OMB Approved No. 2900-0068
Respondent Burden: 40 minutes

Department of Veterans Affairs

APPLICATION FOR SUPPLEMENTAL SERVICE-DISABLED VETERANS INSURANCE (SRH)

IMPORTANT INFORMATION

Eligibility
Supplemental Service-Disabled Veterans Insurance offers up to $30,000 in additional coverage to disabled veterans who:

1. Have Service-Disabled Veterans Insurance (RH) coverage in force, and
2. Have obtained a waiver of premiums on their Service-Disabled Veterans Insurance (RH) coverage.

Eligible veterans must apply for Supplemental Service-Disabled Veterans Insurance (SRH) within one year from receiving a notice from the VA Insurance Center that their application for waiver of premiums on their Service-Disabled Veterans Insurance (RH) coverage was approved **OR** before your 65th birthday, whichever comes first.

If you do not have Service-Disabled Veterans Insurance (RH) coverage, you cannot apply for Supplemental Service-Disabled Veterans Insurance. Instead use VA Form 29-4364, Application for Service-Disabled Veterans Insurance to apply for coverage.

Premiums
Veterans whose application for Supplemental Service-Disabled Insurance (SRH) is approved, must pay premiums for this coverage. **There is no waiver of premiums for this additional coverage.**

Mailing Address
If you meet these criteria, please complete and sign the application and then send immediately to:

Department of Veterans Affairs Regional Office and Insurance Center (SRH)
P.O. Box 7208
Philadelphia, PA 19101

Beneficiary Designation
The beneficiary designation on this form will change all previous designations under this file number unless you checked the box in Item 11 stating that you only wanted the change to apply to your Supplemental policy. You can change your beneficiary at any time; we simply need the change in writing. Please keep a copy of this designation with your important papers.

What Your Beneficiary Must Do To File For Death Benefits
We will be able to pay your insurance as quickly as possible, if your beneficiary completes the following steps when filing a claim for your insurance:

1. Mail or fax us a letter saying that he or she is the beneficiary of your government life insurance. **Your beneficiary must sign the letter using his or her own full name.** The letter should include:
   - ◯ The Insurance File Number (shown on the other side of this form on the top right)
   - ◯ His or her relationship to you (spouse, child, friend, etc.)
   - ◯ His or her Social Security Number
   - ◯ The address where the check is to be mailed **OR** the name of the bank with the routing and account numbers for the account you would like the money deposited in
   - ◯ A daytime telephone number, including the area code
2. Attach a copy of the death certificate to the letter. The death certificate should show the cause of death. **It does not need to be notarized, a copy is acceptable.**
3. Mail or fax the letter and death certificate to:

   Via Mail: Department of Veterans Affairs
   Regional Office and Insurance Center
   P.O. Box 7208 (Attn: SRH)
   Philadelphia, PA 19101

   Via Fax: Toll-Free at 1-888-748-5822

Questions
If you have questions about Government Life Insurance, you can call us toll-free at **1-800-669-8477.** Insurance Specialists are available from Monday through Friday, 8:30 a.m. to 6:00 p.m., Eastern time. We recommend that you call on Wednesdays, Thursdays, or Fridays when you can reach us more quickly. You can also visit our website at **www.insurance.va.gov.** The website provides detailed information on a range of topics, including applying for insurance and filing death claims.

1. First Name, Middle Name, Last Name of Insured	3.Insurance File Number
2. Mailing Address for Insurance Purposes	4. Social Security Number
	5. Date of Birth *(Month, Day, Year)*
	6. DayTime Telephone Number *(Include Area Code)*
	7. Email Address

8. Enter the amount, plan, and premium of the insurance for which you are applying. (See Pamphlet 29-9 - Service-Disabled Veterans Insurance Information and Premium Rates)

A. Amount of Insurance	B. Plan of Insurance	C. Monthly Premium

9. Check the method showing how you wish to pay for this insurance

☐ A. I want to pay premiums by a monthly deduction from my VA Compensation or Pension. *(We will start the deduction for you if the insurance is approved)*

☐ B. I want to pay premiums by a monthly allotment from my military service/retirement pay. *(We will start the allotment for you if the insurance is approved)*

☐ C. I want VA to automatically withdraw the premium each month from my checking account (VA MATIC) ***(Send your first payment with this application)***

☐ D. I will send premiums directly to VA as follows: ***(Send your first payment with this application)***

☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

10. Beneficiary Designation and Optional Settlement

Complete Name and Address of Each Principal and Contingent Beneficiary (For married women, enter her own first and middle names. For example, Mary Rose Smith, not Mrs. John Smith)	Beneficiary's Social Security Number (If known. This is not required for this designation be valid)	Relationship of the beneficiary to you	Share to be paid to each beneficiary (Use $ amounts, %, or fractions)	Payment Option for Each Beneficiary (See pamphlet for more information)
				Lump Sum
				Lump Sum
				Lump Sum
Or to survivors				Lump Sum
Contingent (Person(s) who get the proceeds if the principal beneficiary(ies) die before the insured. If none, write "NONE"				
				Lump Sum
				Lump Sum
				Lump Sum
				Lump Sum

11. This beneficiary change cancels all prior Beneficiary and Option selections and will apply to all my Government Life Insurance policies under my file number unless the box is checked..

☐ I would like this change to apply only to my Supplemental Service-Disabled Insurance policy. Please keep the existing beneficiary designation on all other insurance policies under the above file number.

12. Signature of Applicant *(Do NOT print, sign in ink)*	13. Date

RESPONDENT BURDEN: We need this information to establish your eligibility for VA Insurance benefits (38 U.S.C. 1922). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 40 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet page at http://www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

PRIVACY ACT NOTICE: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses identified in the VA system of records, 36VA00, Veterans and Armed Forces Personnel U.S. Government Life Insurance Records-VA, published in the Federal Register. Your obligation to respond is voluntary, but your failure to provide us the information could impede processing. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. The VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect. The responses you submit are considered confidential (38 U.S.C. 5701).