

Claim for Accelerated Benefits

Servicemembers' Group Life Insurance Family Coverage (FSGLI)

The Accelerated Benefit Option allows the service member to receive up to 50% of his/her spouse's FSGLI benefit if the spouse has been diagnosed by a physician as being terminally ill with nine (9) months or less to live. Only the service member can apply for this benefit.

The amount of insurance proceeds payable to the service member at the time of his/her spouse's death will be reduced by the amount of accelerated benefit the service member chooses to receive now. The FSGLI premium will be lowered to reflect the reduced coverage amount.

How to Submit a Claim for Accelerated Benefits

The service member's spouse, his/her physician, and the service member's branch of service, must complete the attached forms as indicated. Completed forms should be submitted as follows:

Active duty service members/Reservists	Army National Guard
Submit completed forms to your branch of service personnel office.	Contact your state headquarters for submission instructions.

Important Information

- If the claim for accelerated benefits is approved, the service member will receive a payment for the amount requested.
- Once the payment is cashed, the accelerated benefit cannot be revoked.
- The service member can receive this benefit only once during the spouse's lifetime.
- The service member may use this benefit for any purpose.
- If the spouse is covered under SGLI Family Coverage, the Office of Servicemembers' Group Life Insurance (OSGLI) will notify the service member's branch of service to reduce the face amount of the spouse's coverage and premium rate.
- If the claim is not approved, the service member has the option of submitting additional medical information or reapplying at a later date.



TO BE COMPLETED BY SERVICE MEMBER

CLAIM FOR ACCELERATED BENEFITS			
Service member's name (first middle last)		Service n Social Security Number	
Service member's mailing address	Service member's Branch of Service	Service member's duty status Active Duty Ready Reserves Army/Air National Guard Separated/Discharged 	
Service member's telephone number		(provide separation/discharge date)	
Spouse's name (first middle last)	Spouse's Social Security	Number	
Amount of spouse's coverage	Amount of Claim (Cannot e	exceed 50% of spouse's total coverage)	
\$	\$		
I acknowledge that I have read all of the attached information about the accelerated benefit. I understand that I can get this benefit only once during my spouse's lifetime and that I can use it for any purpose I choose. I further understand that the face amount of my spouse's coverage will be reduced by the amount of accelerated benefit I choose to receive now.			
Signature	Date		

TO BE COMPLETED BY SERVICE MEMBER'S SPOUSE

AUTHORIZATION TO RELEASE MEDICAL RECORDS
To all physicians, hospitals, medical service providers, pharmacists, employers, other insurance companies, and all other agencies and organizations:
You are authorized to release a copy of all my medical records, including examinations, treatments, history, and prescriptions, to the Office of Servicemembers' Group Life Insurance (OSGLI) or its representatives.
Spouse's printed Name
Spouse's signature Date
A photocopy of this authorization will be considered as effective and valid as the original. Valid for one year from date signed.



TO BE COMPLETED BY SERVICE MEMBER'S OR VETERAN'S PHYSICIAN

ATTENDING PHYSICIAN'S CERTIFICATION	ON		
Patient's name		Patient's Social Security Number	
Diagnosis	ICD-9-CM/ICD-10-CM Dise	ase Code*	
Description of Present Medical Condition (Please att	ach results of x-rays, E.K.G. or o	ther tests)	
Is the patient mentally competent in the handling of	his/her own affairs? □ Yes		
The patient applied for an accelerated benefit under his/her government life insurance coverage. To qualify, the patient must have a life expectancy of nine (9) months or less. Does your patient meet this requirement?			
Attending physician's name	State in which you are	Specialty	
(please print)	licensed to practice		
Mailing address	Telephone number	Fax number	
Signature	Date		

*International Classification of Diseases, 9th revision, Clinical Modification/International Classification of Diseases, 10th revision, Clinical Modification



TO BE COMPLETED BY THE PERSONNEL OFFICE OF THE SERVICE MEMBER'S UNIT

Complete only if the service member's spouse is covered under FSGLI.

BRANCH OF SERVICE STATEMENT		
Service member's name	Service member's Social Security Number	Service member's Branch of Service
Spouse's Name	Spouse's Social Security N	umber
Amount of FSGLI Coverage	Monthly premium amount	
\$	\$	
Name and title of person completing this form	Telephone number	Fax number
Service member's duty station and address		
Signature of person completing this form		
Note: After completing this section, the personnel officer		ce member's casualty branch.

TO BE COMPLETED BY THE SERVICE MEMBER'S CASUALTY BRANCH

Certified by:	
Name	Title
Branch of Service	Certification date
Telephone number	Fax number

Notice: It is fraudulent to complete these forms with information you know to be false or to omit important facts. Criminal and/or civil penalties can result from such acts.



lethod of Payment			
I HEREBY CERTIFY that all statements made in this claim are true to the best of my knowledge, information, and belief, and that no evidence necessary to a settlement of this claim is suppressed or withheld. My preferred method of payment is:			
Lump Sum – Check			
Lump Sum – Electronic Funds Transfer (EFT) – Please provide you banking information below.			
For EFT only – Please provide your banking information below to have the benefit paid by Electronic Funds Transfer. Bank Routing Number Bank Account Number			
Checking Savings			
ank Name Bank Phone Number			
irst Name MI Last Name			
Customer's Name Street Address City, State, Zip Check No. 1234 The bank account number varies in length and may contain dashes or			
number is always ORDER OF\$			
9 digits and appears between the is symbols Bank Name Street Address City, State, Zip Dollars b), so that address			
↓■ 223207349 ■↓ 00123012201234↓ 1234			
Bank Routing Number Bank Account Number Check Number (not needed)			
I have selected payment by Electronic Funds Transfer, I authorize The Prudential Insurance Company of America (Prudential) to make electronic deposits on my Death Claim proceeds into the above account. I understand that I must be the named account holder on this account and that any deposit made to an inactive account greement will be returned to Prudential and reissued as a manual check. In addition, if any overpayment of such Death Claim proceeds is credited to this account in rror, I authorize Prudential to withdraw the difference between the benefit amount paid and the recalculated amount of the benefit actually due under the terms of the usurance coverage.			