



APPLICATION FOR CASH SURRENDER GOVERNMENT LIFE INSURANCE

Important Notice About Information Collection: We need this information to determine, establish or verify your eligibility for VA Insurance benefits (38 U.S.C. 5902). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 10 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 www.whitehouse.gov/library/omb/OMBINVC.html#VA. 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 5, Code of Federal Regulations 1.526 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).

1. FIRST-MIDDLE-LAST NAME <i>(Type or print)</i>	2. INSURANCE FILE NUMBER F
3. MAILING ADDRESS <i>(Must be completed)</i>	4. POLICY NUMBER <i>(Include letter prefix)</i>
	5. DAYTIME TELEPHONE NUMBER <i>(Include Area Code)</i> ()
	6. SOCIAL SECURITY NUMBER

7. I HEREBY SURRENDER MY: *(Check appropriate box)*

<input type="checkbox"/> BASIC INSURANCE POLICY	<input type="checkbox"/> BASIC INSURANCE AND PAID-UP ADDITIONS
<input type="checkbox"/> PAID-UP ADDITIONS ONLY	<input type="checkbox"/> USE SURRENDER VALUE TO BUY REDUCED PAID-UP INSURANCE
<input type="checkbox"/> PARTIAL SURRENDER OF PAID-UP ADDITIONS <i>(Amount of check)</i> \$ _____	

8. FUTURE DIVIDEND OPTION

<input type="checkbox"/> PAY TO ME IN CASH	<input type="checkbox"/> APPLY TO PAY PREMIUMS IN ADVANCE	<input type="checkbox"/> HOLD ON DIVIDEND CREDIT
<input type="checkbox"/> APPLY TO PAY INDEBTEDNESS	<input type="checkbox"/> APPLY TO BUY PAID-UP ADDITIONS	<input type="checkbox"/> HOLD ON DIVIDEND DEPOSIT
<input type="checkbox"/> NETCASH	<input type="checkbox"/> NETLOLI	<input type="checkbox"/> NETPUA

NET OPTIONS - Dividend pays annual premium and remainder is used to reduce loan (NETLOLI), buy additional insurance (NETPUA), or refunded to veteran (NETCASH).

I hereby surrender all my right, title and interest in the basic insurance policy and/or paid-up additions represented by the policy number shown in Item 4 for the purpose of obtaining the cash surrender value.

9. FULL SIGNATURE OF INSURED <i>(Do not print)</i>	10. DATE
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11. HOW WOULD YOU LIKE TO RECEIVE THIS PAYMENT?

<input type="checkbox"/> BY CHECK	<input type="checkbox"/> BY DIRECT DEPOSIT (Please attach a voided personal check)	
(NOTE: If you are currently on Direct Deposit, this will stop all future payments by electronic transfer until we receive instructions from you.)	(NOTE: The account must be in the name of the veteran. Direct Deposit will continue with all future payments to this account. You must notify us of any changes.)	
<input type="checkbox"/> ADDRESS SHOWN IN ITEM 3	A. NAME OF FINANCIAL INSTITUTION	B. TRANSIT/ROUTING NUMBER
<input type="checkbox"/> TEMPORARY ADDRESS SHOWN BELOW <i>(Please print)</i>	C. DEPOSITOR ACCOUNT NUMBER	D. TELEPHONE NUMBER OF FINANCIAL INSTITUTION ()
	E. ADDRESS OF FINANCIAL INSTITUTION	F. TYPE OF DEPOSITOR ACCOUNT <input type="checkbox"/> CHECKING <input type="checkbox"/> SAVINGS

IMPORTANT - After this form has been completed and signed, it should be mailed to:
 Department of Veterans Affairs
 P.O. Box 7327
 Philadelphia, PA 19101

NOTE: IF YOU PREFER, INSTEAD OF MAILING THIS FORM, IT MAY BE FAXED TO 1-888-748-5828
 PLEASE DO NOT RETURN YOUR POLICY WITH THIS APPLICATION

QUESTIONS ABOUT YOUR INSURANCE? CALL US TOLL-FREE AT 1-800-669-8477.