EVERY QUESTION MUST BE ANSWERED, BE SURE TO SIGN ON THIS SIDE

3. VA CLAIM NUMBER *(If any)*	4. SOCIAL SECURITY NUMBER	5. DATE OF BIRTH *(Month, Day, Year)*	6. DAYTIME TELEPHONE NUMBER *(Include Area Code)* ( )

7. ENTER AMOUNT, PLAN AND PREMIUM OF THE INSURANCE FOR WHICH YOU ARE APPLYING

A. AMOUNT OF INSURANCE	B. PLAN OF INSURANCE	C. MONTHLY PREMIUM

8. 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 BANK ACCOUNT (VA MATIC)
(SEND YOUR FIRST PAYMENT WITH THIS APPLICATION - We will contact you for additional information needed to start the withdrawal)

☐ D. I WILL SEND PREMIUMS DIRECTLY TO VA AS FOLLOWS:
(SEND YOUR FIRST PAYMENT WITH THIS APPLICATION)

☐ MONTHLY ☐ QUARTERLY ☐ SEMI-ANNUALLY ☐ ANNUALLY

9A. ARE YOU NOW WORKING?	9B. DO YOU WORK FULL-TIME?	9C. IF NOT WORKING OR WORKING PART-TIME, EXPLAIN WHY
☐ YES ☐ NO	☐ YES ☐ NO	

10A. ARE YOU NOW HOSPITALIZED?	10B. NAME AND ADDRESS OF HOSPITAL
☐ YES ☐ NO *(If "YES," for what condition(s)?)*	

11. HAVE YOU AT ANY TIME REQUIRED ANY FORM OF TREATMENT OR REHABILITATION OR BEEN FORCED TO DISCONTINUE EMPLOYMENT AS A RESULT OF THE USE OF ALCOHOL OR DRUGS, INCLUDING MARIJUANA, SEDATIVES, STIMULANTS, BARBITURATES, ETC.?

☐ YES ☐ NO *(If "YES," give date(s) and type of treatment(s))*

12. HAVE YOU HAD ANY OF THE FOLLOWING:	YES	NO
A. DIZZY OR FAINTING SPELLS?		
B. TUBERCULOSIS, BRONCHITIS, OR PLEURISY?		
C. MENTAL OR NERVOUS DISORDERS?		
D. BLOOD DISORDER?		
E. HEART CONDITION?		
F. CANCER, TUMOR, OR GOITER?		
G. ULCERS OR GALLSTONES?		
H. DIABETES?		
I. EPILEPSY OR PARALYSIS?		
J. HIGH BLOOD PRESSURE?		

13. IF YOUR ANSWER TO ANY PART OF ITEM 12 IS "YES" GIVES DATES, DURATION, AND OTHER DETAILS
(If more space is needed, attach a separate sheet)

14. HAVE YOU HAD ANY OTHER PHYSICAL DEFECT OR DISEASE?

☐ YES ☐ NO *(If "YES," explain)*

15B. HEIGHT FEET INCHES	15C. HAS YOUR WEIGHT CHANGED MORE THAN TEN POUNDS DURING THE PAST TWO YEARS? *(If "YES," give complete details including amount gained or lost and length of time present weight maintained)*
15B. WEIGHT LBS.	☐ YES ☐ NO

CERTIFICATION: I have reviewed all of my answers above and certify that they are true and correct to the best of my knowledge and belief.

16A. SIGNATURE OF APPLICANT *(Do not print: sign in ink)*	16B. DATE

IMPORTANT INFORMATION

This form may be used by any person released from active service in the Armed Forces on or after April 25, 1951, who has a service-connected disability and meets good health standards as established by the Secretary. The application for insurance and payment of the required premium must be made within two years from the date of notice by the Department of Veterans Affairs (VA) that any disabilities are determined to be service-connected (this time period is reduced to one year if the date VA notified of your service-connected disability was prior to September 1, 1991). Only the veteran, or COURT-APPOINTED guardian, or VA recognized fiduciary, can apply for this insurance. DO NOT DELAY SENDING THIS DESIGNATION if you do not have a beneficiary's Social Security Number handy. Your application and designation are still valid even if you do not know the Social Security Number, so send this form promptly upon completion. Having the beneficiary's Social Security Number will help us locate the beneficiary.

After completion of this application, submit it IMMEDIATELY to:

DEPARTMENT OF VETERANS AFFAIRS
REGIONAL OFFICE AND INSURANCE CENTER (RH)
P.O. BOX 7208
PHILADELPHIA, PA 19101

If you have any questions about this insurance, please call toll-free at 1-800-669-8477.