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(c) Subject to the $90,000 maximum amount of insurance, and to the reduced maximum amount of insurance available to the eligible veteran, he or she is entitled to be insured under VMLI or to apply for such insurance as often as he or she becomes obligated under a mortgage loan or a refinanced mortgage loan on a housing unit or a successor housing unit owned and occupied by the eligible veteran. Where a veteran who is not automatically insured under VMLI applies for such insurance, he or she shall be required to meet the health standards and other conditions established by the Secretary for such insureds.

(Authority: 38 U.S.C. 501, 2106)

[37 FR 282, Jan. 8, 1972, as amended at 42 FR 43836, Aug. 31, 1977; 52 FR 48682, Dec. 24, 1987; 59 FR 59921, Nov. 21, 1994; 61 FR 29027, June 7, 1996]

PART 9—SERVICEMEMBERS' GROUP LIFE INSURANCE AND VETERANS' GROUP LIFE INSURANCE

Sec.

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AUTHORITY: 38 U.S.C. 501, 1965–1980A, unless otherwise noted.

SOURCE: 40 FR 4135, Jan. 28, 1975, unless otherwise noted.

EDITORIAL NOTE: Nomenclature changes to part 9 appear at 62 FR 35970, July 3, 1997, and 62 FR 45733, Sept. 9, 1997.

§ 9.1 Definitions.

The following definitions are in addition to those definitions in 38 U.S.C. 101 and 1965:

(a) The term *policy* means Group Policy No. G–32000, which was effective September 29, 1965, purchased from the insurer pursuant to 38 U.S.C. 1966, executed and attested on December 30, 1965, and amended thereafter.

(b) The term *administrative office* means the Office of Servicemembers' Group Life Insurance, located at 80 Livingston Avenue, Roseland, New Jersey 07068.

(c) The term *insurer* means the commercial life insurance company or companies selected under 38 U.S.C. 1966 to provide insurance coverage specified in the policy.

(d) The term *reinsurer* means any life insurance company meeting all the criteria set forth in § 9.10 which reinsures a portion of the total amount of insurance covered by the policy and issues individual life insurance policies to members under the provisions of 38 U.S.C. 1968(b) and 1977(e).

(e) The term *converter* means any life insurance company meeting all the criteria set forth in § 9.10 which issues individual life insurance policies to members under the provisions of 38 U.S.C. 1968(b) and 1977(e).

(f) The term *coverage* means Servicemembers' Group Life Insurance or Veterans' Group Life Insurance payable while the member is insured under the policy.

(g) The term *termination of duty* means (1) In the case of active duty or active duty for training being performed under a call or order that does not specify a period of less than 31 days-discharge, release or separation from such duty.

(2) In the case of other duty—the member's release from his or her obligation to perform any duty in his or her uniformed service (active duty, or active duty for training or inactive duty training) whether arising from limitations included in a contract of enlistment or similar form of obligation or arising from resignation, retirement or other voluntary action by which the obligation to perform such duty ceases.

(h) The term *break in service* means the situation(s) in which: (1) A member terminates duty or obligation to perform duty in one service and enters on duty or assumes the obligation to perform duty in another uniformed service, regardless of the length of time intervening.

(2) A member reenters on duty or resumes an obligation to perform duty as a Reserve in the same uniformed service and 1 calendar day or more has elapsed following termination of the prior period of duty or obligation to perform duty.

(i) The term *disability* means any type of injury or disease whether mental or physical.

(j) The term *total disability* means any impairment of mind or body which continuously renders it impossible for the insured to follow any substantially gainful occupation. Without prejudice to any other cause of disability, the permanent loss of the use of both feet, of both hands, or of both eyes, or of one foot and one hand, or of one foot and one eye, or of one hand and one eye, or the total loss of hearing of both ears, or the organic loss of speech shall be deemed to be total disability. Organic loss of speech will mean the loss of the ability to express oneself, both by voice and whisper, through the normal organs of speech if such loss is caused by organic changes in such organs. Where such loss exists, the fact that some speech can be produced through the use of an artificial appliance or other organs of the body will be disregarded.

(k)(1) The term *member's stillborn child* means a member's biological child—

(i) Whose death occurs before expulsion, extraction, or delivery; and

(ii) Whose—

(A) Fetal weight is 350 grams or more; or

(B) If fetal weight is unknown, duration in utero is 20 completed weeks of gestation or more, calculated from the date the last normal menstrual period began to the date of expulsion, extraction, or delivery.

(2) The term does not include any fetus or child extracted for purposes of an abortion.

(l) The term *member of the family* as used in §9.5(e)(2) means an individual with any of the following relationships to a person who is convicted of intentionally and wrongfully killing the decedent or determined in a civil proceeding to have intentionally and wrongfully killed the decedent:

(1) Spouse;

(2) Biological, adopted, or step child;

(3) Biological, adoptive, or step parent;

(4) Biological, adopted, or step sibling; or

(5) Biological, adoptive, or step grandparent or grandchild.

(Authority: 38 U.S.C. 501(a), 1980A)

[40 FR 4135, Jan. 28, 1975, as amended at 53 FR 17698, May 18, 1988; 61 FR 20135, May 6, 1996; 67 FR 52413, Aug. 12, 2002; 70 FR 75946, Dec. 22, 2005; 73 FR 71930, Nov. 26, 2008; 74 FR 59479, Nov. 18, 2009; 74 FR 62706, Dec. 1, 2009; 77 FR 60306, Oct. 3, 2012; 77 FR 70376, Nov. 26, 2012]

§9.2 Effective date; applications.

(a) The effective date of Servicemembers' Group Life Insurance will be in accordance with provisions set forth in 38 U.S.C. 1967.

(b) The effective date of Veterans' Group Life Insurance will be as follows:

(1) For members whose Servicemembers' Group Life Insurance coverage ceases under 38 U.S.C. 1968 (a)(1)(A) and 38 U.S.C. 1968(a)(4), the effective date shall be the 121st day after termination of duty. An application and the initial premium must be received by the administrative office within 120 days following termination of duty or separation or release from such assignment.

(2) For members whose Servicemembers' Group Life Insurance coverage was extended because of total disability, the effective date shall be the day following the end of the 1-year period of extended coverage or the day following the end of the total disability, whichever is the earlier date, but in no event before the 121st day following termination of duty. An application and the initial premium must be received by the administrative office within 1 year following termination of duty.

(3) For members who qualify for coverage under 38 U.S.C. 1967(b), the effective date shall be the 121st day after termination of duty. An application, the initial premium, and proof of disability must be received by the administrative office within 120 days following termination of duty.

(4) For members of the Individual Ready Reserve or the Inactive National Guard, the effective date shall be the

date an application and the initial premium are received by the administrative office. The application and initial premium must be received by the administrative office within 120 days of becoming a member of either organization.

(Authority: 38 U.S.C. 1977)

(c) If either an application or the initial premium has not been received by the administrative office within the time limits set forth above, Veterans' Group Life Insurance coverage may still be granted if an application, the initial premium, and evidence of insurability are received by the administrative office within 1 year and 120 days following termination of duty, except that evidence of insurability is not required during the initial 240 days following termination of duty.

(d) The effective date for Servicemembers' Group Life Insurance or Veterans' Group Life Insurance in any case not otherwise covered under this section or under 38 U.S.C. 1967(a) shall be the date an application and the initial premium are received by the administrative office.

(e) For purposes of this section, an application, an initial premium, and any evidence necessary to effect Servicemembers' Group Life Insurance or Veterans' Group Life Insurance coverage will be considered to have been received by the administrative office if:

(1) They are properly addressed to the administrative office, and

(2) The proper postage is affixed, and

(3) They are legibly postmarked within the time limit required for receipt by the administrative office.

(Authority: 38 U.S.C. 501, 1967, 1968, 1977)

[61 FR 20135, May 6, 1996, as amended at 62 FR 35970, July 3, 1997; 77 FR 66071, Nov. 1, 2012]

§ 9.3 Waiver or reduction of coverage.

(a) Full-time coverage which is in effect will terminate or be reduced at midnight of the last day of the month a member's written notice requesting such termination or reduction is received by his or her uniformed service. In the case of a member paying premiums directly to the administrative office, full-time coverage will terminate or be reduced as of the last day of the month for which the last full premium was paid. Termination or reduction of coverage is effective for the entire remaining period of active duty unless the member reinstates his or her coverage under the provisions of 38 U.S.C. 1967(c). If, following termination of duty, a member reenters duty (in the same or another uniformed service), a waiver or reduction for the previous period of duty will not apply to the subsequent period of duty.

(b) Part-time coverage will terminate or be reduced at the end of the last day of the period of duty then being performed if the member is on active duty or active duty for training when the waiver or reduction is filed; at the end of the period of inactive duty training then being performed if the member is on inactive duty training when the waiver or reduction is filed; or on the date the waiver or reduction is received by his or her uniformed service if the member is not on active duty, active duty for training; or inactive duty training on the date the waiver or reduction is filed.

(1) When a member insured under part-time coverage waives his or her right to group coverage or elects a reduced amount of insurance, such waiver or election, unless changed, is effective throughout the period of the member's continuous reserve obligation in the same uniformed service. If, following termination of duty, the member reenters duty or resumes the obligation to perform duty (in the same or another uniformed service), the waiver or reduction will not apply to the subsequent period of duty or obligation.

(2) If a reservist insured under part-time coverage is called or ordered to active duty or active duty for training under a call or order that does not specify a period of less than 31 days and is separated or released from such duty and then resumes his or her reserve obligation, any waiver or election of reduced coverage made while eligible for part-time coverage, unless changed, shall be effective throughout the entire period of part-time coverage, the active duty or active duty for training period and 120 days thereafter and the period of immediately resumed reserve obligation.

(3) If a member, other than a member referred to in paragraph (b)(2) of this section, upon termination of duty qualifying him or her for full-time coverage assumes an obligation to perform duty as a reservist, any waiver or election previously made by the member shall not apply to coverage arising from his or her reservist obligation. Furthermore, during the 120 days following termination of such duty the full-time coverage shall not be reduced by any waiver or election made by a member as a reservist.

[40 FR 4135, Jan. 28, 1975, as amended at 48 FR 8070, Feb. 25, 1983; 53 FR 17698, May 18, 1988. Redesignated and amended at 61 FR 20135, May 6, 1996]

§9.4 Beneficiaries and options.

Any designation of beneficiary or election of settlement options is subject to the provisions of 38 U.S.C. 1970 and 1977 and the following provisions:

(a) Any designation of beneficiary or settlement option election made by any member insured under Servicemembers' Group Life Insurance for full-time coverage or part-time coverage will remain in effect until properly changed by the member or canceled automatically for any of the following reasons:

(1) The insurance terminates following separation or release from all duty in a uniformed service.

(2) The member enters on duty in another uniformed service.

(3) The member reenters on duty in the same uniformed service more than 1 calendar day after separation or release from all duty in that uniformed service.

(b) A change of beneficiary may be made at any time and without the knowledge or consent of the previous beneficiary.

(c) Until and unless otherwise changed, a beneficiary designation and settlement option election of record on the date a statutory increase in coverage takes effect shall be considered to be a beneficiary and optional settlement election for the increased amount as well, and any beneficiary named therein shall be entitled to the same percentage (%) share of the new total coverage amount as that beneficiary was entitled to prior to the statutory increase in coverage.

(Authority: 38 U.S.C. 501)

[40 FR 4135, Jan. 28, 1975, as amended at 53 FR 17699, May 18, 1988. Redesignated and amended at 61 FR 20135, 20136, May 6, 1996]

§9.5 Payment of proceeds.

Proceeds shall be paid in accordance with provisions set forth in 38 U.S.C. 1970 and the following provisions:

(a) If proceeds are to be paid in installments, the first installment will be payable as of the date of death. The amount of each installment will be computed so as to include interest on the unpaid balance at the then effective rate.

(b) If, following the death of an insured member who has designated both principal and contingent beneficiaries and elected to have payment made in 36 equal monthly installments, the principal beneficiary dies before all 36 installments have been paid, the remaining installments will be paid as they fall due to the contingent beneficiary. At the death of such a contingent beneficiary, and in other instances of a beneficiary's death, where there is no contingent beneficiary, the value of any unpaid installments, discounted to the date of his or her death at the same rate used for inclusion of interest in the computation of installments will be paid, without further accrual of interest, in one sum to the estate of the beneficiary or continent beneficiary last receiving payment.

(c) In instances where payment in installments is made at the election of the beneficiary, upon his or her request, the value of such installments as remain unpaid will be discounted to the date of payment at the same rate used for inclusion of interest in the computation of installments and paid to him or her in one sum.

(d) If a member whose coverage is extended due to total disability converts the group insurance to an individual policy which is effective before he or she ceases to be totally disabled or before the end of 1 year following termination of duty, whichever is earlier, and dies while group insurance would be in effect, except for such conversion, the group insurance will be payable,

provided the individual policy is surrendered for a return of premiums and without further claim. When there is no such surrender, any amount of group insurance in excess of the amount of the individual policy will be payable.

(e)(1) The proceeds payable because of the death of an individual insured under Servicemembers' Group Life Insurance or Veterans' Group Life Insurance (''decedent'') shall not be payable to any person described in paragraph (e)(2) of this section. A Servicemembers' Group Life Insurance Traumatic Injury Protection benefit payable under § 9.20(j)(3) shall not be payable to any person described in paragraph (e)(2) of this section.

(2) The persons described in this paragraph are:

(i) A person who is convicted of intentionally and wrongfully killing the decedent or determined in a civil proceeding to have intentionally and wrongfully killed the decedent;

(ii) A person who is convicted of assisting or aiding, or determined in a civil proceeding to have assisted or aided, a person described in paragraph (e)(2)(i) of this section; and

(iii) A member of the family of a person described in paragraph (e)(2)(i) or (e)(2)(ii) of this section who is not related to the decedent by blood, legal adoption, or marriage.

(3) The Servicemembers' Group Life Insurance or Veterans' Group Life Insurance proceeds or Servicemembers' Group Life Insurance Traumatic Injury Protection benefit not payable under paragraph (e)(1) of this section to any person described in paragraph (e)(2) of this section is not payable to such persons even though the criminal conviction or civil determination is pending appeal.

(4)(i) Servicemembers' Group Life Insurance or Veterans' Group Life Insurance proceeds or a Servicemembers' Group Life Insurance Traumatic Injury Protection benefit not payable under paragraphs (e)(1) and (e)(2) of this section shall be payable to the first person or persons listed in paragraphs (e)(4)(i)(A) through (F) of this section who are surviving on the date of the decedent's death in the following order of precedence:

(A) To the next eligible beneficiary designated by the decedent in a writing received by the appropriate office of the applicable uniformed service before the decedent's death in the uniformed services in the case of Servicemembers' Group Life Insurance proceeds or a Servicemembers' Group Life Insurance Traumatic Injury Protection benefit, or in a writing received by the administrative office defined in § 9.1(b) of this part before the decedent's death in the case of Veterans' Group Life Insurance proceeds;

(B) To the decedent's widow or widower;

(C) To the decedent's child or children, in equal shares, and descendants of deceased children by representation;

(D) To the decedent's parents, in equal shares, or to the survivor of them;

(E) To the duly appointed executor or administrator of the decedent's estate;

(F) To other next of kin of the decedent as determined by the insurer (defined in § 9.1(c) of this part) under the laws of the domicile of the decedent at the time of the decedent's death.

(ii) Payment of Servicemembers' Group Life Insurance or Veterans' Group Life Insurance proceeds or a Servicemembers' Group Life Insurance Traumatic Injury Protection benefit to any person under paragraph (e)(4)(i) of this section shall bar recovery of those proceeds or that benefit by any other person.

(f) If a stillborn child is otherwise eligible to be insured by the Servicemembers' Group Life Insurance coverage of more than one member, the child shall be insured by the coverage of the child's insured biological mother.

(Authority: 38 U.S.C. 501(a), 1965(10), 1967(a)(4)(B))

[40 FR 4135, Jan. 28, 1975, as amended at 50 FR 12252, Mar. 28, 1985. Redesignated and amended at 61 FR 20135, 20136, May 6, 1996; 77 FR 60306, Oct. 3, 2012; 77 FR 70376, Nov. 26, 2012]

§ 9.6 Assignments.

Servicemembers' Group Life Insurance, Veterans' Group Life Insurance

and benefits thereunder are not assignable.

[40 FR 4135, Jan. 28, 1975. Redesignated at 61 FR 20135, May 6, 1996]

§9.7 Administrative decisions.

(a) Determinations of the Department of Veterans Affairs are conclusive under the policy with respect to the following:

(1) The status of any person being within the term *member* and whether or not he or she is covered at any point of time under the policy including *travel-time* under 38 U.S.C. 1967(b) and death within 120 days thereafter from a disability incurred or aggravated while on duty.

(2) The fact and date of a member's termination of active duty, or active duty for training, and the fact, date and hours of a member's performance of inactive duty training.

(3) The fact and dates with respect to a member's absence without leave, confinement by civilian authorities under a sentence adjudged by a civil court, or confinement by military authorities under a court-martial sentence involving total forfeiture of pay and allowances.

(4) The operation of the forfeiture provision provided in 38 U.S.C. 1973 with respect to any member.

(5) The existence of total disability or insurability at standard premium rates under 38 U.S.C. 1968.

(b) When determination is required on a claim that a member who waived coverage, or whose coverage was forfeited for one of the offenses listed under 38 U.S.C. 1973 was in fact insured, or that a member who elected to be insured was insured for an amount greater than the amount shown in the record, and there is no record of an application to be insured or to increase the amount of insurance as required under 38 U.S.C. 1967(c):

(1) The person making the claim will be required to submit all evidence available concerning the member's actions and intentions with respect to Servicemembers' Group Life Insurance or Veterans' Group Life Insurance.

(2) Request will be made to the member's uniformed service and any other likely source of information considered necessary, for whatever evidence in the form of copies of payroll or personnel records, statements of persons having knowledge of the facts, etc., is essential to a decision in the matter.

Based on the evidence obtained, a formal determination will be made as to whether the member involved is deemed to have applied to be insured, or to be insured for an amount other than the amount shown in the record. The determination will include a finding as to the member's health status for insurance purposes based on the evidence available.

(Authority: 38 U.S.C. 1967)

(c) In making the determination required under paragraph (b) of this section, the following will be considered:

(1) The possibility that due to widespread geographic distribution, inadequate means of communication and the nature of the group insurance program, members may not be adequately and accurately informed, especially in time of war or military emergency, about the detailed requirements for obtaining insurance protection.

(2) Payroll deductions made without objection by a member, following waiver or termination of coverage, representing premiums for insurance or additional insurance, may, by virtue of continuity or the circumstances surrounding their initiation, be indicative that the member did apply. Such deductions without a formal application of record may be considered as evidence that the member's application was not in proper form or misplaced. They may also be considered as evidence that an application was not made solely because of erroneous or incomplete counseling or absence of counseling on the part of the responsible personnel of the uniformed service.

(d) Questions for determination under this section as well as those involving coverage of groups and classes of members and other questions are properly referable to the Assistant Director for Insurance. Authority to make any determinations required under this section is delegated to the

Under Secretary for Benefits and Assistant Director for Insurance.

[40 FR 4135, Jan. 28, 1975, as amended at 53 FR 17699, May 18, 1988. Redesignated and amended at 61 FR 20135, 20136, May 6, 1996]

§ 9.8 Termination of coverage.

Termination of coverage will be in accordance with the provisions of 38 U.S.C. 1968 and § 9.3 of this part and the following provisions:

(a) In the case of a member whose coverage is forfeited under 38 U.S.C. 1973, coverage terminates at the end of the day preceding the day on which the act or omission forming the basis for such forfeiture occurred.

(b) In the event of discontinuance of the group policy, coverage terminates at the end of the day preceding the date of the discontinuance of the policy except for those members who are insured under Veterans' Group Life Insurance in which event coverage terminates at the expiration of the day preceding the anniversary of the effective date of such insurance which first occurs, 90 days or more after the discontinuance of the group policy.

[40 FR 4135, Jan. 28, 1975, as amended at 48 FR 8071, Feb. 25, 1983; 53 FR 17699, May 18, 1988; 57 FR 11910, Apr. 8, 1992. Redesignated and amended at 61 FR 20135, 20136, May 6, 1996; 62 FR 35970, July 3, 1997]

§ 9.9 Conversion privilege.

(a) With respect to a member on active duty or active duty for training under a call or order to duty that specifies a period of less than 31 days, and a member insured during inactive duty training scheduled in advance by competent authority there shall be no right of conversion unless the insurance is continued in force under 38 U.S.C. 1967(b) or 1968(a) for 120 days following a period of such duty, as the result of a disability incurred or aggravated during such a period of duty.

(b) The individual policy of life insurance to which an insured may convert under 38 U.S.C. 1968(b) or 1977(e) shall not have disability or other supplementary benefits and shall not be term insurance or any policy which does not provide for cash values. Term riders providing level or decreasing insurance for which an additional premium is charged may be attached to an eligible basic conversion policy, but the rider will be excluded from the conversion pool agreement under the policy.

(c) The insurer will establish a conversion pool in cooperation with the reinsurers and converters in accordance with the terms of the policy. Its purpose will be to provide for the determination and maintenance of appropriate charges arising from excess mortality under individual conversion policies issued in accordance with this section and provide for the appropriate distribution of the risk of loss due to such excess mortality among the reinsurers and converters.

[40 FR 4135, Jan. 28, 1975, as amended at 53 FR 17699, May 18, 1988. Redesignated and amended at 61 FR 20135, 20136, May 6, 1996]

§ 9.10 Health standards.

(a) For the purpose of determining if a member who incurred a disability or aggravated a preexisting disability during a period of active duty or active duty for training under a call to duty specifying a period of less than 31 days or during a period of inactive duty was rendered uninsurable at standard premium rates, the underwriting criteria used by the insurer in determining good health for persons applying to it for life insurance in amounts not exceeding the maximum amount of coverage then available under 38 U.S.C. 1967 will be used.

(Authority: 38 U.S.C. 1967)

(b) For all other purposes of determining if a member meets the necessary health requirements except paragraph (a) of this section, the underwriting criteria used by the insurer in determining good health for group life insurance purposes will be used.

[40 FR 4135, Jan. 28, 1975, as amended at 53 FR 17699, May 18, 1988. Redesignated at 61 FR 20135, May 6, 1996]

§ 9.11 Criteria for reinsurers and converters.

The following criteria will control eligibility for reinsuring and converting companies:

(a) The company must be a legal reserve life insurance company as classified by the insurance supervisory authorities of the State of domicile.

Qualified fraternal organizations are included.

(b) The company must have been in the life insurance business for a continuous period of 5 years prior to October 1, 1965, or the December 31 preceding any redeterminations of the allocations. In the event of a merger, the 5-year requirement may be satisfied by either the surviving company or by one of the absorbed companies. Upon joint application by a subsidiary of a participating company, together with the parent company, the 5-year requirement may be waived provided such parent company owns more than 50 percent of the outstanding stock of the subsidiary and has been a legal reserve life insurance company for a period of 10 years or more.

(c) The company must be licensed to engage in life insurance in at least one State of the United States or the District of Columbia.

(d) The company will not be one: (1) Certified by the Department of Defense as being under suspension for cause for purpose of allotment or on-base solicitation privileges.

(2) That solicits life insurance applications as conversion or other replacement of Servicemembers' Group Life Insurance or Veterans' Group Life Insurance coverage in jurisdictions in which it is not licensed.

(3) That fails to take effective action to correct an improper practice followed by it or its agents within 30 days after written receipt of notice issued by the insurer or the Assistant Director for Insurance. Improper practice includes:

(i) The use for solicitation purposes of lists of names and addresses of former members without obtaining reasonable assurance that such lists have not been obtained contrary to regulations of the Department of Defense or other uniformed service;

(ii) Failure to reveal sources and copies of mailing lists upon proper request or to otherwise cooperate in an authorized investigation of a reported improper practice;

(iii) The use of written or oral representations which may mislead the person addressed as to the true role of the company or its representatives as one of the participating companies;

(iv) The use of written or oral representations which may mislead the person addressed as to rights, privileges, coverage, premiums, or similar matters under Servicemembers' Group Life Insurance, Veterans' Group Life Insurance, or any policy issued or proposed to be issued as a conversion or other replacement coverage;

(v) Violation of regulations of a uniformed service concerning solicitation of life insurance; and

(vi) The use of written or oral references to Servicemembers' Group Life Insurance, Veterans' Group Life Insurance or conversions of Servicemembers' Group Life Insurance or Veterans' Group Life Insurance in connection with the attempted sale of an insurance policy which would not be, in fact, a conversion policy or a policy issued in lieu of a conversion, if those references might lead a person addressed to believe there is a connection between the policy being sold and coverage under Servicemembers' Group Life Insurance, Veterans' Group Life Insurance or a conversion of it.

(e) Each reinsuring and converting company must agree to issue conversion policies to any qualified applicant regardless of race, color, religion, sex, or national origin, under terms and conditions established by the primary insurer.

[40 FR 4135, Jan. 28, 1975. Redesignated at 61 FR 20135, May 6, 1996]

§9.12 Reinsurance formula.

The allocation of insurance to the insurer and each reinsurer will be based upon the following:

(a) An amount of the total life insurance in force under the policy in proportion to the company's total life insurance in force in the United States where:

The first $100 million in force is counted in full,

The second $100 million in force is counted at 75 percent,

The third $100 million in force is counted at 50 percent,

The fourth $100 million in force is counted at 25 percent,

And any amount above $400 million in force is counted at 5 percent.

(b) The allocation will be redetermined at the beginning of each policy

year for the primary insurer and the companies then reinsuring, with the portion as set forth in paragraph (a) of this section based upon the corresponding in force (excluding the Servicemembers' Group Life Insurance in force) as of the preceding December 31.

(c) Any life insurance company, which is not initially participating in reinsurance or conversions, but satisfies the criteria set forth in § 9.11, may subsequently apply to the primary insurer to reinsure and convert, or to convert only. The participation of such company will be effective as of the beginning of the policy year following the date on which application is approved by the insurer.

[40 FR 4135, Jan. 28, 1975. Redesignated and amended at 61 FR 20135, 20136, May 6, 1996]

§ 9.13 Actions on the policy.

The Assistant Director for Insurance will furnish the name and address of the insuring company upon written request of a member of the uniformed services or his or her beneficiary. Actions at law or in equity to recover on the policy, in which there is not alleged any breach of any obligation undertaken by the United States, should be brought against the insurer.

[40 FR 4135, Jan. 28, 1975. Redesignated and amended at 61 FR 20135, 20136, May 6, 1996]

§ 9.14 Accelerated Benefits.

(a) *What is an Accelerated Benefit?* An Accelerated Benefit is a payment of a portion of your Servicemembers' Group Life Insurance or Veterans' Group Life Insurance to you before you die.

(b) *Who is eligible to receive an Accelerated Benefit?* You are eligible to receive an Accelerated Benefit if you have a valid written medical prognosis from a physician of 9 months or less to live, and otherwise comply with the provisions of this section.

(c) *Who can apply for an Accelerated Benefit?* Only you, the insured member, can apply for an Accelerated Benefit. No one can apply on your behalf.

(d) *How much can you request as an Accelerated Benefit?* (1) You can request as an Accelerated Benefit an amount up to a maximum of 50% of the face value of your insurance coverage.

(2) Your request for an Accelerated Benefit must be $5,000 or a multiple of $5000 (for example, $10,000, $15,000).

(e) *How much can you receive as an Accelerated Benefit?* You can receive as an Accelerated Benefit the amount you request up to a maximum of 50% of the face value of your insurance coverage, minus the interest reduction. The interest reduction is the amount the Office of Servicemembers' Group Life Insurance actuarially determines to be the amount of interest that would be lost because of the early payment of part of your insurance coverage. This means that if you have $100,000 in coverage and you request the maximum amount that you are eligible to request as an Accelerated Benefit, you will be paid $50,000 minus the interest reduction.

(f) *How do you apply for an Accelerated Benefit?* (1) You can obtain an application form entitled ''Claim for Accelerated Benefits'' by writing the Office of Servicemembers' Group Life Insurance, 290 W. Mt. Pleasant Avenue, Livingston, New Jersey 07039; calling the Office of Servicemembers' Group Life Insurance toll-free at 1–800–219–1473; or downloading the form from the Internet at *www.insurance.va.gov*. You must submit the completed application form to the Office of Servicemembers' Group Life Insurance, 290 W. Mt. Pleasant Avenue, Livingston, New Jersey 07039.

(2) As stated on the application form, you will be required to complete part of the application form and your physician will be required to complete part of the application form. If you are an active duty servicemember, your branch of service will also be required to complete part of the form.

To Be Completed by Insured

Claim for Accelerated Benefits

Your name: _____
Social Security Number: _____
Your home address: _____
Date of birth: _____
Branch of Service (if covered under SGLI): __
Your mailing address (if different from above): _____
Amount of SGLI coverage: $ _____
Amount of claim (can be no more than one-half of coverage in increments of $5,000): __
Type of coverage (check one):

SGLI (circle one of the following): *Active Duty Ready Reserve Army or Air National Guard Separated or Discharged*
VGLI

NOTE: If you checked SGLI, you must also have your military unit complete the attached form.

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 lifetime and that I can use it for any purpose I choose. I further understand that the face amount of my coverage will reduce by the amount of accelerated benefit I choose to receive now.

Your signature: _____
Date: _____

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.

Printed name: _____
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 Physician

Attending Physician's Certification

Patient's name: _____
Patient's Social Security Number: _____
Diagnosis: _____
ICD–9–CM Disease Code *: _____
Description of present medical condition (please attach results of x-rays, E.K.G. or other tests): _____

Is the patient capable of handling his/her own affairs? _____ Yes____ No____

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? _____ Yes____ No____

Attending Physician's name (please print): __
State in which you are licensed to practice:
Specialty: _____
Mailing address: _____
Telephone number: _____
Fax Number: _____
Signature: _____
Date: _____

*ICD–9–CM is an acronym for International Classification of Diseases, 9th revision, Clinical Modification.

To Be Completed by Personnel Office of Servicemember's Unit

(Complete this form only if the applicant for Accelerated Benefits is covered under SGLI.)

Branch of Service Statement

Servicemember's name: _____
Social Security Number: _____
Branch of Service: _____
Amount of SGLI coverage: $ _____
Monthly premium amount: $ _____
Name of person completing this form: _____
Telephone Number: _____
Fax Number: _____
Title of person completing this form: _____
Duty Station and address: _____
Signature of person completing this form: __
Date: _____

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.

(g) *Who decides whether or not an Accelerated Benefit will be paid to you?* The Office of Servicemembers' Group Life Insurance will review your application and determine whether you meet the requirements of this section for receiving an Accelerated Benefit.

(1) They will approve your application if the requirements of this section are met.

(2) If the Office of Servicemembers' Group Life Insurance determines that your application form does not fully and legibly provide the information requested by the application form, they will contact you and request that you or your physician submit the missing information to them. They will not take action on your application until the information is provided.

(h) *How will an Accelerated Benefit be paid to you?* An Accelerated Benefit will be paid to you in a lump sum.

(i) *What happens if you change your mind about an application you filed for Accelerated Benefits?* (1) An election to receive the Accelerated Benefit is made at the time you have cashed or deposited the Accelerated Benefit. After that time, you cannot cancel your request for an Accelerated Benefit. Until that time, you may cancel your request for benefits by informing the Office of Servicemembers' Group Life Insurance

in writing that you are canceling your request and by returning the check if you have received one. If you want to change the amount of benefits you requested or decide to reapply after canceling a request, you may file another application in which you request either the same or a different amount of benefits.

(2) If you die before cashing or depositing an Accelerated Benefit payment, the payment must be returned to the Office of Servicemembers' Group Life Insurance. Their mailing address is 290 W. Mt. Pleasant Avenue, Livingston, New Jersey 07039.

(j) *If you have cashed or deposited an Accelerated Benefit, are you eligible for additional Accelerated Benefits?* No.

(Approved by the Office of Management and Budget under control number 2900–0618)

(Authority: 38 U.S.C. 1965, 1966, 1967, 1980)

[67 FR 52413, Aug. 12, 2002]

§ 9.20 Traumatic injury protection.

(a) *What is traumatic injury protection?* Traumatic injury protection provides for the payment of a specified benefit amount to a member insured by Servicemembers' Group Life Insurance who sustains a traumatic injury directly resulting in a scheduled loss.

(b) *What is a traumatic event?* (1) A traumatic event is the application of external force, violence, chemical, biological, or radiological weapons, or accidental ingestion of a contaminated substance causing damage to a living being occurring—

(i) On or after December 1, 2005, or

(ii) On or after October 7, 2001, and through and including November 30, 2005, if the scheduled loss is a direct result of a traumatic injury incurred in Operation Enduring Freedom or Operation Iraqi Freedom.

(2)(i) The term *incurred in Operation Enduring Freedom* means a service member was deployed outside of the United States on orders in support of Operation Enduring Freedom or served in a geographic location that qualified the service member for the Combat Zone Tax Exclusion under 26 U.S.C. 211.

(ii) The term *incurred in Operation Iraqi Freedom* means a service member was deployed outside of the United States on orders in support of Operation Iraqi Freedom or served in a geographic location that qualified the service member for the Combat Zone Tax Exclusion under 26 U.S.C. 211.

(3) A traumatic event does not include a medical or surgical procedure in and of itself.

(c) *What is a traumatic injury?* (1) A traumatic injury is physical damage to a living body that is caused by a traumatic event as defined in paragraph (b) of this section.

(2) For purposes of this section, the term ''traumatic injury'' does not include damage to a living body caused by—

(i) A mental disorder; or

(ii) A mental or physical illness or disease, except if the physical illness or disease is caused by a pyogenic infection, biological, chemical, or radiological weapons, or accidental ingestion of a contaminated substance.

(3) For purposes of this section, all traumatic injuries will be considered to have occurred at the same time as the traumatic event.

(d) *What are the eligibility requirements for payment of traumatic injury protection benefits?* You must meet all of the following requirements in order to be eligible for traumatic injury protection benefits.

(1) You must be a member of the uniformed services who is insured by Servicemembers' Group Life Insurance under section 1967(a)(1)(A)(i), (B) or (C)(i) of title 38, United States Code, on the date you sustained a traumatic injury, except if you are a member who experienced a traumatic injury on or after October 7, 2001, through and including December 1, 2005, and your scheduled loss was a direct result of injuries incurred in Operation Enduring Freedom or Operation Iraqi Freedom. (For this purpose, you will be considered a member of the uniformed services until midnight on the date of termination of your duty status in the uniformed services that established your eligibility for Servicemembers' Group Life Insurance, notwithstanding an extension of your Servicemembers' Group Life Insurance coverage under section 1968(a) of title 38, United States Code.)

(2) You must suffer a scheduled loss that is a direct result of a traumatic injury and no other cause.

(3) You must survive for a period not less than seven full days from the date of the traumatic injury. The seven day period begins on the date and Zulu (Greenwich Meridean) time of the traumatic injury and ends 168 full hours later.

(4) You must suffer a scheduled loss under paragraph (e)(7) of this section within two years of the traumatic injury.

(5) You must suffer a traumatic injury before midnight on the date of termination of your duty status in the uniformed services that established eligibility for Servicemembers' Group Life Insurance. For purposes of this section, the scheduled loss may occur after the date of termination of your duty status in the uniformed services that established eligibility for Servicemembers' Group Life Insurance.

(e) *What is a scheduled loss and what amount will be paid because of that loss?* (1) The term ''scheduled loss'' means a condition listed in the schedule in paragraph (e)(7) of this section if directly caused by a traumatic injury. A scheduled loss is payable at the amount specified in the schedule.

(2) The maximum amount payable under the schedule for all losses resulting from traumatic events occurring within a seven-day period is $100,000. We will calculate the seven-day period beginning with the day on which the first traumatic event occurs.

(3) A benefit will not be paid if a scheduled loss is due to a traumatic injury—

(i) Caused by—

(A) The member's attempted suicide, while sane or insane;

(B) An intentionally self-inflicted injury or an attempt to inflict such injury;

(C) Diagnostic procedures, preventive medical procedures such as inoculations, medical or surgical treatment for an illness or disease, or any complications arising from such procedures or treatment;

(D) Willful use of an illegal substance or a controlled substance unless administered or consumed on the advice of a medical professional; or

(ii) Sustained while a member was committing or attempting to commit a felony.

(4) A benefit will not be paid for a scheduled loss resulting from—

(i) A physical or mental illness or disease, whether or not caused by a traumatic injury, other than a pyogenic infection or physical illness or disease caused by biological, chemical, or radiological weapons or accidental ingestion of a contaminated substance; or

(ii) A mental disorder whether or not caused by a traumatic injury.

(5) Amount Payable under the Schedule of Losses. (i) The maximum amount payable for all scheduled losses resulting from a single traumatic event is limited to $100,000. For example, if a traumatic event on April 1, 2006, results in the immediate total and permanent loss of sight in both eyes, and the loss of one foot on May 1, 2006, as a direct result of the same traumatic event, the member will be paid $100,000.

(ii) If a member suffers more than one scheduled loss from separate traumatic events occurring more than seven full days apart, the scheduled losses will be considered separately and a benefit will be paid for each loss up to the maximum amount according to the schedule. For example, if a member suffers the loss of one foot at or above the ankle on May 1, 2006, from one event, the member will be paid $50,000. If the same member suffers loss of sight in both eyes from an event that occurred on November 1, 2006, the member will be paid an additional $100,000.

(6) *Definitions.* For purposes of this paragraph (e)(6)—

(i) The term *quadriplegia* means the complete and irreversible paralysis of all four limbs.

(ii) The term *paraplegia* means the complete and irreversible paralysis of both lower limbs.

(iii) The term *hemiplegia* means the complete and irreversible paralysis of the upper and lower limbs on one side of the body.

(iv) The term *uniplegia* means the complete and irreversible paralysis of one limb of the body.

(v) The term *complete and irreversible paralysis* means total loss of voluntary

movement resulting from damage to the spinal cord or associated nerves, or to the brain, that is deemed clinically stable and unlikely to improve.

(vi) The term *inability to carry out activities of daily living* means the inability to independently perform at least two of the six following functions:

(A) Bathing.

(B) Continence.

(C) Dressing.

(D) Eating.

(E) Toileting.

(F) Transferring in or out of a bed or chair with or without equipment.

(vii) The term *pyogenic infection* means a pus-producing infection.

(viii) The term *contaminated substance* means food or water made unfit for consumption by humans because of the presence of chemicals, radioactive elements, bacteria, or organisms.

(ix) The term *chemical weapon* means chemical substances intended to kill, seriously injure, or incapacitate humans through their physiological effects.

(x) The term *biological weapon* means biological agents or microorganisms intended to kill, seriously injure, or incapacitate humans through their physiological effects.

(xi) The term *radiological weapon* means radioactive materials or radiation-producing devices intended to kill, seriously injure, or incapacitate humans through their physiological effects.

(xii) The term *medical professional* means a licensed practitioner of the healing arts acting within the scope of his or her practice. Some examples include a licensed physician, optometrist, nurse practitioner, registered nurse, physician assistant, or audiologist.

(xiii) The term *hospitalization* means an inpatient stay in a facility that is:

(A)(*1*) Accredited by the Joint Commission or its predecessor, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or accredited or approved by a program of the qualified governmental unit in which such institution is located if the Secretary of Health and Human Services has found that the accreditation or comparable approval standards of such qualified governmental unit are essentially equivalent to those of the Joint Commission or JCAHO;

(*2*) Used primarily to provide, by or under the supervision of physicians, to inpatients diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons;

(*3*) Requires every patient to be under the care and supervision of a physician; and

(*4*) Provides 24-hour nursing services rendered or supervised by a registered professional nurse and has a licensed practical nurse or registered nurse on duty at all times; or

(B) Any Armed Forces medical facility that is authorized to provide inpatient and/or ambulatory care to eligible service members.

(xiv) The term *total and permanent loss of sight* means:

(A) Visual acuity in the eye of 20/200 or less (worse) with corrective lenses lasting at least 120 days;

(B) Visual acuity in the eye of greater (better) than 20/200 with corrective lenses and a visual field of 20 degrees or less lasting at least 120 days; or

(C) Anatomical loss of the eye.

(xv) The term *total and permanent loss of speech* means organic loss of speech or the ability to express oneself, both by voice and whisper, through normal organs for speech, notwithstanding the use of an artificial appliance to simulate speech. Loss of speech must be clinically stable and unlikely to improve.

(xvi) The term *total and permanent loss of hearing* means average hearing threshold sensitivity for air conduction of at least 80 decibels, based on hearing acuity measured at 500, 1,000, and 2,000 Hertz, that is clinically stable and unlikely to improve.

(xvii) The term *burns* means 2nd degree (partial thickness) or worse burns covering at least 20 percent of the body, including the face and head, or 20 percent of the face alone. Percentage of the body burned may be measured using the Rule of Nines or any means generally accepted within the medical profession.

(xviii) The term *coma* means a state of profound unconsciousness that is measured at a Glasgow Coma Score of 8 or less.

(xix) The term *limb salvage* means a series of operations designed to save an arm or leg with all of its associated parts rather than amputate it. For purposes of this section, a surgeon must certify that the option of amputation of the limb(s) was a medically justified alternative to salvage, and the patient chose to pursue salvage.

(xx) The term *amputation* means the severance or removal of a limb or genital organ or part of a limb or genital organ resulting from trauma or surgery. With regard to limbs an amputation above a joint means a severance or removal that is closer to the body than the specified joint is.

(xxi) The term *anatomical loss of the penis* is defined as amputation of the glans penis or any portion of the shaft of the penis above the glans penis (*i.e.* closer to the body) or damage to the glans penis or shaft of the penis that requires reconstructive surgery.

(xxii) The term *permanent loss of use of the penis* is defined as damage to the glans penis or shaft of the penis that results in complete loss of the ability to perform sexual intercourse that is reasonably certain to continue throughout the lifetime of the member.

(xxiii) The term *anatomical loss of the testicle(s)* is defined as the amputation of, or damage to, one or both testicles that requires testicular salvage, reconstructive surgery, or both.

(xxiv) The term *permanent loss of use of both testicles* is defined as damage to both testicles resulting in the need for hormonal replacement therapy that is medically required and reasonably certain to continue throughout the lifetime of the member.

(xxv) The term *anatomical loss of the vulva, uterus, or vaginal canal* is defined as the complete or partial amputation of the vulva, uterus, or vaginal canal or damage to the vulva, uterus, or vaginal canal that requires reconstructive surgery.

(xxvi) The term *permanent loss of use of the vulva or vaginal canal* is defined as damage to the vulva or vaginal canal that results in complete loss of the ability to perform sexual intercourse that is reasonably certain to continue throughout the lifetime of the member.

(xxvii) The term *anatomical loss of the ovary(ies)* is defined as the amputation of one or both ovaries or damage to one or both ovaries that requires ovarian salvage, reconstructive surgery, or both.

(xxviii) The term *permanent loss of use of both ovaries* is defined as damage to both ovaries resulting in the need for hormonal replacement therapy that is medically required and reasonably certain to continue throughout the lifetime of the member.

(xxix) The term *total and permanent loss of urinary system function* is defined as damage to the urethra, ureter(s), both kidneys, bladder, or urethral sphincter muscle(s) that requires urinary diversion and/or hemodialysis, either of which is reasonably certain to continue throughout the lifetime of the member.

(f) Schedule of Losses.

For losses listed in paragraphs (f)(1) through (19) of this section, multiple losses resulting from a single traumatic event may be combined for purposes of a single payment (except where noted otherwise); however, the total payment amount may not exceed $100,000 for losses resulting from a single traumatic event. Payments for losses listed in paragraphs (f)(20) through (21) of this section may not be made in addition to payments for losses under paragraphs (f)(1) through (19)—only the higher amount will be paid. The total payment amount may not exceed $100,000 for losses resulting from a single traumatic event.	
If the loss is—	Then the amount payable for the loss is—
(1) Total and permanent loss of sight:	
• For each eye	$50,000

(2) Total and permanent loss of hearing:	
• For one ear	$25,000
• For both ears	$100,000
(3) Total and permanent loss of speech	$50,000
(4) Quadriplegia	$100,000
(5) Hemiplegia	$100,000
(6) Paraplegia	$100,000
(7) Uniplegia:	
• For each limb*	$50,000
**Note: Payment for uniplegia of arm cannot be combined with loss 9, 10, or 14 for the same arm. Payment of uniplegia of leg cannot be combined with loss 11, 12, 13, or 15 for the same leg.*	
(8) Burns	$100,000
(9) Amputation of a hand at or above the wrist:	
• For each hand*	$50,000
**Note: Payment for loss 9 cannot be made in additional to payment for loss 10 for the same hand.*	
(10) Amputation at or above the metacarpophalangeal joint(s) of either the thumb or the other 4 fingers on 1 hand:	
• For each hand*	$50,000
**Note: Payment for loss of the thumb cannot be made in addition to payment for loss of the other 4 fingers for the same hand.*	
(11) Amputation of a foot at or above the ankle:	
• For each foot.*	$50,000
**Note: Payment for loss 11 cannot be made in addition to payments for losses 12 or 13 for the same foot.*	
(12) Amputation at or above the metatarsophalangeal joints of all toes on 1 foot:	
• For each foot*	$50,000
**Note: Payment for loss 12 cannot be made in addition to payments for loss 13 for the same foot.*	
(13) Amputation at or above the metatarsophalangeal joint(s) of either the big toe, or the other 4 toes on 1 foot	
• For each foot	$25,000
(14) Limb salvage of arm:	
• For each arm*	$50,000
**Note: Payment for loss 14 cannot be made in addition to payments for losses 9 or 10 for the same arm.*	
(15) Limb salvage of leg:	
• For each leg*	$50,000
**Note: Payment for loss 15 cannot be made in addition to payments for losses 11, 12 or 13 for the same leg.*	
(16) Facial Reconstruction:	
• Jaw—surgery to correct discontinuity loss of the upper or lower jaw	$75,000
• Nose—surgery to correct discontinuity loss of 50% or more of the cartilaginous nose	$50,000
• Lips—surgery to correct discontinuity loss of 50% or more of the upper or lower lip	
—For one lip	$50,000
—For both lips	$75,000
• Eyes—surgery to correct discontinuity loss of 30% or more of the periorbita.	
—For each eye	$25,000
• Facial Tissue—surgery to correct discontinuity loss of the tissue in 50% or more of any of the following facial subunits: forehead, temple, zygomatic, mandibular, infraorbital or chin.	
—For each facial subunit	$25,000

Note 1: Losses due to facial reconstruction may be combined with each other, but the maximum benefit for facial reconstruction may not exceed $75,000.	
Note 2: Any injury or combination of losses under facial reconstruction may also be combined with other losses in paragraphs 9.20(f)(1)–(18) and treated as one loss, provided that all losses are the result of a single traumatic event. However, the total payment amount may not exceed $100,000.	
(17) Coma from traumatic injury AND/OR Traumatic Brain injury resulting in inability to perform at least 2 Activities of Daily Living (ADL):	
• at 15th consecutive day of coma or ADL loss*	$25,000
• at 30th consecutive day of coma or ADL loss*	an additional $25,000
• at 60th consecutive day of coma or ADL loss*	an additional $25,000
•; at 90th consecutive day of coma or ADL loss*	an additional $25,000
Note 1: Duration of coma and inability to perform ADLs includes date of onset of coma or inability to perform ADLs and the first date on which member is no longer in a coma or is able to perform ADLs.	
(18) Hospitalization due to traumatic brain injury:*	
• at 15 consecutive day of hospitalization**	$25,000
**Note: Payment for hospitalization replaces period in loss 17.*	
***Note: Duration of hospitalization includes dates on which member is transported from the injury site to a facility described in § 9.20(e)(6)(xiii), admitted to the facility, transferred between facilities, and discharged from the facility.*	
(19) Genitourinary Losses:	
• Anatomical loss of the penis	$50,000
• Permanent loss of use of the penis	$50,000
• Anatomical loss of one testicle	$25,000
Anatomical loss of both testicles	$50,000
• Permanent loss of use of both testicles	$50,000
• Anatomical loss of the vulva, uterus, or vaginal canal	$50,000
• Permanent loss of use of the vulva or vaginal canal	$50,000
• Anatomical loss of one ovary	$25,000
• Anatomical loss of both ovaries	$50,000
• Permanent loss of use of both ovaries	$50,000
• Total and permanent loss of urinary system function	$50,000
Note 1: Losses due to genitourinary injuries may be combined with each other, but the maximum benefit for genitourinary losses may not exceed $50,000.	
Note 2: Any genitourinary loss may be combined with other injuries listed in § 9.20(f)(1) through (18) and treated as one loss, provided that all losses are the result of a single traumatic event. However, the total payment may not exceed $100,000.	
(20) Traumatic injury, other than traumatic brain injury, resulting in inability to perform at least 2 Activities of Daily Living (ADL):	
• at 30th consecutive day of ADL loss*	$25,000
• at 60th consecutive day of ADL loss*	an additional $25,000
• at 90th consecutive day of ADL loss*	an additional $25,000
• at 120th consecutive day of ADL loss*	an additional $25,000
**Note: Duration of inability to perform ADLs includes date of onset of inability to perform ADLs and the first date on which member is able to perform ADLs.*	
(21) Hospitalization due to traumatic injury other than traumatic brain injury:*	
• at 15th consecutive day of hospitalization**	$25,000
**Note: Payment for hospitalization replaces the first payment period in loss 19.*	

***Note: Duration of hospitalization includes dates on which member is transported from the injury site to a facility described in § 9.20(e)(6)(xiii), admitted to the facility, transferred between facilities, and discharged from the facility.*	

(g) *Who will determine eligibility for traumatic injury protection benefits?* Each uniformed service will certify its own members for traumatic injury protection benefits based upon section 1032 of Public Law 109–13, section 501 of Public Law 109–233, and this section. The uniformed service will certify whether you were at the time of the traumatic injury insured under Servicemembers' Group Life Insurance and whether you have sustained a qualifying loss.

(h) *How does a member make a claim for traumatic injury protection benefits?* (1)(i) A member who believes he or she qualifies for traumatic injury protection benefits must complete Part A of the Application for TSGLI Benefits Form and sign the form.

(ii) If a member is unable to sign the Application for TSGLI Benefits Form due to the member's physical or mental incapacity, the form must be signed by the member's guardian; if none, the member's agent or attorney acting under a valid Power of Attorney; if none, the member's military trustee.

(iii) If a member suffered a scheduled loss as a direct result of the traumatic injury, survived seven full days from the date of the traumatic event, and then died before the maximum benefit for which the service member qualifies is paid, the beneficiary or beneficiaries of the member's Servicemembers' Group Life Insurance policy should complete an Application for TSGLI Benefits Form.

(2) If a member seeks traumatic injury protection benefits for a scheduled loss occurring after submission of a completed Application for TSGLI Benefits Form for a different scheduled loss, the member must submit a completed Application for TSGLI Benefits Form for the new scheduled loss and for each scheduled loss that occurs thereafter and for each increment of a scheduled loss that occurs thereafter. For example, if a member seeks traumatic injury protection benefits for a scheduled loss due to coma from traumatic injury and/or the inability to carry out activities of daily living due to traumatic brain injury (§ 9.20(f)(17)), or the inability to carry out activities of daily living due to loss directly resulting from a traumatic injury other than an injury to the brain (§ 9.20(f)(19)), a completed Application for TSGLI Benefits Form must be submitted for each increment of time for which TSGLI is payable. Also, for example, if a service member suffers a scheduled loss due to a coma, a completed Application for TSGLI Benefits Form should be filed after the 15th consecutive day that the member is in the coma, for which $25,000 is payable. If the member remains in a coma for another 15 days, another completed Application for TSGLI Benefits Form should be submitted and another $25,000 will be paid.

(i) *How does a member or beneficiary appeal an adverse eligibility determination?* (1) Notice of a decision regarding a member's eligibility for traumatic injury protection benefits will include an explanation of the procedure for obtaining review of the decision. An appeal of an eligibility determination, such as whether the loss occurred within 365 days of the traumatic injury, whether the injury was self-inflicted or whether a loss of hearing was total and permanent, must be in writing. An appeal must be submitted by a member or a member's legal representative or by the beneficiary or the beneficiary's legal representative, within one year of the date of a denial of eligibility, to the office of the uniformed service identified in the decision regarding the member's eligibility for the benefit.

(2) An appeal regarding whether a member was insured under Servicemembers' Group Life Insurance when the traumatic injury was sustained must be in writing. An appeal must be submitted by a member or a member's legal representative or by the beneficiary or the beneficiary's legal representative within one year of the date of a denial of eligibility to the

Office of Servicemembers' Group Life Insurance.

(3) Nothing in this section precludes a member from pursuing legal remedies under 38 U.S.C. 1975 and 38 CFR 9.13.

(j) *Who will be paid the traumatic injury protection benefit?* The injured member who suffered a scheduled loss will be paid the traumatic injury protection benefit in accordance with title 38 U.S.C. 1980A except under the following circumstances:

(1) If a member is legally incapacitated, the member's guardian or agent or attorney acting under a valid Power of Attorney will be paid the benefit on behalf of the member.

(2) If no guardian, agent, or attorney is authorized to act as the member's legal representative, a military trustee who has been appointed under the authority of 37 U.S.C. 602 will be paid the benefit on behalf of the member. The military trustee will report the receipt of the traumatic injury benefit payment and any disbursements from that payment to the Department of Defense.

(3) If a member dies before payment is made, the beneficiary or beneficiaries who will be paid the benefit will be determined in accordance with 38 U.S.C. 1970(a).

(k) The Traumatic Servicemembers' Group Life Insurance program will be administered in accordance with this rule, except to the extent that any regulatory provision is inconsistent with subsequently enacted applicable law.

(Authority: 37 U.S.C. 602, 603; 38 U.S.C. 501(a), 1980A)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0671)

[70 FR 75946, Dec. 22, 2005, as amended at 72 FR 10365, Mar. 8, 2007; 73 FR 71930, Nov. 26, 2008; 76 FR 75460, Dec. 2, 2011]

PART 10—ADJUSTED COMPENSATION

ADJUSTED COMPENSATION; GENERAL

Sec.
10.0 Adjusted service pay entitlements.
10.1 Issuance of duplicate adjusted service certificate without bond.
10.2 Evidence required of loss, destruction or mutilation of adjusted service certificate.
10.3 Issuance of duplicate adjusted service certificate with bond.
10.4 Loss, destruction, or mutilation of adjusted service certificate while in possession of Department of Veterans Affairs.
10.15 Designation of more than one beneficiary under an adjusted service certificate.
10.16 Conditions requisite for change in designation of beneficiary.
10.17 Designation of beneficiary subsequent to cancellation of previous designation.
10.18 Approval of application for change of beneficiary heretofore made.
10.20 ''Demand for payment'' certification.
10.22 Payment to estate of decedent.
10.24 Payment of death claim on lost, destroyed or mutilated adjusted service certificate with bond.
10.25 Payment of death claim on adjusted service certificate without bond.
10.27 Definitions.
10.28 Proof of death evidence.
10.29 Claims for benefits because of elimination of preferred dependent.
10.30 Proof of remarriage.
10.31 Dependency of mother or father.
10.32 Evidence of dependency.
10.33 Determination of dependency.
10.34 Proof of age of dependent mother or father.
10.35 Claim of mother entitled by reason of unmarried status.
10.36 Proof of marital cohabitation under section 602 or section 312 of the Act.
10.37 Claim of widow not living with veteran at time of veteran's death.
10.38 Proof of age of veteran's child.
10.39 Mental or physical defect of child.
10.40 Payment on account of minor child.
10.41 Definition of ''child''.
10.42 Claim of child other than legitimate child.
10.43 Claim by guardian of child of veteran.
10.44 Evidence required to support claim of mother or father.
10.45 Definition of ''widow''.
10.46 Authentication of statements supporting claims.
10.47 Use of prescribed forms.

PAYMENTS

10.50 Section 601 and section 603 payments made on first day of calendar quarter.
10.51 Payments to minor child.
10.52 Duplication of payments prohibited.
10.53 Payment on duplicate certificate.

AUTHORITY: 72 Stat. 1114; 38 U.S.C. 501. Rights and benefits are continued in effect by sec. 12(b), 72 Stat. 1264, 38 U.S.C. note prec. Part 1.

SOURCE: 13 FR 7122, Nov. 27, 1948, unless otherwise noted.