



Prudential

Office of Servicemembers'
Group Life Insurance

Claim for Accelerated Benefits

Servicemembers' Group Life Insurance (SGLI)
Veterans' Group Life Insurance (VGLI)

About the Accelerated Benefit Option

The Accelerated Benefit Option allows you to receive up to 50% of your SGLI or VGLI benefit if you have been diagnosed by your physician as being terminally ill (as defined in Public Law 105-368) with nine (9) months or less to live. Only you (the insured) can apply for this benefit.

The amount of insurance proceeds payable to your beneficiaries at the time of your death will be reduced by the amount of accelerated benefit you choose to receive now. Your premium will be lowered to reflect your reduced coverage amount.

How to Submit a Claim for Accelerated Benefits

You, your physician and, if you're covered under SGLI, your branch of service must complete the attached forms as indicated. Completed forms should be submitted as follows:

Active duty service members/Reservists	Army National Guard	Veterans
Submit completed forms to your branch of service personnel office.	Contact your state headquarters for submission instructions.	Submit completed forms to: The Prudential Insurance Company of America PO Box 70173 Philadelphia, PA 19176-0173 Fax: 877-832-4943

Important Information

- If your claim for accelerated benefits is approved, you will receive a check for the amount requested.
- Once the payment is cashed, the accelerated benefit cannot be revoked.
- You can receive this benefit only once during your lifetime.
- You may use this benefit for any purpose you choose.
- If you're covered under SGLI, the Office of Servicemembers' Group Life Insurance (OSGLI) will notify your branch of service to reduce the face amount of your coverage and your premium rate.
- If you die before cashing the accelerated benefit check, your next of kin should return the check to OSGLI.
- If your claim is not approved, you have the option of submitting additional medical information or reapplying at a later date.



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TO BE COMPLETED BY SERVICE MEMBER OR VETERAN

CLAIM FOR ACCELERATED BENEFITS		
Name (first middle last)		Social Security Number
Home address	Date of birth (mm/dd/yyyy)	Branch of Service (if covered under SGLI)
Mailing address (if different from home address)	Amount of SGLI/VGLI coverage \$	Amount of claim (Cannot exceed 50% of your total coverage) \$
Telephone Number	Email Address (Your email address is being requested so that we can provide you with a tracking number once your claim has been processed)	
Type of coverage (check one) <input type="checkbox"/> VGLI <input type="checkbox"/> SGLI (if covered under SGLI, indicate your current status) <input type="checkbox"/> Active Duty <input type="checkbox"/> Ready Reserve <input type="checkbox"/> Army or Air National Guard <input type="checkbox"/> Separated or Discharged		
Important: If you checked SGLI, your branch of service personnel office must complete page 4.		
I acknowledge that I have read all of the attached information about the accelerated benefit. I understand that I can get this benefit only once during my lifetime and that I can use it for any purpose I choose. I further understand that the face amount of my coverage will reduce by the amount of accelerated benefit I choose to receive now.		
Signature _____		Date Signed _____

AUTHORIZATION TO RELEASE MEDICAL RECORDS
To all physicians, hospitals, medical service providers, pharmacists, employers, other insurance companies, and all other agencies and organizations:
You are authorized to release a copy of all my medical records, including examinations, treatments, history, and prescriptions, to the Office of Servicemembers' Group Life Insurance (OSGLI) or its representatives.
Print Name _____
Signature _____ Date Signed _____
<i>A photocopy of this authorization will be considered as effective and valid as the original. Valid for one year from date signed.</i>



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TO BE COMPLETED BY SERVICE MEMBER'S OR VETERAN'S PHYSICIAN

ATTENDING PHYSICIAN'S CERTIFICATION		
Patient's name		Patient's Social Security Number
Diagnosis	ICD-9-CM/ICD-10-CM Disease Code*	
Description of Present Medical Condition (Please attach any supporting documentation such as x-rays, E.K.G. results, or test results.)		
Is the patient capable of handling his/her own affairs? <input type="checkbox"/> Yes <input type="checkbox"/> No		
The patient applied for an accelerated benefit under his/her government life insurance coverage. To qualify, the patient must have a life expectancy of nine (9) months or less. Does your patient meet this requirement? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Attending physician's name (please print)	State in which you are licensed to practice	Specialty
Mailing address	Fax number	Telephone number
Signature _____ Date Signed _____		

**International Classification of Diseases, 9th revision, Clinical Modification/International Classification of Diseases, 10th revision, Clinical Modification*

