Prudential

Office of Servicemembers' Group Life Insurance

Please send the completed form and all attachments to:

OSGLI
PO Box 41618
Philadelphia, PA 19176

SGLI Disability Extension Application and Instructions

IMPORTANT INFORMATION ABOUT THE SERVICEMEMBERS' GROUP LIFE INSURANCE (SGLI) DISABILITY EXTENSION

The SGLI Disability Extension provides coverage for up to two years from your date of separation at no cost to you. The SGLI Disability Extension is available to Veterans who are totally disabled and had SGLI coverage at the time of their separation from service. To be considered totally disabled, **you must have any impairment of mind or body which continuously renders it impossible for you to follow any substantially gainful occupation, OR have one of the following conditions,** regardless of employment status:

1. Permanent loss of use of any of the following:
   - both hands
   - both feet
   - both eyes
   - one foot and one eye
   - one hand and one foot
   - one hand and one eye
2. Total loss of hearing in both ears
3. Organic loss of speech (lost ability to express oneself, both by voice and whisper, through normal organs for speech. Note: Being able to speak with an artificial appliance is still considered a loss of speech.)

For more information about the SGLI Disability Extension, please visit:
www.benefits.va.gov/insurance/sglidisabled.asp

HOW TO APPLY FOR THE SGLI DISABILITY EXTENSION

- **Review and follow the applicable instructions within each section.**
- **Mail your completed application and required documentation to the address above or fax to 800-236-6142.**

Important: You must include a copy of your most recent separation orders and your most recent **Leave and Earnings Statement (LES)** with your application. You may also send in a copy of your **DD-214** or **NGB22** in lieu of your **separation orders** and LES.

If your application is approved:

- You will receive written notification of your approval from the Office of Servicemembers' Group Life Insurance (OSGLI).
- Your SGLI coverage will be extended for a maximum of two years from your date of separation or until you are able to work, whichever comes first.
- Around 60 days prior to the end of your SGLI Disability Extension you will receive a billing statement for Veterans' Group Life Insurance (VGLI). Your VGLI coverage will begin the day after your SGLI Disability Extension ends, provided we've received your first VGLI premium payment. If you do not receive a billing statement at this time, please contact OSGLI immediately. If you don't pay the initial premium, you won't have the coverage. If you do not want VGLI, simply disregard the billing statement and you will not be enrolled for coverage. It is important that you provide OSGLI with up-to-date contact information to ensure you receive the billing statement.
- If your application is not approved, you will receive written notification of your denial. If you applied for the SGLI-DE within 1 year and 120 days from separation, you will also receive instructions on additional steps you can take to have your application considered for VGLI coverage.

QUESTIONS?

If you have any questions, please send an email to sgli.extension@prudential.com or call 800-419-1473, Monday through Friday, between 8:00 a.m. and 5:00 p.m. Eastern Time.

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SGLI Disability Extension Application
Veteran's Statement

Please read the instructions on page 1 before completing this form.

1 Veteran Information

First Name | MI | Last Name

Social Security Number | Date of Birth (MM DD YYYY) | Gender ☐ Male ☐ Female

Address Line 1

Address Line 2

City | State | ZIP Code

Country | Phone Number

Email Address

Date of Separation (MM DD YYYY) | Branch of Service | SGLI Coverage Amount $

2 Eligibility

Has VA rated you totally disabled based on individual unemployability*? ☐ Yes ☐ No

If yes, you must include a complete copy of the VA rating decision document from VA with your application.

*Unemployability means that VA has determined that you are incapable of obtaining or maintaining gainful employment due to your disability.

STOP **If you checked yes, skip sections 3 and 4 and complete sections 5 and 6 only. You do not need to complete section 7.**

3 Veteran's Impairment Statement

Do you have any of the following conditions?

• Permanent loss of use of both hands	☐ Yes	☐ No
• Permanent loss of use of both feet	☐ Yes	☐ No
• Permanent loss of use of both eyes	☐ Yes	☐ No
• Permanent loss of use of one hand and one foot	☐ Yes	☐ No
• Permanent loss of use of one foot and one eye	☐ Yes	☐ No
• Permanent loss of use of one hand and one eye	☐ Yes	☐ No
• Total loss of hearing in both ears	☐ Yes	☐ No
• Organic loss of speech*	☐ Yes	☐ No

*Organic loss of speech is the lost ability to express oneself, both by voice and whisper, through normal organs for speech. Note: Being able to speak with an artificial appliance is still considered a loss of speech.

- **Important: If you checked yes to any of the conditions above, you must include either a complete copy of your VA or Military rating decision supporting this loss.**

STOP **If you checked yes to any of the conditions above, skip section 4 and complete sections 5 and 6 only. You do not need to complete section 7.**

4 Work Status

Choose the box that describes your current work status:

- ☐ I am currently working more than 20 hours per week.
- ☐ I am currently working 20 hours per week or less.
- ☐ I am not currently working, but have worked since I separated from service.
- ☐ I have not worked since my separation from service due to my disability.

Are you currently working with special conditions or accommodations? ☐ Yes ☐ No

If yes, you must provide evidence of condition or accommodation. Satisfactory evidence may include a letter from your employer on company letterhead.

A special condition or accommodation is any condition or accommodation without which an individual would be unable to work without more supervision or assistance than required by other workers performing similar work.

Provide your work history since your separation from service in the chart below. Include any periods of self-employment. If you need more space than is allowed, use a separate sheet of paper and include it with your application. If you have not worked since separating from service, do not complete.

Name, address and phone number of employer	Type of work (e.g., seasonal, occasional, or year-round)	Average number of hours worked per week	Dates of employment	
			From (mm/dd/yyyy)	To (mm/dd/yyyy)

5 Veteran's Signature

I declare that, to the best of my knowledge and belief, the above statements are complete and true. Any deception or false statement, either my reference, omission, or otherwise can result in loss of coverage or denial of a claims for benefits.

X _____ Date of Signature (MM DD YYYY)

Veteran's Signature

Important: Be sure to include a copy of your most recent separation orders and Leave and Earnings Statement (LES) with your application. You may also send in a copy of your DD-214 or NGB22 in lieu of your separation orders and LES.

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Office of Servicemembers' Group Life Insurance

Authorization Form

6 **Authorization for Release of Information to the Office of Service-members' Group Life Insurance**

This Authorization is intended to comply with the HIPAA Privacy Rule

Claimant's Social Security Number

Name of Insured:

First Name | MI | Last Name

Date of Birth (MM DD YYYY)

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided treatment, payment or services pertaining to:

First Name | MI | Last Name

Print Name of Deceased or Patient

or on my (his/her) behalf ("My Providers") to disclose my (his/her) entire medical record for me or my dependents and any other health information concerning me (him/her) to the Office of Servicemembers' Group Life Insurance (OSGLI) and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

I authorize all non-health organizations, any insurance company, employer or other person or institutions to provide any information, data or records relating to credit, financial, earnings, travel, activities or employment history to OSGLI.

Unless limits* are shown below, this form pertains to all of the records listed above.

By my signature below, I acknowledge that any agreements I (he/she) have made to restrict my (his/her) protected health information do not apply to this authorization and I instruct My Providers to release and disclose my (his/her) entire medical record without restriction.

This information is to be disclosed under this Authorization so that OSGLI may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits, 2) obtain reinsurance; 3) administer coverage; and 4) conduct other legally permissible activities that relate to any coverage I (he/she) have (has) or have (has) applied for with OSGLI.

This authorization shall remain in force for 24 months following the date of my signature below, while the coverage is in force. A copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to OSGLI at: P.O. Box 41618, Philadelphia, PA 19176. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that OSGLI has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this authorization to release my (his/her) complete medical record, OSGLI may not be able to process my claim for benefits and may not be able to make any benefit payments. I understand that I have the right to request and receive a copy of this authorization.

*Limits, if any:

Date of Signature (MM DD YYYY)

X

Signature of Insured/Patient or Personal Representative

Description of Personal Representative's Authority or Relationship to Patient

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SGLI Disability Extension Application Physician's Statement

STOP (This is not required if you answered yes to section 2 or 3 and are including a complete copy of your VA rating and/or your Military rating decision document.)

7 Instructions for the Physician:

This form must be completed by your physician. Upon its completion, please send the entire application to OSGLI, at the address noted above.

Your patient has requested coverage under the Servicemembers' Group Life Insurance (SGLI) Disability Extension program. Answer all applicable parts of this form completely. Your answers should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Please be as specific as you can.

Patient's First Name | MI | Last Name

Patient's Social Security Number

Does the patient have an impairment of mind or body that continuously renders it impossible for him/her to follow any substantially gainful occupation? ☐ Yes ☐ No

If you answered yes above, please provide details below. Include the date the impairment began and date the impairment prevented the patient from gainful employment.

What is the patient's clinical diagnosis? ICD Code is Required | Diagnosis Date (MM DD YYYY)

Primary:_____

Secondary: _____

Secondary: _____

Please describe any relevant test procedures performed.

Please describe any relevant surgical procedures performed.

Please list any medications the patient is currently taking.

Was the patient hospitalized? ☐ Yes ☐ No

If yes, provide dates of hospitalization:

From (MM DD YYYY) To (MM DD YYYY)

Has the patient worked since his/her impairment began? ☐ Yes ☐ No ☐ Don't know

Is the patient working against your advice and is such work harming the patient's health or substantially aggravating the patient's impairment? ☐ Yes ☐ No

If you answered yes above, please provide details below.

Is the patient capable of handling his/her own affairs? ☐ Yes ☐ No

Physician's Name | MI | Last Name

Physician's Specialty | Physician's Phone Number

Physician's Address

City | State | ZIP Code

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information in connection with the filing an insurance application commits a fraudulent insurance act, is/may be guilty of a crime and may be prosecuted and punished under state law. Penalties include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided on behalf of the applicant, for the purpose of misleading, information concerning any fact material thereto.

I have read and understand the terms and requirements of the fraud warning as I certify the above statement is true.

X Physician's Signature

Date of Signature (MM DD YYYY)