 38 C.F.R. Part 9.

Section C. Program Responsibility

l. The overall responsibility for administration of the SGLI and VGLI programs is vested in the Veterans Administration (VA).

2. Officer Services Branch (OSB), Division of Commissioned Personnel (DCP), Office of the Surgeon General (OSG), is responsible for assisting and counseling active duty officers regarding their participation in SGLI.

Section D. Type and Amount of Insurance

l. SGLI is a group life insurance policy purchased from a commercial life insurance company by the VA. The insurance issued under the group policy is term insurance.

2. Packets furnished to PHS officers when they are called to active duty contain Form SGLV 8290, "Servicemen's Group Life Insurance Certificate," which explains in general terms the officer's rights and benefits under SGLI and VGLI programs. Upon reporting for active duty, officers are automatically covered for the maximum sum available. However, an officer may elect in writing to cancel or change to a lesser amount of insurance within the limits allowed (see Exhibit I). Form SGLV 8286, "Servicemen's Group Life Insurance Election" (see Exhibit III), should be completed to reduce the amount of insurance coverage or to cancel the insurance entirely. A written request in memorandum form may be used if the form is not available.

3. When completed, signed, dated, and witnessed, Form SGLV 8286, or memorandum request, must be submitted to:

Officer Services Branch
Division of Commissioned Personnel/OSG
Room 4-35 Parklawn Building
Rockville, Maryland 10857

The date on which the form or memorandum is received at the above address will determine the effective date of the action requested.

Section E. Designation of Beneficiary

L. An officer insured under SGLI may designate a veneficiary or beneficiaries to receive the proceeds of his or her life insurance in case of his or her death while insured. A beneficiary or contingent beneficiary may be any person, firm, corporation, or legal entity, individually or as a trustee. However, if the designation of a beneficiary is not made, an order of preference for beneficiaries is provided by law.

2. Designation or change of beneficiary should be made on From SGLV 8286, or by memorandum if the form is not available, and submitted to the address listed in Section D.3., above. The form or memorandum must be witnessed, signed, and dated by the witness, below the signature of the officer. The original is to be placed in the officer's personnel file. A copy is to be retained by the officer for information purposes.

Section F. Cost of Insurance

l. The cost of SGLI is shared by the member and the Federal Government.

2. Monthly contributions will be deducted automatically from the officer's pay. See Exhibit I for contribution rates. The first deduction from pay will include the full cost for the month of entry on active duty (regardless of date) plus a one-month advance premium. No deduction will be made from the officer's final pay for the month in which he/she separates from active duty.

3. Refunds will not be made of amounts deducted for automatic coverage before the effective date of an election not to be covered, or an election for a reduced amount of insurance.

Section G. Coverage While Officer Is on Leave Without Pay

To maintain SGLI coverage, an officer on leave without pay must pay the premium for coverage directly to OSB. His/her check or money order must be made out to the Department of Health and Human Services, and must be accompanied by a memorandum identifying the check or money order as a payment to cover the officer's share of his/her insurance. Payments to cover the amount that would normally be deducted from pay, must be made in advance on no less than a semi-annual basis. However, it is recommended that payments be made in advance on a yearly basis to best protect the interests of the officer. When the officer terminates the leave without pay status and continues on active duty, monthly deductions from his/her pay will again be taken automatically.

Section H. Reinstatement

If an officer on active duty who had elected to cancel or reduce insurance, later wants to obtain or change coverage, application should be made on VA Form 29-8285, "Request for Insurance" (see Exhibit IV). The form should be completed in duplicate and signed in the presence of a witness who will complete the certification below the officer's signature. Both copies should be sent to OSB (see address in D.3.). Action will be initiated to withhold premiums effective on the date the VA Form 29-8285 is received in OSB. However, if the application is disapproved by the Office of Servicemen's Group Life Insurance (OSGLI), any premiums deducted will be credited to the officer's pay account.

Section I. Conversion to VGLI

l. Upon separation or retirement, an officer's SGLI will continue automatically for 120 days. During that period VA will send to the officer a computer-printed From SGLV 8714-l, "Application for Veterans Group Life Insurance (Veterans Separated Less Than 120 Days)" (see Exhibit V), showing the necessary data. It will also contain information about continuing group coverage under the VGLI program. For members who are eligible to become insured under VGLI, the beneficiary election for SGLI will remain in effect for not more than 60 days following the effective date of VGLI coverage. Consequently, when SGLI is converted to VGLI, the insured should be sure to fill in the beneficiary designation portion of the form to redesignate beneficiaries. This form is then submitted directly to:

Office of Servicemen's Group Life Insurance
212 Washington Street
Newark, New Jersey 07102

2. a. VGLI is a five-year nonrenewable term policy purchased from a commercial company by the VA and administered by OSGLI. VGLI is issued in the amounts specified for SGLI. However, the VGLI policy may be in an amount no greater than that of the SGLI policy in effect upon separation or retirement. The application form and the first monthly premium payment payable to SGLI should be mailed to OSGLI (see I.1. above). Premiums may be made in advance on a quarterly, semi-annual, or annual basis. The cost of the insurance premium is based on the amount of insurance issued and on the age of the officer at the time the insurance is granted. For insurance amounts and rates see Exhibit II.

   b. If information is not received from VA within a month of separation, the individual should write to OSGLI or his or her nearest VA office.

3. Unless totally disabled (see Section I.4. below), if the officer does not submit the premium and application within 120 days, he/she still may be granted VGLI. VA Form 20-8714-2 "Application for Veterans Group Life Insurance (Veterans Separated more than 120 Days)" (Exhibit VI), the initial premium, and evidence of insurability must be submitted to OSGLI within one year after the officer's SGLI coverage is terminated. VA Form 29-8714-2 may be obtained from OSGLI, or the nearest VA office.

4. If the veteran is totally disabled on the date of separation from service, SGLI coverage will continue for one year after the separation date or until the insured ceases to be totally disabled, whichever is the earlier date, but in no case prior to 120 days after separation date. The insured may apply for VGLI anytime during this one-year period that SGLI remains in effect. A medical examination and evidence of continuing disability may be requested. However, if the totally disabled veteran does not meet the requirements to apply for VGLI within the time limits set forth above, the coverage still may be granted. In such cases, an application (VA Form 29-8714-2), evidence of insurability, and the initial premium must be submitted to OSGLI within one year after the individuals SGLI coverage is terminated.

5. a. At the end of the five-year period, the insured has a right to convert such insurance to an individual policy with any one of the participating companies. Prior to the expiration date of VGLI, OSGLI will furnish the insured with information on how to convert to such policy and a list of eligible companies.

   b. An application must be filed with and the first premium paid to, the company selected before the coverage under VGLI terminates.

Section J. Death Claim

l. All claims for death benefits for any member who dies while insured under SGLI must be submitted to OSGLI (see address in I.1., above). Form SGLV

8283, "Claim for Death Benefits" (Exhibit VII), is to be used in submitting a claim. Upon notification of the death of an active duty member, the form is furnished by OSB to the beneficiary.

2. In the case of the death of a separated or retired officer insured by VGLI, notification of the death, accompanied by a certified copy of the death certificate, must be sent with Form SGLV 8283 to OSGLI by the beneficiary. OSGLI or the nearest VA office will furnish Form SGLV 8283 to the beneficiary upon request.

3. Upon receipt by OSGLI of due proof that an insured member has died, OSGLI will pay to the proper beneficiary the amount for which the member is insured under VGLI.

Section K. Miscellaneous

l. The SGLI and VGLI proceeds are not assignable. Payments of benefits to a beneficiary are exempt from taxation and are not subject to claims of creditors of the insured or creditors of the beneficiary except certain claims of the United States.

2. An officer may retain other Government or private insurance while insured under SGLI and VGLI.

3. The forms prescribed for use in the SGLI and VGLI programs are available upon request from OSB (see address in Section D.3 above).

4. Additional information about the SGLI and VGLI programs may be obtained from the officer's administrative officer, the CPOD Benefits Representative, and the nearest VA office.

Section L. Privacy Act Provisions

Personnel records are subject to the Privacy Act of 1974. Commissioned Corps Personnel Manual, INSTRUCTION 7, Subchapter CC26.l, "Rights, Responsibilities and Personnel Records of PHS Officers Under the Privacy Act," sets forth the procedures to be followed in the maintenance of these records. The applicable system of records if 09-37-0002, "PHS Commissioned Corps General Personnel Records, HHS/OASH/OM."

EXHIBIT I

MONTHLY CONTRIBUTIONS FOR SGLI
Effective January 1, 1984

Amount of Insurance*	Monthly Cost**
$50,000	$4.00
$40,000	3.20
$30,000	2.40
$20,000	1.60
$10,000	.80

NOTE: As set forth in Section D.2., officers may elect in writing not to participate in SGLI or may elect in writing an amount less than the $50,000 maximum provided the lesser amount is evenly divisible by $10,000.

* The amount of coverage was increased from the initial maximum by legislation in 1970, 1974, 1981, and 1985.

** Monthly cost of premium has been reduced as follows:

1965 - 20¢ per $1000.
1972 - 17¢ per $1000.
1978 - 15¢ per $1000.
1982 - 11.6¢ per $1000.
1984 - 8¢ per $1000.

Exhibit II

MONTHLY CONTRIBUTIONS FOR VGLI
Effective July 1, 1986

Amount of Insurance	Age at Issuance					
	29 and Below	30-34	35-44	45-49	50-59	60 and Over
$50,000	$6.00	$10.00	$17.00	$21.00	$26.00	$37.50
$40,000	4.80	8.00	13.60	16.80	20.80	30.00
$30,000	3.60	6.00	10.20	12.60	15.60	22.50
$20,000	2.40	4.00	6.80	8.40	10.40	15.00
$10,000	1.20	2.00	3.40	4.20	5.20	7.50

NOTE: Individuals may elect in writing an amount that is no greater than that of the SGLI policy in effect upon separation and retirement. However, the amount elected must be evenly divisible by $10,000.

MONTHLY CONTRIBUTIONS FOR VGLI
Prior to July 1, 1986

Amount of Insurance	Age at Issuance	
	Less Than 35	35 and Over
$50,000	$8.50	$17.00
$40,000	6.80	13.60
$30,000	5.10	10.20
$20,000	3.40	6.80
$10,000	1.70	3.40

EXHIBIT III

(PLEASE READ INSTRUCTIONS ON THE REVERSE SIDE BEFORE COMPLETING AND SUBMITTING THIS FORM)

SERVICEMEN'S GROUP LIFE INSURANCE ELECTION

IMPORTANT – This form is for use by ACTIVE DUTY AND RESERVE MEMBERS. This form does not apply to and cannot be used for any other Government Life Insurance.

USE THIS FORM FOR ▶ 1. REDUCING OR REFUSING INSURANCE 2. STATING TO WHOM AND HOW INSURANCE SHOULD BE PAID

(Do not make erasures, corrections or changes. Complete a new form)

LAST NAME - FIRST NAME - MIDDLE NAME	RANK, TITLE OR GRADE	SERVICE OR SOCIAL SECURITY NO.

BRANCH OF SERVICE *(Do not abbreviate)*	CURRENT DUTY LOCATION

1. REDUCING OR REFUSING INSURANCE

By law you are automatically insured for $50,000. If you do not want $50,000 insurance write below in your own handwriting "I want only $40,000, $30,000, $20,000, $10,000 insurance", or "I want no insurance" as you prefer. Reduced or refused insurance can be restored only by written request with proof of good health and compliance with other requirements.

▶ _____ BE SURE TO COMPLETE PART 2

2. BENEFICIARY(IES) AND PAYMENT TO BENEFICIARY(IES) *(Read instructions C and D on reverse)*

IMPORTANT -- You must write in the spaces below:
(1) The names and other information for persons you want to receive your insurance, or
(2) "By Law" in your own handwriting if you wish the law to apply *(as explained on reverse)*

Insurance is paid in a lump sum or 36 equal monthly installments at the option of the beneficiary(ies). If you insert "36" under "Payments to Beneficiary," payment will be made only in 36 equal monthly installments.

I DESIGNATE THE FOLLOWING BENEFICIARIES TO RECEIVE PAYMENT OF MY INSURANCE PROCEEDS AS SHOWN BELOW:

COMPLETE NAME AND ADDRESS OF EACH BENEFICIARY *(If married woman, give her own first and middle names and husband's last name)*	RELATIONSHIP TO INSURED	SHARES TO BE PAID TO EACH BENEFICIARY *(Use fractions such as 1/2, 2/3, 3/4, or "ALL")*	PAYMENTS TO BENEFICIARY *(Insert "36" if only monthly payments desired. See D on reverse)*
PRINCIPAL *(First)*			
CONTINGENT *(Second - If principal beneficiary dies before me or before completion of installment payments to the principal beneficiary)*			

NOTE: If more than one principal beneficiary is named, the share of any such beneficiary who dies before me shall be distributed equally among the surviving principal beneficiaries. If there is no surviving principal beneficiary the proceeds shall be distributed equally to the surviving contingent beneficiaries. This Designation of Beneficiary shall be void if none of the designated beneficiaries is living at my death. If after completion of this form my insurance is increased, this beneficiary designation shall apply to the full amount in force unless a new designation is made.

I UNDERSTAND that this form cancels any prior beneficiary or payment instructions and that unless I have named the beneficiary(ies) above, my insurance will be paid under the "Provisions of the Law" as explained on the reverse of this form.

I UNDERSTAND that I cannot have combined SGLI and VGLI coverage at the same time for more than $50,000.

SIGN HERE IN INK ▶ _____ *DATE COMPLETED* _____
(Signature of member) (Do not print)

WITNESSED AND RECEIVED BY	RANK, TITLE OR GRADE	ORGANIZATION	DATE RECEIVED

SGLV - 8286, AUG 1986 SUPERSEDES SGLV 8286, JUN 1984 WHICH WILL NOT BE USED 20782

EXHIBIT IV

REQUEST FOR INSURANCE

(Servicemen's Group Life Insurance)

IMPORTANT - This form is for use by ACTIVE DUTY and RESERVE MEMBERS. Please read instructions on reverse before completing this form. NOTE: No insurance may be granted unless a completed application form has been received. (38 C.F.R. 9.3).

PART I - TO BE COMPLETED BY MEMBER

1. AMOUNT OF SERVICEMEN'S GROUP LIFE INSURANCE INCREASE DESIRED	2. AMOUNT OF SERVICEMEN'S GROUP LIFE INSURANCE NOW IN FORCE
$	$
3. FIRST NAME - MIDDLE NAME - LAST NAME OF MEMBER	4. SERVICE NUMBER OR SOCIAL SECURITY NUMBER

5. BRANCH OF SERVICE (Do not abbreviate)	6. DATE OF BIRTH (Mo., day, yr.)	7. WEIGHT	8. HEIGHT	9. SEX
		LBS.	FT. IN.	

10. ARE YOU IN GOOD HEALTH? ☐ YES ☐ NO (If "No," explain)

11. HAVE YOU EVER BEEN DECLINED OR POSTPONED FOR ANY FORM OF LIFE OR HEALTH INSURANCE OR OFFERED A POLICY WITH A RATED-UP PREMIUM BECAUSE OF HEALTH REASONS ONLY? (If so, give name of company, date and other details.)

☐ YES ☐ NO

12. HAVE YOU HAD OR BEEN TREATED FOR OR HAD KNOWN INDICATIONS OF:	YES (√)	NO (√)		YES	NO
A. HEART CONDITION?			C. NERVOUS DISORDER?		
B. HIGH BLOOD PRESSURE?			D. DIABETES?		
			E. CANCER OR TUMORS?		

13. DO YOU HAVE ANY KNOWN PHYSICAL OR MENTAL IMPAIRMENTS, DEFORMITIES, OR ILL HEALTH NOT COVERED ABOVE?

☐ YES ☐ NO (If "Yes" complete item 14.)

14. IF YOUR ANSWER TO ANY PART OF ITEM 12A THRU 13 IS "YES," GIVE DATES, DURATION AND OTHER DETAILS (If more space is needed, attach separate sheet.)

CERTIFICATION

The answers I have given above are for securing approval of this request for insurance and I CERTIFY THAT they are true and complete to the best of my knowledge and belief. I understand that the insurance being requested requires approval of evidence of insurability by the Office of Servicemen's Group Life Insurance. I further understand that should I fail to furnish satisfactory evidence of insurability, the fact that withholdings have been made from my pay for the insurance being requested shall not create any liability for the insurance, and that I shall be entitled to appropriate credit for such withholdings.

15A. SIGNATURE AND RANK, TITLE OR GRADE OF MEMBER	15B. ORGANIZATION AND MAILING ADDRESS	15C. DATE COMPLETED

PART II - TO BE COMPLETED BY MEMBER'S COMMANDING OFFICER

I CERTIFY THAT the statements made above to the best of my knowledge are true and correct and that the member is now performing full and unrestricted military duty and is physically qualified to perform all duties of his/her rank or position and there is no obvious impairment. I further certify that the signature above is that of the member named and according to the records of this department, this member is eligible to apply for the additional insurance requested on this form.

16A. SIGNATURE OF COMMANDING OFFICER	16C. ORGANIZATION AND MAILING ADDRESS	16D. DATE RECEIVED
16B. RANK, TITLE OR GRADE		

FOR USE OF THE OFFICE OF SERVICEMEN'S GROUP LIFE INSURANCE	☐ APPROVED ☐ DISAPPROVED	SIGNATURE OF OSGLI REPRESENTATIVE	DATE

VA FORM APR 1979 **29-8285** EXISTING STOCKS OF VA FORM 29-8285, JAN 1976, WILL BE USED OSGLI COPY 1

EXHIBIT V

FOR OSGLI USE ONLY 4

APPLICATION FOR VETERANS GROUP LIFE INSURANCE

(Veterans Separated Less Than 120 Days)

Your application and first premium must be returned within 120 days after your separation or discharge from service. NOTE: No insurance may be granted unless a completed application form and first premium have been received (38 U.S.C. 777).

RETURN APPLICATION AND FIRST PREMIUM TO:
Office of Servicemen's Group Life Insurance
213 Washington Street, Newark, NJ 07102
DO NOT RETURN APPLICATION TO VA

SOCIAL SECURITY NO.	DATE OF BIRTH	SEPARATION DATE	SERVICE BRANCH	SERVICE NUMBER	AMOUNT OF SGLI INSURANCE

IMPORTANT

USE THIS FORM only if you have been separated from active duty and you are within the 120 calendar days since separation. To be eligible for Veterans Group Life Insurance, you must have had Servicemen's Group Life Insurance.

You may apply for insurance in a lesser amount but not greater than the amount carried at separation.

See additional information on the reverse, and complete items 1 through 6 below.

1. AGE OF APPLICANT ON 121st DAY AFTER SEPARATION ▼

2. AMOUNT OF VETERANS GROUP LIFE INSURANCE REQUESTED

AMOUNT OF INSURANCE	CHECK (√)	MONTHLY PREMIUM AGE 34 AND UNDER	MONTHLY PREMIUM AGE 35 AND OVER
$35,000		$5.95	$11.90
30,000		5.10	10.20
25,000		4.25	8.50
20,000		3.40	6.80
15,000		2.55	5.10
10,000		1.70	3.40
5,000		.85	1.70

3. ENTER AMOUNT OF PREMIUM ENCLOSED
$

DO NOT WRITE IN SPACE BELOW – FOR OSGLI USE ONLY

ENTER DATE OF RECEIPT

DD 214	MED.	PEND.	PREMIUM APPLIED	NO. MOS.
			$	

ACTION TAKEN ☐ APPROVED ☐ REJECTED

SGLI REPRESENTATIVE | DATE

NOTE: MAKE REMITTANCE PAYABLE TO "SGLI." Attach premium for the amount of insurance desired (no cash or stamps, please). There is no provision for allotments or deductions from your veteran benefits.

4. DESIGNATION OF BENEFICIARY(IES) (SEE ITEMS C AND D ON THE REVERSE.)

I DESIGNATE THE FOLLOWING BENEFICIARIES TO RECEIVE PAYMENT OF MY INSURANCE PROCEEDS:

A. COMPLETE NAME AND ADDRESS OF EACH BENEFICIARY (If married women, give her own first and middle names and husband's last name)	B. RELATIONSHIP TO INSURED	C. SHARES TO BE PAID EACH BENEFICIARY (Use fractions such as 1/2, 1/3, 1/4, or "ALL")	D. PAYMENTS TO BENEFICIARY (See Item D on reverse)
PRINCIPAL (First) BENEFICIARY (See Item C5 on Reverse)			
CONTINGENT (Second) BENEFICIARY (If principal beneficiary dies before me or before completion of installment payments to the principal beneficiary.)			

NOTE: I UNDERSTAND that this form cancels any prior beneficiary or payment instructions and that unless I have named the beneficiary(ies) above, my insurance will be paid as explained in paragraph C2 on the Reverse.

I UNDERSTAND that I cannot have combined SGLI and VGLI coverage at the same time for more than $35,000 (see par. A2 on Reverse).

5. SIGNATURE OF APPLICANT (Do not print – Sign in ink)

6. DATE

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

SGLV-8714-1 JUL 1984

EXISTING STOCKS OF VA FORM 29-8714-1, NOV 1981, WILL BE USED

EXHIBIT VI

Form Approved
OMB No. 2900-0240

OSGLI 4 USE ONLY

APPLICATION FOR VETERANS GROUP LIFE INSURANCE
(Veterans Separated More Than 120 Days)

RETURN COMPLETED FORM TO:
OFFICE OF SERVICEMEN'S GROUP LIFE INSURANCE
212 Washington Street
Newark, New Jersey 07102

IMPORTANT - No insurance may be granted unless a completed application form has been received (38 U.S.C. 777). This application and first premium MUST BE sent to the above Office of Servicemen's Group Life Insurance within 1 year after the 120 days following your separation, together with proof of service. USE THIS FORM ONLY if you have separated from active duty on or after August 1, 1974, and it is after the 120 days following your separation. To be eligible for Veterans Group Life Insurance, you must have had coverage under Servicemen's Group Life Insurance. You may apply for insurance in a lesser amount but not greater than the amount carried at separation. See "Important Information and Instructions" before completing this form.

1. NAME AND ADDRESS OF APPLICANT (Type or print)
(FIRST NAME - MIDDLE NAME - LAST NAME)
(NUMBER AND STREET OR RURAL ROUTE, APT. NO.)
(CITY OR P.O., STATE AND ZIP CODE)

2. SOCIAL SECURITY NO.

3. DATE OF SEPARATION

4. DATE OF BIRTH (Mo., Day, Yr.)

5. BRANCH OF SERVICE

DO NOT WRITE IN SPACE BELOW - FOR OSGLI USE ONLY

ENTER DATE OF RECEIPT

DD214	MED.	PEND.	PREMIUM APPLIED	NO. MOS.

ACTION TAKEN
☐ APPROVED ☐ REJECTED

SGLI REPRESENTATIVE | DATE

6. AGE OF APPLICANT ON 121ST DAY AFTER SEPARATION ▼

7. AMOUNT OF VETERANS GROUP LIFE INSURANCE REQUESTED

AMOUNT OF INSURANCE	CHECK (√)	MONTHLY PREMIUM AGE 34 AND UNDER	MONTHLY PREMIUM AGE 35 AND OVER
$35,000		$5.95	$11.90
30,000		5.10	10.20
25,000		4.25	8.50
20,000		3.40	6.80
15,000		2.55	5.10
10,000		1.70	3.40
5,000		.85	1.70

8. AMOUNT OF PREMIUM ENCLOSED
$

NOTE: MAKE REMITTANCE PAYABLE TO "SGLI." Attach premium for the amount of insurance desired (No cash or stamps please). Also attach proof of service (See par. B on reverse). There is no provision for allotments or deductions from your veteran benefits.

HEALTH INFORMATION

9. HAVE YOU HAD OR BEEN TREATED FOR OR HAD KNOWN INDICATIONS OF (If "Yes" explain in "Remarks" on reverse.)	YES (√)	NO (√)
A. HEART CONDITION?		
B. HIGH BLOOD PRESSURE?		
C. NERVOUS DISORDER?		
D. DIABETES?		
E. CANCER OR TUMORS?		

10. ARE YOU NOW IN GOOD HEALTH? (If "No," explain in Remarks.) ☐ YES ☐ NO

11. HAVE YOU EVER BEEN DECLINED OR POSTPONED FOR ANY FORM OF LIFE OR HEALTH INSURANCE OR OFFERED A POLICY WITH A RATED-UP PREMIUM BECAUSE OF HEALTH REASONS ONLY? ☐ YES ☐ NO
(If "Yes," give name of company, date, and complete details on reverse side.)

12. DO YOU HAVE ANY KNOWN PHYSICAL IMPAIRMENTS, DEFORMATIES, OR ILL HEALTH NOT COVERED ABOVE OR A SERVICE-CONNECTED DISABILITY? ☐ YES ☐ NO
(If "Yes," give complete details on the reverse and furnish VA claim file number.)

13. WEIGHT

14. HEIGHT

15. HAVE YOU EVER USED BARBITUATES, HEROIN, OPIATES OR OTHER NARCOTICS EXCEPT AS PRESCRIBED BY A PHYSICIAN, OR BEEN TREATED FOR ALCOHOLISM? ☐ YES ☐ NO (If "Yes," give complete details on the reverse)

16. HAVE YOU BEEN IN ANY HOSPITAL OR OTHER INSTITUTION FOR OBSERVATION, REST, DIAGNOSES OR TREATMENT DURING THE PAST FIVE YEARS? ☐ YES ☐ NO (If "Yes," give complete details on the reverse)

17. HAVE YOU BEEN ABSENT FROM WORK BECAUSE OF SICKNESS OR INJURY DURING THE LAST SIX MONTHS? ☐ YES ☐ NO (If "Yes," give complete details on the reverse)

I DESIGNATE THE FOLLOWING BENEFICIARIES TO RECEIVE PAYMENT OF MY INSURANCE PROCEEDS AS SHOWN BELOW:

18A. COMPLETE NAME AND ADDRESS OF EACH BENEFICIARY	18B. RELATIONSHIP TO INSURED	18C. SHARE TO EACH (Use fractions, such as 1/2, 2/3, 3/4, or "All")	18D. PAYMENTS (See Par. E of instructions)
PRINCIPAL BENEFICIARY (First - See NOTE below)			
CONTINGENT (Second - If principal beneficiary dies before me or before completion of installment payments to the principal beneficiary)			

NOTE – If more than one principal beneficiary is named, the share of any such beneficiary who dies before me shall be distributed equally among the surviving principal beneficiaries. If there is no surviving principal beneficiary, the proceeds shall be distributed equally or as specified to the surviving contingent beneficiaries. This Designation of Beneficiary shall be void if none of the designated beneficiaries are living at my death. If after completion of this form my insurance is increased, this beneficiary designation shall apply to the full amount in force unless a new designation is made. I UNDERSTAND that this form cancels any prior beneficiary or payment instructions and that unless I have named the beneficiary(ies) above, my insurance will be paid under the "provisions of the law" as explained in Paragraph D of the "Instructions."

19. SIGNATURE OF APPLICANT (Do not print - Sign in ink.) | 20. DATE

I UNDERSTAND that I cannot have combined SGLI and VGLI coverage at the same time for more than $35,000.

PENALTY - The law provides that whoever makes any statement of a material fact [illegible] shall be punished by fine or imprisonment or both.

VA FORM 29-8714-2 JUL 1982 SUPERSEDES VA FORM 29-8714-2, OCT. 1980 WHICH WILL NOT BE USED. PAGE 2 632°80

EXHIBIT VII

CLAIM FOR DEATH BENEFITS

Servicemen's Group Life Insurance
(Veterans' Group Life Insurance)

FOR OSGLI USE ONLY

RETURN COMPLETED FORM TO
OFFICE OF SERVICEMEN'S GROUP LIFE INSURANCE
213 Washington Street
Newark, New Jersey 07102

NOTE: THIS FORM IS NOT TO BE USED FOR NATIONAL SERVICE LIFE INSURANCE (NSLI) Policy Numbers Prefixed by V, H, RH, RS, W, J, JR and JS or UNITED STATES GOVERNMENT LIFE INSURANCE (USGLI) Policy Numbers Prefixed by K

1. NAME OF DECEASED (First, middle, last) | 2. SOCIAL SECURITY NO. | 3. DATE OF DEATH

4. BRANCH OF SERVICE | 5. DUTY STATUS ON DATE OF DEATH (If known) ☐ ACTIVE DUTY ☐ DISCHARGED OR SEPARATED ☐ DRILLING RESERVIST ☐ INDIVIDUAL READY RESERVIST | 6. IF DISCHARGED OR SEPARATED, GIVE DATE (If known) (Month, day, year)

PLEASE READ THE IMPORTANT INFORMATION AND INSTRUCTIONS ON REVERSE BEFORE COMPLETING

PART I – INFORMATION CONCERNING CLAIMANT

7. NAME (First, middle, last) MR MRS MISS MS. | 8. RELATIONSHIP TO DECEASED | 9. DATE OF BIRTH (Month, day, year) | 10. SOCIAL SECURITY NUMBER

NOTE – Complete Items 11A through 14C if you are the widow or widower of deceased.

11A. DATE OF MARRIAGE | 11B. PLACE OF MARRIAGE (City and State) | 12. DID MARRIAGE CONTINUE UNTIL DATE OF DEATH? ☐ YES ☐ NO

13A. DID DECEASED HAVE ANY PREVIOUS MARRIAGES? ☐ YES ☐ NO (If "Yes," complete 13B and 13C) | 13B. PREVIOUS MARRIAGE TERMINATED BY ☐ DEATH ☐ DIVORCE | 13C. DATE PREVIOUS MARRIAGE TERMINATED

14A. DID YOU HAVE ANY PREVIOUS MARRIAGES? ☐ YES ☐ NO (If "Yes," complete 14B and 14C) | 14B. PREVIOUS MARRIAGE TERMINATED BY ☐ DEATH ☐ DIVORCE | 14C. DATE PREVIOUS MARRIAGE TERMINATED

NOTE – If you are not the named beneficiary, widow or widower of the deceased, complete Parts II and III

PART II – INFORMATION CONCERNING NEXT-OF-KIN OF DECEASED

List below the name, age, relationship, and address of *(Check appropriate places below)*

(a) Widow or Widower. ☐ None ☐ Death Give Date ______

If none, was insured ever married? ☐ Yes ☐ No If yes, did marriage terminate by ☐ Divorce Give Date ______

(b) If there is no surviving widow or widower, list all the children of the deceased. Include any adopted child or illegitimate child stating which class it is and list the descendants of any deceased child or children. If none, check here ☐

(c) If there are no children or descendants of children, list the surviving parent or parents

Is father deceased? ☐ Yes ☐ No Is mother deceased? ☐ Yes ☐ No

(d) If there are no survivors within the degrees indicated in (a) through (c), list below the next of kin who may be capable of inheriting from the deceased (brothers, sisters, descendants of deceased brothers, sisters, etc.)

15A. NAME	15B. AGE	15C. RELATIONSHIP TO DECEASED	15D. ADDRESS

NOTE – Complete Items 16 and 17 ONLY if any of the persons listed above are under age 21.

16. NAME AND ADDRESS OF GUARDIAN FOR ANY MINOR CHILDREN LISTED ABOVE IF ONE HAS BEEN APPOINTED BY THE COURT (Attach copy of appointment paper issued by court) | 17. IF A GUARDIAN HAS NOT BEEN APPOINTED, WILL ONE BE APPOINTED? ☐ YES ☐ NO

PART III – INFORMATION CONCERNING THE ESTATE OF THE DECEASED

18. NAME AND ADDRESS OF EXECUTOR OR ADMINISTRATOR (IF ANY) APPOINTED BY THE COURT TO SETTLE THE ESTATE OF THE DECEASED | 19. IF AN EXECUTOR OR ADMINISTRATOR HAS NOT BEEN APPOINTED, WILL ONE BE APPOINTED? ☐ YES ☐ NO

PART IV – CERTIFICATION BY CLAIMANT

I HEREBY CERTIFY that all statements made in this claim are true to the best of my knowledge, information, and belief, and that no evidence necessary to a settlement of this claim is suppressed or withheld. *In the event the insured has not previously elected monthly installments, I request* that the Death Benefit be paid in *(Check one)* ☐ One Sum ☐ 36 Equal Monthly Installments

20. SIGNATURE OF CLAIMANT | 21. ADDRESS (Number and Street, City, State and ZIP Code, Apt. No.) | 22. DATE

WARNING: Any intentional false statement in this claim or willful misrepresentation relative thereto is subject to punishment by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001)

SGLV-8283 JAN 1986 SUPERSEDES VA FORM 29-8283, AUG 1980 WHICH WILL NOT BE USED
IF ADDITIONAL SPACE IS REQUIRED, ATTACH SEPARATE SIGNED SHEETS