OMB Approved No. 2900-0179
Respondent Burden: 30 minutes

Department of Veterans Affairs

(For use of VA Index)

APPLICATION FOR CHANGE OF PERMANENT PLAN (MEDICAL)

(CHANGE TO A POLICY WITH A LOWER RESERVE VALUE)

PRIVACY ACT INFORMATION: No insurance may be changed unless a completed application form has been received (38 CFR 8.36 and 6.48). The information provided on a voluntary basis will be used by VA employees and your authorized representatives in the maintenance of Government insurance programs. Responses may be disclosed outside the VA only if the disclosure is authorized under the Privacy Act, including the routine uses identified in 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 30 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.

INSTRUCTIONS

This form is used to change a permanent plan of insurance to another permanent plan with a lower reserve value.

The difference between the reserve of the two plans may be applied to a policy loan, applied to future premiums, or refunded to you in cash.

REQUIREMENT: You must be in good health to change to a plan with a lower reserve value. Please complete all the health questions on the back of this form.

The beneficiary and/or optional settlement under the new policy will remain the same as under the old policy. If a change is desired, submit VA Form 29-336.

It is not possible to change from a permanent plan to term insurance. Call our toll-free number for information on the available plans.

Complete and return this form to:

Department of Veterans Affairs
Regional Office and Insurance Center (COP)
P.O. Box 7208
Philadelphia, PA 19101

1. FIRST NAME - MIDDLE NAME - LAST NAME OF INSURED	2. INSURANCE FILE NUMBER *(Include letter prefix)*

3. MAILING ADDRESS

4. SOCIAL SECURITY NUMBER	5. VA FILE NUMBER *(If any)*	6. DAYTIME TELEPHONE NUMBER

7. POLICY NUMBER	8. AMOUNT OF INSURANCE APPLIED FOR	9. PLAN OF INSURANCE APPLIED FOR	10. DO YOU WISH TO CONTINUE OR ADD THE TOTAL DISABILITY INCOME PROVISION
	$		YES ☐ NO ☐

11. DISPOSITION OF RESERVE CREDIT

☐ PAY FUTURE PREMIUMS ☐ APPLY TO INDEBTEDNESS ☐ PAY IN CASH

12. METHOD OF PREMIUM PAYMENT

☐ DIRECT PAYMENT TO VA (Complete Item 13) ☐ MONTHLY ALLOTMENT FROM SERVICE PAY

☐ MONTHLY DEDUCTION FROM VA BENEFIT CHECK ☐ MONTHLY DEDUCTION FROM YOUR CHECKING ACCOUNT

13. MODE OF PREMIUM PAYMENT

☐ MONTHLY ☐ QUARTERLY ☐ SEMI-ANNUALLY ☐ ANNUALLY

IF YOU HAVE ANY QUESTIONS ABOUT YOUR INSURANCE, CALL TOLL FREE 1-800-669-8477

The purpose of questions listed below is to secure complete information regarding the condition of the applicant's health. All diseases, injuries, abnormalities, deformities, or infirmities must be stated and fully described. Statements made by the applicant in this application are relied upon in granting insurance. Consequently, any deception or knowingly false statement either by inference, omission, or otherwise may result in cancellation of the insurance or in the refusal to pay a claim on the policy.

It may be necessary to ask for a physical examination in connection with this application.

Please answer every question, date and sign this application.

NOTE: Complete the following employment questions. If additional space is needed, attach a separate sheet of paper.

1A. ARE YOU NOW WORKING? ☐ YES ☐ NO	1C. IF NOT WORKING OR WORKING PART-TIME, EXPLAIN WHY
1B. DO YOU WORK FULL TIME? ☐ YES ☐ NO	

HAVE YOU EVER HAD OR BEEN TREATED FOR ANY OF THE FOLLOWING:: (Check all that apply)

	YES	NO		YES	NO
2. DISEASE OF THE HEART OR ARTERIES; CHEST PAIN?	☐	☐	14. ANY DISEASE OF THE PROSTRATE OR TESTES IF A MALE; UTERUS, OVARIES OR BREASTS IF A FEMALE?	☐	☐
3. HIGH BLOOD PRESSURE?	☐	☐	15. DO YOU USE OR HAVE YOU BEEN TREATED FOR USE OF ALCOHOL OR ANY HABIT FORMING DRUG?	☐	☐
4. CANCER, TUMOR OR POLYP?	☐	☐	16. WITHIN THE PAST 5 YEARS, HAVE YOU BEEN TREATED BY A PHYSICIAN?	☐	☐
5. LUNG DISEASE?	☐	☐	17. ARE YOU NOW OR HAVE YOU EVER BEEN HOSPITALIZED FOR ILLNESS, DISEASE OR INJURY?	☐	☐
6. EPILEPSY, UNCONSCIOUSNESS, DIZZINESS OR IMPAIRMENT OF NERVOUS SYSTEM?	☐	☐	18. DO YOU HAVE ANY SERVICE CONNECTED DISABILITIES?	☐	☐
7. EMOTIONAL OR MENTAL DISORDER?	☐	☐	19. HAVE YOU EVER APPLIED FOR DISABILITY COMPENSATION OR PENSION?	☐	☐
8. DISEASE OF THE BLOOD?	☐	☐	20. HAS ANY APPLICATION YOU HAVE MADE FOR PRIVATE OR GOVERNMENT LIFE, HEALTH, DISABILITY OR ACCIDENT INSURANCE BEEN REFUSED, POSTPONED, APPROVED AT SUB-STANDARD RATES OR ON A DIFFERENT BASIS THAN APPLIED FOR?	☐	☐
9. TUBERCULOSIS, PLEURISY, OR BRONCHITIS?	☐	☐			
10. DIABETES?	☐	☐			
11. ARTHRITIS, PARALYSIS, OR DISEASE, OR DEFORMITY OF THE BONES, MUSCLES, OR JOINTS?	☐	☐			
12. DISEASE OR ULCER OF STOMACH, INTESTINES, OR RECTUM?	☐	☐	21. HEIGHT FEET INCHES		
13. ANY DISEASE OF THE URINARY TRACT? SUGAR, ALBUMIN, OR BLOOD IN URINE?	☐	☐	22. WEIGHT POUNDS		

23. REMARKS *(Give complete details to YES answers. Include dates, diagnosis, physicians or hospitals, and names and addresses. Indicate after each disability whether service-connected or nonservice connected. If additional space is needed, attach a separate sheet of paper)*

I consent that any hospital, physician or surgeon who has treated or examined me for any purpose, or whom I have consulted professionally may divulge to the Department of Veterans Affairs any information obtained by them, or it, concerning myself. I understand that the Government will rely on the truth of these answers. I HAVE READ THE ABOVE ANSWERS AND TO THE BEST OF MY KNOWLEDGE, THEY ARE TRUE.

I am obliged to advise the Department of Veterans Affairs of any change of health condition arising after the signing and prior to the delivery of this form to the Department of Veterans Affairs.

18A. SIGNATURE	18B. DATE