

Group Life Insurance

SERVICEMEMBERS' GROUP LIFE INSURANCE TRAUMATIC INJURY PROTECTION PROGRAM (TSGLI)

Administered by the Office of Servicemembers' Group Life Insurance

TSGLI Appeal Request Form

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 Email	Submit Claim by Postal Mail
Army All Components	Phone: 888-276-9472 Website: www.hrc.army.mil/content/Traumatic Servicemembers' Group Life Insurance	502-613-4513	usarmy.knox.hrc.mbx.tagd-tsgli-claims @mail.mil	US Army Human Resources Command 1600 Spearhead Division Avenue, Dept 420 PDR-C (TSGLI) Fort Knox, KY 40122-5402
Marine Corps All Components	Phone: 877-216-0825 or 703-975-4069 Website: www.woundedwarrior.marines.mil	800-770-9968	t-sgli@usmc.mil	HQ, Marine Corps Attn: WWR-TSGLI 1998 Hill Avenue Quantico, VA 22134
Navy All Components	Phone: 1-877-270-2162 Website: www.mynavyhr.navy.mil/ Support-Services/Casualty/TSGLI/	901-874-2265	MILL_TSGLI.FCT@navy.mil	Commander, Navy Personnel Command Attn: PERS-00C 5720 Integrity Drive Millington, TN 38055-1300
Air Force and Space Force Active Duty	Phone: 800-525-0102, Option 1, Option 1		AFPC.DPFCS.Pol_Trng_CaseMgt@ us.af.mil	AFPC/DPFCS 550 C Street West, Suite 14 Randolph AFB, TX 78150-4716
Air Force Reserves and Air National Guard	Phone: 800-525-0102, Option 3, Option 1	720-847-3887	casualty.arpc1@us.af.mil	HQ, ARPC/DPTTB 18420 E. Silver Creek Ave. Building 390 MS 68 Buckley AFB, CO 80011
Coast Guard	Phone: 202-795-6638 Website: www.dcms.uscg.mil/PSD/fs/TSGLI		ARL-PF-CGPSC-PSDFS- COMPENSATION@uscg.mil	Commander (CG) Personnel Service Center (PSC) Attn: TSGLI Case Manager, PSC-PSD-FS-Casualty U.S. Coast Guard STOP 7200 2700 Martin Luther King Jr Ave SE Washington, DC 20593-7200
Public Health Service	Phone: 240-276-8799	240-276-8817 or 240-453-6030	compensationbranch@psc.hhs.gov	PHS Compensation Branch 1101 Wootton Parkway Suite: 100 Rockville, MD 20852
NOAA Corps	Phone: 301-713-3444	301-713-4140	Director.cpc@noaa.gov	U.S. Dept. of Commerce NOAA/OMAO/CPC 8403 Colesville Rd, Suite 500 Silver Spring, MD 20910



TSGLI APPEAL REQUEST FORM

Instructions

Use this form when filing an appeal for previously denied benefits under the Servicemembers' Group Life Insurance Traumatic Injury Protection (TSGLI) program. Requests must be submitted to your branch's TSGLI office or Appeal office within one year of a claim's denial date. Please review your previous decision letter for instructions on where to submit your appeal and whether this form is required. If you are submitting a new claim or claiming losses that were not previously reviewed, an Application for TSGLI Benefits (SGLV-8600) needs to be completed.

Who Makes the Decision on My Appeal?

Your branch of service TSGLI office, or its higher appeal authority, will make the decision on your appeal based upon the information provided on this form and any supporting documentation you provide. They will then forward their decision to the Office of Servicemembers' Group Life Insurance (OSGLI) for appropriate action.

1.	First Name MI Last Name
2.	SSN (Last 4 digits) Date of Birth (MM DD YYYY)
3.	Address: Street or PO Box
.	
	City State ZIP Code
4.	Phone Number Email Address
5.	Date of traumatic event/injury (MM DD YYYY) Location
J .	
6.	List losses from TSGLI Schedule of Losses that are being appealed.
٠.	Electroscopy in in 1902. Solidation of Ecology appearable
Th	ird-Party Authorization
	(Optional) I authorize the following person to speak with OSGLI or the Branch of Service about my claim (this can be a spouse,
	parent, friend, or another person who is helping you with your claim).
	First Name MI Last Name
Gu	ıardian, Power of Attorney, or Military Trustee Information
	portant Note: Please include copies of the letters of guardianship, conservatorship, Power of Attorney, or DD Form 2827 –
Αp	pplication for Trusteeship etc. with this form. Failure to include this documentation will delay processing of your appeal.
Co	implete this section ONLY if a guardian, power of attorney, or military trustee will receive payment on behalf of the member.
Firs	st Name MI Last Name
Ma	iling Address (number and street) Apartment (if any)
City	y State ZIP Code
Tel	ephone Number Fax Number

7. Reason for appeal: Please check the box(es) that explain the reason(s) for your appeal. After each selected reason please provide a brief description of any new supporting evidence (Example: specific page number(s) in medical records, date(s) of medical records, police report, supporting statements etc.).
NOTE: To avoid delays in the review process, please highlight any new and material evidence within medical records and submit only the new evidence/documentation that supports the appeal. There is no need to resubmit all previously submitted documents as they will be considered when your appeal is reviewed.

10	support my appeal, I am providing new evidence or documentation to support: (check all that apply):					
	LI coverage was in effect at the time of the traumatic event.					
	Description of new evidence:					
	New medical evidence to support my loss.					
	Description of new evidence:					
	My loss occurred within 730 days of the traumatic event.					
	Description of new evidence:					
	My loss was not due to a physical or mental illness.					
	Description of new evidence:					
	My loss was the direct result of a traumatic event.					
	Description of new evidence:					
П	My traumatic injury was not willfully caused by my own actions.					
	Description of new evidence:					
	Description of new evidence.					
	I was not committing or attempting to commit a felony when my traumatic injury occurred.					
	Description of new evidence:					
	I did not willfully use an illegal or controlled substance leading up to my traumatic injury.					
	Description of new evidence:					
	My loss was not the result of a medical or surgical procedure.					
	Description of new evidence:					
	Modern was not the vesselt of an attenuated existed					
ш	My loss was not the result of an attempted suicide. Description of new evidence:					
	Description of new evidence.					
	Other (reason is not listed above).					
_	Description of new evidence:					

Please provide any addi	itional supporting details to	be considered wh	nen your appeal is re	view	ed.
		Dat 	te Signed (MM DD YYYY)		
ture					Authority to act on behalf of the Servicemember (Guardian, POA, etc.)

* 8 7 3 2 6 0 4 *

Payment	Payment Option 1—Prudential's Alliance Account® Complete the mailing address below (street address only, no PO boxes).		
Options Please choose one			
of the three payment			
options by checking the appropriate box	Servicemember's Mailing Address for Payment—No PO Boxes	Apartment, Ward or Room (if any)	
and filling in the			
requested information.	City State ZIP Code		
Payment Option 1 — Prudential's			
Alliance Account			
An interest-bearing account will be	Payment Option 2—Electronic Funds Transfer (EFT)		
established in	To have the payment made by EFT, fill in your banking information below.		
the name of the	Bank Routing Number Bank Account Number		
Servicemember, who can access		Checking	
the money using		Savings	
the draft book. A guardian or power	Bank Name Bai	nk Phone Number	
of attorney may sign			
Alliance Account® drafts on behalf of	First Name MI Last Name		
the Servicemember, if			
proof of appointment is submitted with the			
claim.	Customer XYZ	Check No. 1246	
Payment Option 2	XYZ Street City, State, ZIP	The bank account number varies in	
– Electronic Funds Transfer	PAY TO THE Sample Check	length and may	
This option can be	The bank routing PAY TO THE Samp.	\$ contain dashes or	
selected by the	number is always	Dollars spaces. The II =	
Servicemember or, if applicable, the	9 digits and	symbol indicates the end of the	
guardian, power of	appears between Bank XYZ UXYZ Street	account number.	
attorney, or military trustee. Payment	the : symbols City, State, ZIP		
will be made to the	A27202754 006666D66666C 1246		
Servicemember's	Bank Routing Number Bank Account Number Check Number	(not needed)	
bank account, or in the case of a		(
military trustee, the	Payment Option 3—Check		
trusteeship account.	Important: If you are a guardian, power of attorney, or military trustee you must con	mplete the information below	
Payment Option 3 – Check	when requesting a check.		
A check will be issued	Mailing Address for Payment—No PO Boxes	Apartment (if any)	
to the Servicemember, guardian, power of			
attorney, or military	City State ZIP Code		
trustee on behalf of the Servicemember.			
tile Servicemember.			
Financial	To receive this counseling, check the box below.		
Counseling	I would like to receive financial counseling with my TSGLI benefit. This counseling	is offered at no cost to you.	
VA sponsors financial counseling	You should get financial counseling as soon as possible after receiving your insurance money and before making any major financial decisions.		
for TSGLI recipients.	For more information on this benefit, visit http://www.benefits.va.gov/insurance/bfcs.asp.		
Signature	X		
The Servicemember, guardian, power of	Signature of servicemember guardian, power of attorney, or military trustee	Description of Authority to	
attorney, or military Date Signed (MM DD YYYY) act on behalf of			
trustee must sign here.		(Guardian, POA, etc.)	



Authorization	Member must complete and sign the HIPAA release below:						
for Release of	l authorize any health plan, physician, health care professional, hospital, clinic, laboratory, p	pharmacy, medical facility, medical					
Information to Branch of Service	examiner or other health care provider that has provided treatment, navment, or services portaining to						
and Office of	First Name MI Last Name						
Servicemembers'							
Group Life Insurance	Date of Birth (MM DD YYYY)						
The Servicemember,							
guardian, power							
of attorney, or or on my behalf ("My Providers") to disclose my entire medical record for me or my dependents and any other							
military trustee	$concerning \ me \ to \ the \ Branch \ of \ Service \ and \ Office \ of \ Service members' \ Group \ Life \ Insurance \ and \ Office \ of \ Service members' \ Group \ Life \ Insurance \ and \ Office \ of \ Service \ of \ of \ Service \ of \ of \ Service \ of \ Office \ of \ Service \ of \ of \ Office \ of \ of \ Office \ of \ o$						
must complete and	and representatives. This also includes information on the diagnosis and treatment of menta						
sign this section.	and tobacco, but excludes psychotherapy notes. OSGLI is an administrative unit created by Prud Group Life Insurance Program. OSGLI administers the TSGLI program on behalf of the Department of						
Failure to	Group the insurance rrogram. Oddti administers the 13dti program on behan of the bepe	artification veteralis Arrans.					
complete this section will	I authorize all non-health organizations, any insurance company, employer, or other person of information, data, or records relating to credit, financial, earnings, travel, activities, or employer.						
delay payment of claim	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 prote this Authorization, and I instruct My Providers to release and disclose my entire medical rec						
comply with the HIPAA Privacy Rule.	TILL () 1 1 1 1 1 1 1 1 1						
	I understand that if I refuse to sign this Authorization to release my complete medical recomy claim for benefits and may not be able to make any benefit payments. I understand that a copy of this Authorization.						
	*Limits, if any:						
	NOTE: This release authorizes the branch of service and OSGLI to look at medical records. You may	y also be asked to provide these document					
Signature	Χ						
The Servicemember,	X Signature of Servicemember guardian, power of attorney, or military trustee	Description of Authority to					
guardian, power of attorney, or military		act on behalf of the member					
trustee must sign here.	Date Signed (MM DD YYYY)	(Guardian, POA, etc.)					

