Prudential

Office of Servicemembers' Group Life Insurance

OSGLI
PO Box 41618
Philadelphia, PA 19176-1618

Phone: 800-419-1473
Fax: 800-236-6142

Veterans' Group Life Insurance Application Instructions

You have one year and 120 days from your date of separation to apply for Veterans' Group Life Insurance (VGLI). To apply for VGLI, visit **benefits.va.gov/insurance**, or complete the attached application and return it to the above address.

Important to know: You may be able to keep your SGLI coverage fo up to two years after your separation if you separated with a disability and meet the legislative requirements. Visit va.gov/life-insurance/options-eligibility/sgli/ to download an application and apply today.

To complete the attached application, follow these easy steps:

1. **Veteran Information.** Complete all fields under "Veteran Information." You **do not** have to fill out fields under "My Correct Address Information Is" if you've provided your correct address in the fields above. Complete all fields under "Additional Contact Information."
2. **Coverage Election and Payment Method.** Choose your coverage amount and billing preferences. The chart below shows the most frequently requested coverage amounts and the monthly premium. Coverage is available in $10,000 increments. For coverage amounts not shown below, please see the rate chart at insurance.va.gov or call 800-419-1473. Your initial VGLI coverage cannot exceed the amount of Servicemembers' Group Life Insurance you had at the time of discharge. However, if you had less than $400,000 of SGLI at discharge and you get VGLI coverage, you will have the opportunity to increase your VGLI coverage by $25,000 on your one-year anniversary and every five-year anniversary thereafter, up to the maximum of $400,000, until age 60.

Amount of Coverage	Age 29 & Under	Age 30–34	Age 35–39	Age 40–44	Age 45–49	Age 50–54	Age 55–59	Age 60–64	Age 65–69	Age 70–74	Age 75–79	Age 80 & Over
$400,000	$28.00	$36.00	$48.00	$64.00	$84.00	$132.00	$240.00	$396.00	$588.00	$904.00	$1,712.00	$1,800.00
$350,000	$24.50	$31.50	$42.00	$56.00	$73.50	$115.50	$210.00	$346.50	$514.50	$791.00	$1,498.00	$1,575.00
$300,000	$21.00	$27.00	$36.00	$48.00	$63.00	$99.00	$180.00	$297.00	$441.00	$678.00	$1,284.00	$1,350.00
$250,000	$17.50	$22.50	$30.00	$40.00	$52.50	$82.50	$150.00	$247.50	$367.50	$565.00	$1,070.00	$1,125.00
$200,000	$14.00	$18.00	$24.00	$32.00	$42.00	$66.00	$120.00	$198.00	$294.00	$452.00	$856.00	$900.00
$150,000	$10.50	$13.50	$18.00	$24.00	$31.50	$49.50	$90.00	$148.50	$220.50	$339.00	$642.00	$675.00
$100,000	$7.00	$9.00	$12.00	$16.00	$21.00	$33.00	$60.00	$99.00	$147.00	$226.00	$428.00	$450.00
$50,000	$3.50	$4.50	$6.00	$8.00	$10.50	$16.50	$30.00	$49.50	$73.50	$113.00	$214.00	$225.00
$10,000	$0.70	$0.90	$1.20	$1.60	$2.10	$3.30	$6.00	$9.90	$14.70	$22.60	$42.80	$45.00

3. **Health Statement.** If your date of separation was less than 240 days ago, then you **do not** need to complete this section. If your date of separation was more than 240 days ago, then please be sure to complete this section.
4. **Beneficiary Designation.** Use this section to name your beneficiaries. If you would like to name more beneficiaries than the application allows, please list those additional beneficiaries on a separate sheet of paper along with your name, Social Security number, signature, and date. Your beneficiary designation is not valid unless it is signed, dated, and received by OSGLI prior to your death.
5. **Authorization/Signature.** Please sign and date the application and send it to OSGLI at the address above. Include your first VGLI premium payment and a copy of your DD-214 or most recent Leave and Earnings Statement with your application. **Your VGLI application is not considered complete unless we receive these items with your application.**

Questions?
For more information about VGLI, please visit insurance.va.gov or call 800-419-1473 (Monday to Friday, 8 a.m. to 5 p.m. ET.).

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Office of Servicemembers' Group Life Insurance

IMPORTANT: No insurance may be granted unless a completed application has been received (38 U.S.C. 1977). Please complete all fields and correct any inaccurate information.

1 VETERAN INFORMATION (INFORMATION ON FILE)

First Name: MI:

Last Name:

Social Security number: – –

Address 1:

Address 2:

City:

State: ZIP Code: – Country:

Date of Birth: – – Gender: ☐ Male ☐ Female Age

Branch of Service: Date of Separation: – – MM DD YYYY

MY CORRECT ADDRESS INFORMATION IS (check this box for changes ☐)

First Name: MI:

Last Name:

Address 1:

Address 2:

City:

State: ZIP Code: – Country:

ADDITIONAL CONTACT INFORMATION

Email:

☐ Please send me general information and newsletters by email

☐ Please send me notices related to my bill or policy by email

Daytime Phone: – – Evening Phone: – –

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2 COVERAGE ELECTION AND PAYMENT METHOD

I am applying for the following amount of coverage: $,

Amount must be in multiples of $10,000 and cannot exceed $400,000 or the amount on date of discharge (whichever is less).

Your SGLI amount on the date of your discharge was: $,

I would like my payment cycle to be: ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

I have enclosed my first premium payment of: $,

☐ Automatic Monthly Deductions from military retirement pay.

☐ Automatic Monthly Deductions from VA Compensation.

My VA claim file number is:

Have you been able to work since leaving the service? ☐ Yes ☐ No

If no, is this due to a disability incurred while in the service? ☐ Yes ☐ No

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

Height: feet inches Weight: pounds

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. Liver or gall bladder disorder?	☐	☐
H. Stomach or intestinal disorder?	☐	☐
I. Arthritis?	☐	☐

In the past five 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 five 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. Do you have 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? _____

Veteran's Signature:

X

Date: – –
MM DD YYYY

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4 BENEFICIARY DESIGNATION

Beneficiary(ies) and Benefit Payment Options

I designate the following beneficiary(ies) to receive my insurance proceeds. I understand that the primary beneficiary(ies) will receive payment upon my death. The share of any primary beneficiary who dies before me will be distributed equally among the remaining primary beneficiaries. If all primary beneficiary(ies) die before me, the insurance will be paid to the secondary beneficiaries. I understand that unless I have named a beneficiary(ies) below, my insurance will be paid under the provisions of the law (38 U.S.C. 1970). The designation below cancels any prior SGLI or VGLI beneficiary designation or payment instruction.

A. Primary Beneficiaries

The total for all primary beneficiaries must equal 100%.

1. Type (Select One) ☐ Child ☐ Parent ☐ Spouse ☐ Other Family ☐ Other ☐ Estate ☐ Charitable Institution

Gender: ☐ Male ☐ Female

First Name: MI:

Last Name:

Other:

Address:

Phone: Social Security number:

Payment: ☐ Lump Sum* ☐ 36 Installments Share: %

2. Type (Select One) ☐ Child ☐ Parent ☐ Spouse ☐ Other Family ☐ Other ☐ Estate ☐ Charitable Institution

Gender: ☐ Male ☐ Female

First Name: MI:

Last Name:

Other:

Address:

Phone: Social Security number:

Payment: ☐ Lump Sum* ☐ 36 Installments Share: %

To list more beneficiary(ies) please copy and attach additional pages.

(must equal 100%) **TOTAL**

*If you elect a lump-sum payment, the beneficiary(ies) will be given the option of receiving the lump-sum payment through the Prudential Alliance Account, by check or Electronic Funds Transfer (EFT). Alliance is not available for payments less than $5,000, payments to individuals residing outside the United States and its territories, and certain other payments. These will be paid by check.

The funds in an Alliance Account begin earning interest immediately and will continue to earn interest until all funds are withdrawn. Interest is accrued daily, compounded daily and credited every month. The interest rate may change and will vary over time subject to a minimum rate that will not change more than once every 90 days. You will be advised in advance of any change to the minimum interest rate via your quarterly Alliance Account statement or by calling Customer Support at (877) 255-4262.

The Bank of New York Mellon is the Administrator of the Prudential Alliance Account Settlement Option, a contractual obligation of The Prudential Insurance Company of America, located at 751 Broad Street, Newark, NJ 07102-3777. Draft clearing and processing support is provided by The Bank of New York Mellon. **Alliance Account balances are not insured by the Federal Deposit Insurance Corporation (FDIC).** The Bank of New York Mellon is not a Prudential Financial company.

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B. Secondary Beneficiaries

The total for all secondary beneficiaries must equal 100%.

1. Type (Select One) ☐ Child ☐ Parent ☐ Spouse ☐ Other Family ☐ Other ☐ Estate ☐ Charitable Institution

Gender: ☐ Male ☐ Female

First Name: MI:

Last Name:

Other:

Address:

Phone: Social Security number:

Payment: ☐ Lump Sum* ☐ 36 Installments Share: %

2. Type (Select One) ☐ Child ☐ Parent ☐ Spouse ☐ Other Family ☐ Other ☐ Estate ☐ Charitable Institution

Gender: ☐ Male ☐ Female

First Name: MI:

Last Name:

Other:

Address:

Phone: Social Security number:

Payment: ☐ Lump Sum* ☐ 36 Installments Share: %

To list more beneficiary(ies) please copy and attach additional pages.

(must equal 100%) **TOTAL**

5 AUTHORIZATION / SIGNATURE

I authorize OSGLI to record and consider the individuals/institutions that I have named on this form as beneficiaries for VGLI benefits, specifically those names I have entered in section A ("Primary Beneficiaries") and also section B ("Secondary Beneficiaries").
I understand that I cannot have combined SGLI and VGLI coverage for more than $400,000. I understand that unless I have named a beneficiary(ies) above, my insurance will be paid under provisions of Federal Law.

Veteran's Signature:

X Date: MM – DD – YYYY

The Veteran must sign and date this form.
The signature date must be the date this form is actually signed.

Submit the completed form by fax to 800-236-6142 or mail to: OSGLI, PO BOX 41618, Philadelphia, PA 19176-9913

Office of Servicemembers' Group Life Insurance (OSGLI) telephone number is 800-419-1473.
Please visit insurance.va.gov to create an online account and see other available features.

Please keep a copy of the completed form for your records.