



DEPARTMENT OF VETERANS AFFAIRS
Regional Office and Insurance Center
Wissahickon Avenue and Manheim Street
P.O. Box 7208
Philadelphia PA 19101

In Reply Refer To:

Claim for Disability Benefits on Government Life Insurance

The insured veteran named above has filed a claim for disability benefits on his/her Government life insurance and indicates that you treated him/her from _____. We would appreciate you providing the information on the following page. The veteran's claim for benefits authorizes us to request this information from you. Thank you for your help.

How to Contact VA About Government Life Insurance

- If you have any questions, call 1-800-669-8477 toll-free from anywhere in the USA.
- VA insurance representatives are available Monday through Friday from 8:30 a.m. to 6:00 p.m., EST.
- You may also visit our website at WWW.INSURANCE.VA.GOV.

Department of Veterans Affairs

(Over)

PRIVACY ACT INFORMATION: This report is authorized by law (38 U.S.C. 1912, 1915, 1942, and 1948). This information is required to help us make a decision on the veteran's claim for disability insurance benefits. Responses may be disclosed outside VA only if the disclosure is authorized under the Privacy Act, including the 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.

RESPONDENT BURDEN: VA may not conduct or sponsor, and respondent is not required to respond to this collection of information unless it displays a valid OMB Control Number. Public reporting burden for this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have comments regarding this burden estimate or any other aspect of this collection of information, call 1-800-827-1000 for mailing information on where to send your comments.

ITEMS THAT MAY NEED TO BE COMPLETED

(Please complete the items marked below)

1. DATE SYMPTOMS FIRST APPEARED (OR DATE OF ACCIDENT)

2. DATE FIRST TREATED FOR THIS CONDITION

3. DATE THE INSURED BECAME UNABLE TO WORK

4. DATE YOU LAST SAW THE INSURED

5. OBJECTIVE SYMPTOMS/DIAGNOSES

6. SINCE FIRST TREATMENT, HAS CONDITION OF INSURED *(Check one)*

REMAINED THE SAME IMPROVED WORSENERD

7. CAN THE INSURED PERFORM HIS/HER NORMAL OCCUPATION?

YES NO

8. IS THE INSURED EXPECTED TO IMPROVE TO THE POINT WHERE EMPLOYMENT WOULD BE POSSIBLE?

YES NO

9A. SIGNATURE OF PHYSICIAN

9B. DATE SIGNED