Servicemembers' Group Life Insurance Disability Extension Application & Instructions

Department of Veterans Affairs
Regional Office and Insurance Center
P.O. Box 7208
Philadelphia PA 19101
Toll-free phone: 1-855-390-3536
Toll-free fax: 1-888-748-5822

General Information

The SGLI Disability Extension provides **free coverage** for up to two years from your date of discharge. The SGLI Disability Extension is available to Veterans who are totally disabled and had SGLI coverage at the time of discharge. To be considered totally disabled, you must have a disability that prevents you from being gainfully employed OR have one of the following conditions, regardless of employment status:

1. Permanent loss of use of any of the following:
- both hands
- both eyes
- both feet
- 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.)

Applying for the SGLI Disability Extension

How to Apply

To apply for the SGLI Disability Extension, you need to complete the following five steps:

1. Complete the attached application.
2. Sign and date the application.
3. Enclose proof of your SGLI coverage and your date of separation (e.g. your DD-214 and your last Leave and Earnings statement from the military)
4. Enclose a copy of either:
   a. Your military Medical Review Board findings of disability, OR
   b. Your VA rating determination.
5. Mail the application to:

VAROIC
P.O. Box 7208
Philadelphia PA 19101

Applying on Behalf of a Veteran?

If you are applying on behalf of an incompetent Veteran, please complete all sections of the form. Please sign your name to the application and indicate your relationship to the Veteran.

If Your Application is Approved

If your application is approved, OSGLI will send you a letter providing proof of coverage. Your SGLI coverage will be extended for a maximum of two years from your date of discharge or until you are able to work, whichever comes first.

Important Note: See the information under **"After Your Extension Ends"** to learn more about what will happen at the end of the free Disability Extension.

If Your Application is Not Approved

If your application is not approved, OSGLI will automatically consider this application as an application for **Veterans' Group Life Insurance (VGLI)**. We encourage you to apply for the the SGLI Disability Extension within 120 days of your discharge date. This will allow you to be automatically approved for Veterans' Group Life Insurance (VGLI) coverage if you are not approved for the SGLI Disability Extension. If you apply after 120 days from discharge and are not eligible for the SGLI Disability Extension, you will have to provide proof of good health to obtain VGLI. If your VGLI coverage is approved, it will be effective the day after your SGLI coverage terminates. You will also need to pay the first VGLI premium for your VGLI coverage to take effect.

For more information on VGLI, go to the VA Insurance website at www.insurance.va.gov.

After Your Extension Ends

At the end of the two-year extension period, OSGLI will notify you that your extension is ending and offer you the opportunity to obtain **Veterans' Group Life Insurance (VGLI)**. VGLI allows you to continue your SGLI coverage by converting it to an affordable term policy that is renewable for life. You will not have to apply separately, as this application will also be considered an application for VGLI. If you choose to convert your free SGLI coverage under the Disability Extension to VGLI, the effective date of VGLI will be the day after your SGLI coverage ends. You will also need to pay the first VGLI premium for your VGLI coverage to take effect.

Application for SGLI Disability Extension

Please complete Sections 1-5 of this application.

Return your completed application to:
VAROIC
P.O. Box 7208
Philadelphia PA 19101

Important: Please read the instructions for applying for the SGLI Disability Extension on pages 1 and 2 before completing this form.

1. Personal Information

Last Name	First Name	Middle Name

Street Address or PO Box	Email Address
	Home Phone Number

City	State	Zip Code	Other Phone Number

Date of Separation	Branch of Service	☐ Male ☐ Female	Social Security Number	Date of Birth

2. Insurance Amount

Your life insurance coverage under the Disability Extension is free. The amount of your life insurance coverage under the Disability Extension is the same amount that you had on your date of separation which is $_____.

3. Eligibility

The following questions will help determine your eligibility for the SGLI Disability Extension. If you need more room for your answers, please use the continuation sheet in section 4 of this application.

A. Your Current Ratings and Statutory Conditions

1. Has VA rated you Individually Unemployable?* ☐ Yes ☐ No

*This means VA has determined that you are incapable of maintaining gainful employment due to your service-connected conditions.

2. 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

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

3. Do you have a disability rating?

			Rating
Military rating	☐ Yes	☐ No	____ %
VA Rating	☐ Yes	☐ No	____ %

Please include a photocopy of either your military Medical Review Board findings of disability or your VA rating determination.

3. Eligibility (cont'd)

B. Your Work Status

Choose one of the five work statuses below and answer the applicable questions.

1. ☐ **I am working full time (more than 20 hours per week)**

   a. Has your medical provider advised you to stop working or reduce work hours due to a worsening service-connected disability?

   ◯ Yes. (Please attach medical evidence that confirms your medical provider's and/or doctor's recommendation.)

   ◯ No

2. ☐ **I am working part time (20 hours or less per week).**

   a. Please provide the following information about your service related disabilities since you were discharged from service. (If you need more space, use the Continuation Sheet in Section 4.

Name or Nature of Your Disabilities	Date Your Disabilities Began	Date your disabilities prevented you from working full time (more than 20 hours per week)

   b. Please provide the following information about your work history since you were discharged from service.

Name and Address of Employers (include self employment)	Type of Work (occasional or seasonal)	Dates of Employment	
		From (MM/DD/YY)	To (MM/DD/YY)

3. ☐ **I have not worked since I was discharged due to my service related disabilities.**

4. ☐ **I am not working currently but have worked since discharge.**

   a. Please explain when and why you stopped working

5. ☐ **I am currently in school.**

   a. Are you attending school to be trained for a new career because you are no longer able to work in your former career due to disabilities caused by your military service?

   ◯ Yes (please complete the chart below)

   ◯ No

Previous Occupation	New Degree/Certification Sought	Desired Future Occupation	Date Training Began

SIGNATURE OF APPLICANT *(Do not print; sign in ink)*	Date

PENALTY: The law provides that whoever makes any statement of a material fact knowing it to be false shall be punished by fine or imprisonment or both

4. Continuation Sheet

Use this page to provide any additional information regarding your eligibility that does not fit on the prior pages.