SERVICEMEMBERS' GROUP LIFE INSURANCE TRAUMATIC INJURY PROTECTION PROGRAM (TSGLI)

Administered by the Office of Servicemembers' Group Life Insurance

Application for TSGLI Benefits

Please submit your completed claim to your branch of service below.

TSGLI Branch of Service Contacts

Branch	Contact Information	Submit Claim by Fax	Submit Claim by E-mail	Submit Claim by Postal Mail
Army All Components	Phone: (800) 237-1336 Website: www.tsgli.army.mil	(866) 275-0684	tsgli@conus.army.mil	Army Human Resources Command Traumatic SGLI (TSGLI) 200 Stovall Street Alexandria, VA 22332-0470
Marine Corps All Components	Phone: (877) 216-0825 or (703) 432-9277 Website: https://www.manpower.usmc.mil/pls/portal/url/page/m_ra_home/wwr/wwr_a_command_element/wwr_d_regimental_staff/3_s3/wwr_tsgli	(888) 858-2315	t-sgli@usmc.mil	HQ, Marine Corps Attn: WWR-TSGLI 3280 Russell Road Quantico, VA 22134
Navy All Components	Phone: (800) 368-3202 / 901-874-2501 DSN 882 Website: www.npc.navy.mil/CommandSupport/ CasualtyAssistance/TSGLI	(901) 874-2265	MILL_TSGLI@navy.mil	Navy Personnel Command Attn: PERS-62 5720 Integrity Drive Millington, TN 38055-6200
Air Force Active Duty	Phone: (800) 433-0048 Website: ask.afpc.randolph.af.mil	(210) 565-2348	afpc.casualty@randolph.af.mil	AFPC/DPWC 550 C Street West, Suite 14 Randolph AFB, TX 78150-4716
Air Force Reserves	Phone: (800) 525-0102	(303) 676-6255	arpc.dippedl@arpc.denver.af.mil	HQ, ARPC/DPPE 6760 E Irvington Place, #4000 Denver, CO 80280-4000
Air National Guard	Phone: (703) 607-0901	(703) 607-0033	tsgliclaims@ngb.ang.af.mil	NCOIC, Customer Operations Air National Guard Bureau 1411 Jefferson Davis Hwy Suite 10718 Arlington, VA 22202
Coast Guard	Phone: (202) 475-5391	(202) 475-5927	compensation@comdt.uscg.mil	COMDT (CG-1222) 2100 2nd Street SW Washington, DC 20593-0001
Public Health Services	Phone: (301) 594-2963	(301) 594-2973 or (800) 733-1303	compensationbranch@psc.hhs.gov	PHS Compensation Branch Parklawn Building 5600 Fishers Lane, Rm 4-50 Rockville, MD 20857
NOAA Corps	Phone: (301) 713-3444	(301) 713-4140	Director.cpc@noaa.gov	U.S. Dept. of Commerce, NOAA 8403 Colesville Rd, Suite 500 Silver Spring, MD 20910

SGLV 8600 Oct, 2008
(Supersedes GL 2005.261 09/2005)
GL.2005.261 Ed. 10/2008

87326001

OMB Control Number: 2900-0671
Respondent Burden: 45 minutes

GENERAL INFORMATION

The Servicemembers' Group Life Insurance Traumatic Injury Protection (TSGLI) program is a rider to Service member's Group Life Insurance (SGLI). The TSGLI rider provides for payment to service members who are severely injured (on or off duty) as the result of a traumatic event and suffer a loss that qualifies for payment under TSGLI. TSGLI is designed to help traumatically injured service members and their families with financial burdens associated with recovering from a severe injury. TSGLI payments range from $25,000 to $100,000 based on the qualifying loss suffered.

WHO IS ELIGIBLE?

Effective December 1, 2005, all service members who are insured under SGLI and …

- experience a **traumatic event**
- that results in a **traumatic injury**
- which is listed as a **qualifying loss**

are eligible to receive a TSGLI payment. Service members who were severely injured between October 7, 2001, and November 30, 2005, in the theaters of operation for Operation Enduring Freedom or Operation Iraqi Freedom may also be eligible for a TSGLI payment. Members should contact their branch of service for more information.

What is a Traumatic Event?
A traumatic event is the application of external force, violence, chemical, biological, or radiological weapons, accidental ingestion of a contaminated substance, or exposure to the elements that causes damage to your body.

What is a Traumatic Injury?
A traumatic injury is the physical damage to your body that results from a traumatic event.

What is a Qualifying Loss?
A qualifying loss is a traumatic injury that is listed on the TSGLI Schedule of Losses, which lists all covered losses and payment amounts. You may view the complete Schedule of Losses and other TSGLI information at **www.insurance.va.gov/sgliSite/TSGLI.htm** Your branch of service TSGLI office will determine whether your injury is a qualifying loss for TSGLI purposes.

HOW TO FILE A TSGLI CLAIM

Filing a TSGLI claim is a three-step process in which the service member [or guardian, power of attorney or military trustee] and a medical professional must complete and submit the appropriate parts of the TSGLI Claim Form as follows:

Step 1	**Step 2**	**Step 3**
The service member [or guardian, power of attorney or military trustee]…	The medical professional…	The medical professional OR the service member [or guardian, power of attorney or military trustee]…
must complete Part A (pages 3 through 6) of the form and give it to a medical professional to complete Part B. Note: If a guardian or power of attorney completes Part A, they must include copies of letters of guardianship, letters of conservatorship, power of attorney, or durable power of attorney (if appropriate).	must complete Part B (pages 7 through 12).	must forward Parts A & B to the member's branch of service TSGLI office listed on the front cover of this form.

COMPLETING THE FORM

Instructions on completing the TSGLI Claim Form are included in each section. When completing the form, the service member, guardian, power of attorney or military trustee **must** complete the service member's Social Security number on each page of the form. If you have questions about completing the form or if the member is deceased, please contact the branch of service TSGLI office listed on the front cover of this form.

CLAIM DECISION AND PAYMENT

Who Makes the Decision on My Claim?
Your branch of service TSGLI office will make the decision on your claim based upon the information in Parts A and B of the TSGLI Claim Form. They will then forward their decision to the Office of Servicemembers' Group Life Insurance (OSGLI) for appropriate action.

Who Will Receive the TSGLI Payment?
Payment will be made directly to the member. If the member is incompetent, payment will be made under the appropriate letters of guardianship/conservatorship or a power of attorney to the guardian, power of attorney or military trustee on the member's behalf. If the member dies after qualifying for payment, the payment will be made to the member's current listed SGLI beneficiary(ies). The member must survive for seven days (168 hours) from the date of the traumatic event to be eligible for TSGLI.

How the TSGLI Payment Will be Made?
If your branch of service TSGLI office approves your claim, OSGLI will make the TSGLI benefit payment. There are three payment methods used for TSGLI benefits: Prudential's Alliance Account®*, Electronic Funds Transfer (EFT), or check.

1. **Prudential's Alliance Account®*** — (for member only) An interest-bearing account will be established in the name of the member. The member can access the money immediately using the draft book ("checkbook"). There are no monthly service fees or per-check charges and additional checks can be ordered at no additional cost. If you have any questions about Alliance, please call Alliance Customer Service toll free at 877-255-4262 or the OSGLI Claim Department toll free at 800-419-1473.
2. **Electronic Funds Transfer (EFT)** — Your bank account will be electronically credited with the TSGLI payment amount. Depending on your bank, payments will be credited three to five days from the date the payment is authorized.

   Note: If the member does not choose EFT and there is no guardian, power of attorney or military trustee, the payment will be made through Prudential's Alliance Account.
3. **Check Payment** — (for guardian, power of attorney or military trustee only) A check will be issued to the guardian or power of attorney or military trustee on behalf of the member.

RESPONDENT BURDEN: We need this information to allow service members who are insured under Servicemembers Group Life Insurance and suffer a loss from a traumatic injury to receive monetary compensation. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 45 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/omb/library/OMBINV.html#VA. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this survey.

PRIVACY ACT NOTICE: VA will not disclose information collected on this survey to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses identified in the VA system of records , 36VA00, Veterans and Armed Forces Personnel U.S. Government Life Insurance Records-VA, and published in the Federal Register. Your obligation to respond is voluntary. Giving us your Social Security number account information is mandatory. Applicants are required to provide their Social Security number under Title 38 USC

1980A. VA will not deny an individual benefits for refusing to provide his or her Social Security number unless the disclosure is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect.

* Open Solutions BIS, Inc. is the Administrator of the Prudential Alliance Account Settlement Option, a contractual obligation of The Prudential Insurance Company of America, located at 751 Broad Street, Newark, NJ 07102-3777. Check clearing is provided by JPMorgan Chase Bank, N.A. and processing support is provided by Integrated Payment Systems, Inc. Alliance Account balances are not insured by the Federal Deposit Insurance Corporation (FDIC). Open Solutions BIS, Inc., JPMorgan Chase Bank, N.A., and Integrated Payment Systems, Inc. are not Prudential Financial companies.

PART A - Member's Claim Information and Authorization - to be completed by the member, guardian, power of attorney or military trustee.

Service member's Social Security Number

1 Service member Information

The service member, guardian, power of attorney or military trustee MUST fill in member's Social Security number at the top of pages 3 through 13 of this form.

Important Note: Contact information must be completed. Incomplete information will delay payment of your claim.

Service member's First Name | MI | Service member's Last Name

Date of Birth (MM DD YYYY)

Gender: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed

Branch of Service: ☐ Army ☐ PHS ☐ Marines ☐ Active Duty ☐ Reserves ☐ Navy ☐ Air Force ☐ NOAA ☐ National Guard ☐ Coast Guard

Rank/Grade

Address of Record (number and street) | Apt. (if any | Telephone Number

City | State | ZIP Code

E-mail Address

Unit (at time of injury)

2 Guardian, Power of Attorney or Military Trustee Information

Important Note: Please include copies of the letters of guardianship, conservatorship, or Power of Attorney, etc. with this form. Failure to include this documentation will delay payment of the claim.

Complete this section ONLY if a guardian, power of attorney or military trustee will receive payment on behalf of the member.

First Name | MI | Last Name

Mailing Address (number and street) | Apartment (if any)

City | State | ZIP Code

Telephone Number | Fax Number

3 Traumatic Injury Information

Injuries that Qualify for TSGLI Payment

In order to qualify for the TSGLI benefit, you must have experienced a **traumatic event** that resulted in a **traumatic injury** that is listed as a **qualifying loss** on the TSGLI Schedule of Losses.

Definitions:

Traumatic Event — A traumatic event is the application of external force, violence, chemical, biological, or radiological weapons, accidental ingestion of a contaminated substance, or exposure to the elements that causes damage to your body.

Traumatic Injury — A traumatic injury is the physical damage to your body that resulted from a traumatic event (illness or disease is not covered).

Qualifying Loss — A qualifying loss is a traumatic injury that is listed on the TSGLI Schedule of Losses. You may view the complete Schedule of Losses at **www.insurance.va.gov/sgliSite/TSGLI.htm**.

PART A - Member's Claim Information and Authorization (cont'd) - to be completed by the member, guardian, power of attorney or military trustee.

Service member's Social Security Number

3 Traumatic Injury Information

Information About Your Loss

Is the loss you are claiming the result of any of the following:

a. an intentionally self-inflicted injury or an attempt to inflict such injury? ☐ Yes ☐ No

b. use of an illegal or controlled substance that was not administered or consumed on the advice of a medical doctor? ☐ Yes ☐ No

c. the medical or surgical treatment of an illness or disease? ☐ Yes ☐ No

d. a traumatic injury sustained while committing or attempting to commit a felony? ☐ Yes ☐ No

e. a physical or mental illness or disease (not including illness or disease caused by a wound infection, a chemical, biological, or radiological weapon, or the accidental ingestion of a contaminated substance)? ☐ Yes ☐ No

If you answered yes…

to any of the questions above, you are not eligible for TSGLI payment and should not file a claim.

If you are not sure…

whether your loss is a result of one of the items above, please contact your Branch of Service TSGLI Office to find out if you are eligible.

Tell us about your traumatic Injury

In the box below, please describe your injury and give the date, time and location where it occurred.

Traumatic Injury Information

Service member's Social Security Number

4 Payment Options

Please choose one of the three payment options by checking the appropriate box and filling in the requested information.

Please choose one of the three payment options below:

☐ **Payment Option 1 - Prudential's Alliance Account® (for member ONLY)** To have the payment made through Prudential's Alliance Account, fill in the mailing address below (street address only, no PO boxes.)

Service member's Mailing Address for Payment - No P.O. Boxes

Apartment, Ward or Room (if any)

City

State

ZIP Code

Payment Option 1 – Prudential's Alliance Account
An interest-bearing account will be established in the name of the member, who can access the money using the draft book ("checkbook").

☐ **Payment Option 2 - Electronic Funds Transfer (EFT)** To have the payment made by EFT, fill in your banking information below. A sample check is provided to help you locate the bank routing and bank account numbers. **Please print clearly.**

Bank Routing Number

Bank Account Number

☐ Checking
☐ Savings

Bank Name

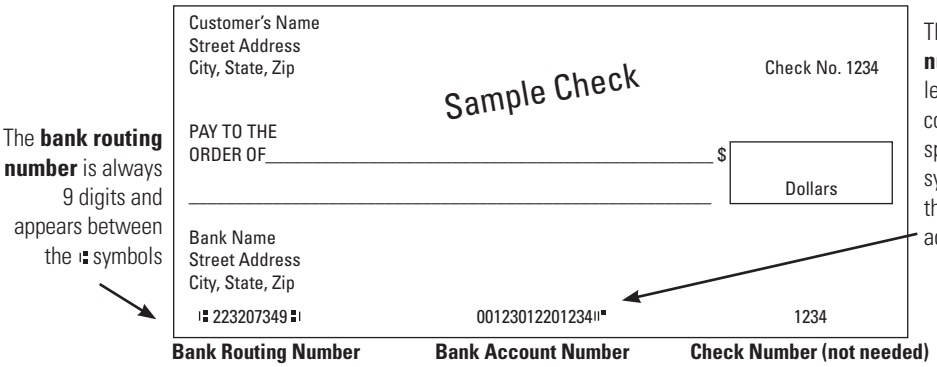
Bank Phone Number

First Name

MI

Last Name

Payment Option 2 – Electronic Funds Transfer
Payment will be made to the bank account indicated. This option can be selected by member or, if applicable, the guardian, power of attorney or miltary trustee.



The **bank routing number** is always 9 digits and appears between the ⑆ symbols

The **bank account number** varies in length and may contain dashes or spaces. The ⑈ symbol indicates the end of the account number.

Payment Option 3 – Check
A check will be issued to the guardian, power of attorney or military trustee on behalf of the service member.

☐ **Payment Option 3 - Check (for guardian, power of attorney or military trustee ONLY)**
To have the payment made by check, fill in the guardian or power of attorney mailing address below.

Mailing Address for Payment - No P.O. Boxes

Apartment (if any)

City

State

ZIP Code

5 Signature

Member, guardian, or power of attorney must sign here.

Description of Authority: If the guardian, power of attorney or military trustee completes this section, they must also indicate their authority to act on behalf of the member (e.g. guardian, conservator, etc.)

Third Party Authorization

☐ (Optional) I authorize the following person to speak with OSGLI or the Branch of Service about my claim (this can be a spouse, parent, friend or another person who is helping you with your claim).

First Name

MI

Last Name

X

Signature of service member, guardian, power of attorney or military trustee

Date (MM DD YYYY)

Description of Authority to act on behalf of the member (Guardian, POA, etc.)

WARNING: Any intentional false statement in this claim or willful misrepresentation relative thereto is subject to punishment by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001)

Member must complete and sign the HIPAA release on next page ▶

Service member's Social Security Number

6

Authorization for Release of Information to Branch of Service and Office of Servicemembers' Group Life Insurance

The member, guardian, power of attorney, or military trustee **must** complete and sign this section.

Failure to complete this section will delay payment of claim

This authorization is intended to comply with the HIPAA Privacy Rule.

Member must complete and sign the HIPAA release, below:

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, medical examiner or other health care provider that has provided treatment, payment or services pertaining to:

First Name | MI | Last Name

Date of Birth (MM DD YYYY)

or on my behalf ("My Providers") to disclose my entire medical record for me or my dependents and any other health information concerning me to the Branch of Service and Office of Servicemembers' Group Life Insurance (OSGLI) and its agents, employees, and representatives. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes. OSGLI, an administrative unit created by Prudential to administer the Servicemembers' Group Life Insurance Program and OSGLI administers the TSGLI program on behalf of the Department of Veterans Affairs.

I authorize all non-health organizations, any insurance company, employer, or other person or institutions to provide any information, data or records relating to credit, financial, earnings, travel, activities or employment history to OSGLI.

Unless limits* are shown below, this form pertains to all of the records listed above.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct My Providers to release and disclose my entire medical record without restriction.

This information is to be disclosed under this Authorization so that my Branch of Service and OSGLI may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits, 2) administer coverage; and 3) conduct other legally permissible activities that relate to any coverage I have applied for with OSGLI.

This authorization shall remain in force for 24 months following the date of my signature below, while the coverage is in force, except to the extent that state law imposes a shorter duration. A copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to OSGLI at: 80 Livingston Avenue, Roseland, NJ 07068. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that OSGLI has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this authorization to release my complete medical record, OSGLI may not be able to process my claim for benefits and may not be able to make any benefit payments. I understand that I have the right to request and receive a copy of this authorization.

*Limits, if any:

NOTE: This release authorizes the branch of service and OSGLI to look at medical records. You may also be asked to provide these documents.

Signature
The member, guardian, power of attorney or military trustee must sign here.

X
Signature of service member, guardian, power of attorney or military trustee

Date (MM DD YYYY)

Description of Authority to act on behalf of the member (Guardian, POA, etc.)

PART B - Medical Professional's Statement - to be completed by a medical professional who is a licensed practitioner of the healing arts acting within the scope of his/her practice.

Service member's Social Security Number

1 Patient Information

Patient's First Name | MI | Patient's Last Name

Date of Injury (MM DD YYYY)

Is the patient capable of handling his/her own affairs? ☐ Yes ☐ No

If patient is deceased, please provide:

Date of Death (MM DD YYYY) | Time of Death ☐ A.M. ☐ P. M.

Cause of Death

2 Hospitalization Information

Please complete this section for ALL patients.

Reason for Hospitalization – Please give the predominant reason the patient was hospitalized

☐ Traumatic Brain Injury ☐ Other Traumatic Injury

Longest Period of Hospitalization – Please give the beginning and ending dates for the longest period of consecutive days the patient was hospitalized. The count of consecutive hospitalization days begins when the injured member is transported to the hospital (if applicable), includes the day of admission, continues through subsequent transfers from one hospital to another, and includes the day of discharge.

Date transported | Date of admittance to first hospital | Date of discharge from last hospital | **OR** ☐ Check here if still hospitalized

Name and location of hospital (if more than one hospital, list all)

Definition of a hospital – A hospital that is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Healthcare Organizations. This includes Combat Support Hospitals, Air Force Theater Hospitals and Navy Hospital Ships.

Hospital does not include a nursing home. Neither does it include an institution, or part of one, which: (1) is used mainly as a place for convalescence, rest, nursing care or for the aged; or (2) furnishes mainly homelike or Custodial Care, or training in the routines of daily living; or (3) is for residential or domiciliary living; or (4) is mainly a school

3 Qualifying Losses Suffered by Patient

Instructions:
Please check the box next to each loss the patient has experienced and fill in any additional information requested. Omitted information, such as sight or hearing measurements, will delay payment of the claim.

Patient's loss MUST meet the definition of loss given.

☐ **Hospitalization**
Hospitalization for at least 15 consecutive days

Hospitalization of at least 15 consecutive days as defined above.

Loss of Sight

Date of onset/loss

☐ Loss of sight in left eye or anatomical loss of left eye

☐ Loss of sight in right eye or anatomical loss of right eye

Visual Acuity and Field

	Left Eye	Right Eye
Best corrected visual acuity		
Visual Field (degrees)		

Loss of Sight is defined as:

- Visual acuity in at least one eye of 20/200 or less (worse) with corrective lenses OR,
- Visual acuity in at least one eye of greater (better) than 20/200 with corrective lenses and a visual field of 20 degrees or less OR,
- Anatomical loss of eye. Loss of sight must be expected to be permanent OR must have lasted at least 120 days

Loss of Speech

Date of onset

☐ Loss of speech

Loss of Speech is defined as:

Organic loss of speech (lost the ability to express oneself, both by voice and whisper, through normal organs for speech), even if member uses an artificial appliance, such as a voice box, to simulate speech. Loss of speech must be clinically stable and unlikely to improve.

PART B - Medical Professional's Statement (cont'd) to be completed by a medical professional who is a licensed practitioner of the healing arts acting within the scope of his/her practice.

Service member's Social Security Number

3 Qualifying Losses Suffered by Patient (cont'd)

Loss of Hearing

☐ Loss of hearing in left ear — Date of onset

☐ Loss of hearing in right ear — Date of onset

Loss of hearing is defined as:

Average hearing threshold sensitivity for air conduction of at least 80 decibels. Hearing Acuity must be measured at 500 Hz, 1000 Hz and 2000 Hz to calculate the average hearing threshold. Loss of hearing must be clinically stable and unlikely to improve.

Hearing Acuity

Average Hearing Acuity (measured without amplification device)

Left Ear ____ db Right Ear ____ db

Burns

☐ 2nd degree or worse burns to the body including face and head

☐ 2nd degree or worse burns to the face only

Percentage of body affected ____ % Percentage of face affected ____ %

Burns are defined as:

2nd degree (partial thickness) or worse burns over 20% of the body including the face and head OR 20% of the face only.

Note: Percentage may be measured using the Rule of Nines or any other acceptable alternative.

Coma

☐ Coma

Date of onset Date of recovery

OR ☐ Check here if coma is ongoing

Glasgow score at 15 days Glasgow score at 30 days Glasgow score at 60 days Glasgow score at 90 days

Coma is defined as:

Coma with brain injury measured at a Glasgow Coma Score of 8 or less that lasts for 15, 30, 60 or 90 consecutive days.

Number of days includes the date the coma began and the date the member recovered from the coma.

Important:

Facial Reconstruction: If the patient is undergoing facial reconstruction, a surgeon MUST certify this section by checking the box, printing his/her name and signing on the appropriate line.

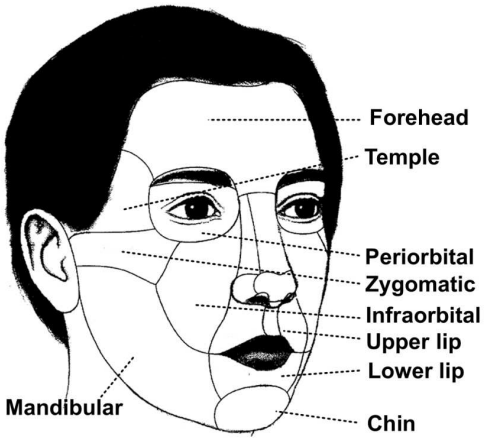
Facial Reconstruction

☐ Upper or lower jaw
☐ 50% of cartilaginous nose
☐ 50% of upper lip
☐ 50% of lower lip
☐ 30% of left periorbita
☐ 30% of right periorbita
☐ 50% of left temple
☐ 50% of right temple
☐ 50% of left zygomatic
☐ 50% of right zygomatic
☐ 50% of left mandibular
☐ 50% of right mandibular
☐ 50% of left infraorbita
☐ 50% of right infraorbita
☐ 50% of chin
☐ 50% of forehead

Facial Reconstruction is defined as:

Reconstructive surgery to correct traumatic avulsions of the face or jaw that cause discontinuity defects, specifically surgery to correct discontinuity loss of the following:

- upper or lower jaw
- 50% or more of the cartilaginous nose
- 50% or more of the upper or lower lip
- 30% or more of the periorbita
- tissue in 50% or more of any of the following facial subunits: forehead, temple, zygomatic, mandibular, infraorbital or chin.



Certification of Surgeon

Date of first surgery

Name of Surgeon

X

Signature of Surgeon

Date (MM DD YYYY)

PART B - Medical Professional's Statement (cont'd) to be completed by a medical professional who is a licensed practitioner of the healing arts acting within the scope of his/her practice.

Service member's Social Security Number

3 Qualifying Losses Suffered by Patient (cont'd)

Amputation is: the severance or removal of a limb or part of a limb, including both severance due to a traumatic injury, or surgical removal that is required for the treatment of a traumatic injury.

Amputation of Hand

	Date of amputation
☐ Amputation of left hand	
☐ Amputation of right hand	

Amputation of Hand is defined as:

Amputation of hand at or above* the wrist

*at or above: closer to the body

Amputation of Fingers

	Date of amputation
☐ Amputation of 4 fingers/ left hand	
☐ Amputation of 4 fingers/ right hand	
☐ Amputation of left thumb	
☐ Amputation of right thumb	

Amputation of Fingers is defined as:

- Amputation of four fingers on the same hand (not including the thumb) at or above* the metacarpophalangeal joint OR,
- Amputation of thumb at or above the metacarpophalangeal joint.

*at or above: closer to the body

Amputation of Foot

	Date of amputation
☐ Amputation of left foot	
☐ Amputation of right foot	

Amputation of Foot is defined as:

- Amputation of foot at or above the ankle OR,
- Amputation of all toes (including the big toe) on the same foot at or above the metatarsophalangeal joint.

*at or above: closer to the body

Amputation of Toes

	Date of amputation
☐ Amputation of 4 toes/ left foot	
☐ Amputation of 4 toes/ right foot	
☐ Amputation of big toe/ left foot	
☐ Amputation of big toe/ right foot	

Amputation of Toes is defined as:

- Amputation of four toes on one foot at or above the metatarsophalangeal joint (not including the big toe)

OR,

- Amputation of big toe at or above the metatarsophalangeal joint.

*at or above: closer to the body

Important:

Limb Salvage: If the patient is undergoing limb salvage, a surgeon MUST certify this section by checking the box, printing his/her name and signing on the appropriate line.

Limb Salvage

	Date of first surgery
☐ Salvage of left arm	
☐ Salvage of left leg	
☐ Salvage of right arm	
☐ Salvage of right leg	

Limb Salvage is defined as:

A series of operations designed to save an arm or leg rather than amputate.

A surgeon must certify that:

- The option of amputation of limb(s) was offered to the patient as a medically justified alternative to limb salvage and
- The patient has chosen to pursue limb salvage.

Certification of Surgeon

☐ The option of amputation was offered to the patient and the patient has chosen to pursue limb salvage.

Name of Surgeon

X

Signature of Surgeon

Date (MM DD YYYY)

Additional Comments

PART B - Medical Professional's Statement (cont'd) to be completed by a medical professional who is a licensed practitioner of the healing arts acting within the scope of his/her practice.

Service member's Social Security Number

3 Qualifying Losses Suffered by Patient (cont'd)

Description of Injury/ Assistance Needed
Please provide a description of the injury and descriptions of the assistance needed to perform each ADL. Failure to provide this information may delay payment of claim.

Paralysis

	Date of onset
☐ Quadriplegia	
☐ Paraplegia	
☐ Hemiplegia	
☐ Uniplegia	

Paralysis is defined as:

Complete paralysis due to damage to the spinal cord or associated nerves, or to the brain. A limb is defined as an arm or a leg with all its parts. Paralysis must fall into one of the four categories listed below:

- Quadriplegia - paralysis of all four limbs
- Paraplegia - paralysis of both lower limbs
- Hemiplegia - paralysis of the upper and lower limbs on one side of the body
- Uniplegia- paralysis of one limb

Inability to Independently Perform Activities of Daily Living (ADL)

Inability to Independently Perform ADL is defined as:
Inability to independently perform at least two of six ADL (bathing, continence, dressing, eating, toileting and transferring). Inability must last for at least 15 consecutive days for traumatic brain injury and at least 30 consecutive days for any other traumatic injury.

The patient is considered unable to perform an activity independently only if he or she **REQUIRES** assistance to perform the activity. If the patient is able to perform the activity by using accommodating equipment, such as a cane, walker, commode, etc., the patient is considered able to independently perform the activity without requiring assistance.

Requires Assistance is defined as:

- physical assistance (hands-on),
- stand-by assistance (within arm's reach),
- verbal assistance (must be instructed because of cognitive impairment),

without which the patient would be **INCAPABLE** of performing the task.

What is the predominant reason the patient is/was unable to independently perform ADL?
Check the predominant reason the patient cannot independently perform ADL and describe the injury in the box provided.

What is the predominant reason the patient is/was unable to independently perform ADL?

☐ Traumatic Brain Injury ☐ Other Traumatic Injury

(Please describe injury and give reason(s) it resulted in inability to perform activities of daily living.)

Which ADL is the patient unable to perform?
Check each ADL the patient cannot perform;
AND;
Fill in the dates inability began and ended or indicate inability is ongoing

☐ **Unable to bathe independently**

Start date ☐☐ ☐☐ ☐☐☐☐ End date ☐☐ ☐☐ ☐☐☐☐

OR ☐ Check here if inability is ongoing

Type of assistance required (check all that apply)

☐ physical assistance (hands-on) ☐ verbal assistance (must be instructed because of cognitive impairment)

☐ stand-by assistance (within arm's reach)

Patient is UNABLE to bathe independently if…

He/she requires assistance from another person to bathe (including sponge bath) more than one part of the body or get in or out of the tub or shower.

Describe assistance needed:

☐ **Unable to maintain continence independently**

Start date ☐☐ ☐☐ ☐☐☐☐ End date ☐☐ ☐☐ ☐☐☐☐

OR ☐ Check here if inability is ongoing

Type of assistance required (check all that apply)

☐ physical assistance (hands-on) ☐ verbal assistance (must be instructed because of cognitive impairment)

☐ stand-by assistance (within arm's reach)

Patient is UNABLE to maintain continence independently if…

He/she is partially or totally unable to control bowel and bladder function or requires assistance from another person to manage catheter or colostomy bag.

Describe assistance needed:

PART B - Medical Professional's Statement (cont'd) to be completed by a medical professional who is a licensed practitioner of the healing arts acting within the scope of his/her practice.

Service member's Social Security Number

3 Qualifying Losses Suffered by Patient (cont'd)

Require Assistance is defined as:
- physical assistance (hands-on),
- stand-by assistance (within arm's reach),
- verbal assistance (must be instructed because of cognitive impairment),

without which the patient would be INCAPABLE of performing the task.

Inability to Independently Perform Activities of Daily Living (ADL) (cont'd)

☐ **Unable to dress independently**

Start date | | | | | | | | End date | | | | | | | |

OR ☐ Check here if inability is ongoing

Type of assistance required (check all that apply)

☐ physical assistance (hands-on) ☐ verbal assistance (must be instructed because of cognitive impairment)

☐ stand-by assistance (within arm's reach)

Patient is UNABLE to dress independently if…

He/she **requires** assistance from another person to get and put on clothing, socks or shoes.

Describe assistance needed:

☐ **Unable to eat independently**

Start date | | | | | | | | End date | | | | | | | |

OR ☐ Check here if inability is ongoing

Type of assistance required (check all that apply)

☐ physical assistance (hands-on) ☐ verbal assistance (must be instructed because of cognitive impairment)

☐ stand-by assistance (within arm's reach)

Patient is UNABLE to eat independently if…

He/she **requires** assistance from another person to:

- get food from plate to mouth OR,
- take liquid nourishment from a straw or cup OR,

he/she is fed intravenously or by a feeding tube

Describe assistance needed:

☐ **Unable to toilet independently**

Start date | | | | | | | | End date | | | | | | | |

OR Check here if inability is ongoing

Type of assistance required (check all that apply)

☐ physical assistance (hands-on) ☐ verbal assistance (must be instructed because of cognitive impairment)

☐ stand-by assistance (within arm's reach)

Patient is UNABLE to toilet independently if…

He/she must use a bedpan or urinal to toilet OR,

he/she **requires** assistance from another person with any of the following: going to and from the toilet, getting on and off the toilet, cleaning self after toileting, getting clothing off and on.

Describe assistance needed:

☐ **Unable to transfer independently**

Start date | | | | | | | | End date | | | | | | | |

OR Check here if inability is ongoing

Type of assistance required (check all that apply)

☐ physical assistance (hands-on) ☐ verbal assistance (must be instructed because of cognitive impairment)

☐ stand-by assistance (within arm's reach)

Patient is UNABLE to transfer independently if…

He/she **requires** assistance from another person to move into or out of a bed or chair.

Describe assistance needed:

PART B - Medical Professional's Statement (cont'd) to be completed by a medical professional who is a licensed practitioner of the healing arts acting within the scope of his/her practice.

Service member's Social Security Number

4 Other Information

To your knowledge, were any of the losses indicated in Part B due to:

a. an intentionally self-inflicted injury or an attempt to inflict such injury,
b. use of an illegal or controlled substance that was not administered or consumed on the advice of a medical doctor,
c. the medical or surgical treatment of an illness or disease,
d. a physical or mental illness or disease (not including illness or disease caused by a pyogenic infection, a chemical, biological, or radiological weapon, or the accidental ingestion of a contaminated

If yes, please explain below:

5 Medical Professional's Comments

Use this block to provide any additional information about the patient's injuries. When a narrative description is required, please be complete and concise.

6 Medical Professional's Information

Name of Medical Professional

First Name | MI | Last Name

Medical Professional's Address (number and street) | Suite

City | State | ZIP Code

Telephone Number | Fax Number

E-mail Address

Specialty | Medical Degree

7 Medical Professional's Signature

☐ I have observed the patient's loss. ☐ I have not observed the patient's loss, but I have reviewed the patient's medical records.

This Medical Professional's Statement is based upon my examination of the patient, and/or, a review of pertinent medical evidence. I understand the patient and/or I may be asked to provide supporting documentation to validate eligibility under the law.

Date (MM DD YYYY)

X

Signature

WARNING: Any intentional false statement in this claim or willful misrepresentation relative thereto is subject to punishment by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001)