Office of Servicemembers' Group Life Insurance
P.O. Box 41618
Philadelphia, PA
19176-9913

800-419-1473
Contact Center
Toll free, worldwide

Apply for VGLI Online at **www.insurance.va.gov**

Dear Veteran,

Thank you for considering Veterans' Group Life Insurance (VGLI).

Servicemembers' Group Life Insurance (SGLI) offered you coverage while you were active duty. Veterans' Group Life Insurance (VGLI) can continue this protection for as long as you need it.

## Veterans' Group Life Application (Form 8714) - Instructions

## Section 1 - Veteran Information

- Please complete the "Veteran Information (Information On File)" and "Additional Contact Information." You do not need to complete "My Correct Address Information."

## Section 2 - Coverage Election and Payment Method

- Confirm the desired amount of coverage. Remember, the amount of coverage cannot exceed the amount of coverage you had on your date of separation.
- To determine your premium, please use the online "Premium Calculator" at:
  www.insurance.va.gov
  Under "Online Policy Access" select "apply for VGLI online"

## Section 3 - Health Statement

- Only complete this section if your date of separation is more than 120 days ago

## Section 4 - Beneficiary Designation

- Please complete the Primary and Secondary Beneficiary sections.

## Section 5 – Authorization / Signature

- Please sign and date the appplication.

**Fax your completed application to: 800-236-6142 or mail it to the address listed above.** For questions, call please call the Contact Center 800-419-1473, Monday to Friday from 8:00 a.m. to 5:00 p.m. Eastern Time, toll free, worldwide

Thank you for your service.

**Apply online today**
**www.insurance.va.gov**

Prudential

**Application For Veterans' Group Life Insurance**

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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 #: – –

Address 1:

Address 2:

City:

State: ZIP Code: – Country:

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

Branch of Service: Date of Separation: – – (M M D D Y Y Y Y)

## 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 5 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 5 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: – – (M M – D D – Y Y Y Y)

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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 principal beneficiary(ies) will receive payment upon my death. The share of any principal beneficiary who dies before me will be distributed equally among the remaining principal beneficiaries. If all principal 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: SSN:

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: SSN:

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.

Open Solutions Inc. is the Service Provider 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. Check clearing is provided by JPMorgan Chase Bank, N.A. and processing support is provided by First Data Payment Services (FDPS). **Alliance Account balances are not insured by the Federal Deposit Insurance Corporation (FDIC).** Open Solutions Inc., JPMorgan Chase Bank, N.A., and First Data Payment Services are not Prudential Financial companies.

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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: SSN:

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: SSN:

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

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

**TOTAL** %

must equal 100%

## 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: M M – D D – Y Y Y Y

***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, P O BOX 41618, Philadelphia, PA 19176-9913

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

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