

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

Administered by the Office of Servicemembers' Group Life Insurance



## Claim for Traumatic Injury Protection (TSGLI) Payment

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

<b>TSGLI Branch of Service Contacts</b>				
<b>Branch</b>	<b>Contact Information</b>	<b>Submit Claim by Fax</b>	<b>Submit Claim by E-mail</b>	<b>Submit Claim by Postal Mail</b>
<b>Army</b> All Components	Phone: (800) 237-1336 Website: www.tsqli.army.mil	(866) 275-0684	tsgli@hoffman.army.mil	Department of the Army Traumatic SGLI (TSGLI) 200 Stovall Street Alexandra, VA 22332-0470
<b>Marine Corps</b> All Components	Phone: (877) 216-0825 or (703) 432-9277 Website: www.manpower.usmc.mil/ TSGLI	(888) 858-2315	t-sgli@usmc.mil	HQ, Marine Corps Attn: MI-TSGLI 3280 Russell Road Quantico, VA 22134
<b>Navy</b> All Components	Phone: (800) 368-3202 Website: www.npc.navy.mil/CommandSupport/ CasualtyAssistance/FSGLI/TSGLI	(901) 874-2265	MILL_TSGLI@navy.mil	Navy Personnel Command Attn: PERS-62 5720 Integrity Drive Millington, TN 38055-6200
<b>Air Force</b> Active Duty	Phone: (800) 433-0048 Website: ask.afpc.randolph.af.mil	(210) 565-2348	afpc.casualty@randolph.af.mil	AFPC/DPFCS 550 C Street West, Suite 14 Randolph AFB, TX 78150-4716
<b>Air Force Reserves</b>	Phone: (800) 525-0102	(303) 676-6255	ramon.rolدان@arpc.denver.af.mil	HQ, ARPC/DPPE 6760 E Irvington Place, #4000 Denver, CO 80280-4000
<b>Air National Guard</b>	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
<b>Coast Guard</b>	Phone: (202) 267-1648	(202) 267-4823	twalsh@comdt.uscg.mil	Commandant, US Coast Guard Attn: CG-12222 100 2ND St, NW Washington, DC 20593-0001
<b>Public Health Services</b>	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
<b>NOAA Corps</b>	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

**CLAIM FOR TRAUMATIC INJURY PROTECTION (TSGLI) PAYMENT**



# GENERAL INFORMATION

## WHO IS ELIGIBLE

Effective December 1, 2005, service members who are insured under SGLI and suffer a qualifying loss as a result of a traumatic event are eligible to receive payment for a total amount not less than \$25,000 and not greater than \$100,000. Service members who were injured between October 7, 2001 and November 30, 2005 in the theaters of operation for Operation Enduring Freedom or Operation Iraqi Freedom also be eligible for TSGLI payment. Members should contact their branch of service for more information.

## HOW TO FILE A TSGLI CLAIM

Filing a TSGLI claim is a three step process in which the service member [or guardian or attorney-in-fact], the attending medical professional and the member's branch of service must complete the appropriate parts of the form as follows:

Step 1	Step 2	Step 3
The service member [or guardian or attorney-in-fact]...	The attending medical professional...	The member's branch of service...
must complete Part A of the form and give it to a medical professional to complete Part B.	must complete Part B and return Part A & B to the branch of service.	must certify the claim and forward it to the Office of Servicemembers' Group Life Insurance.

If you have questions about completing the form or if the member is deceased, please contact your branch of service listed on the front cover of this form.

## HOW THE TSGLI PAYMENT WILL BE MADE

There are three methods of payment for TSGLI benefits:

1. Electronic Funds Transfer (EFT)
2. Prudential's Alliance Account®\*
3. Check

### 1. Electronic Funds Transfer (EFT)

The TSGLI benefit will be electronically credited to the bank account specified. Depending on the member's 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 or attorney-in-fact, the payment will be made through Prudential's Alliance Account.

### 2. Prudential's Alliance Account®\*

The benefit will be deposited into Prudential's Alliance Account in the member's name and the member will receive a checkbook. The Alliance Account is a personal interest-bearing account that gives the member ready access to the money, whenever it is needed. To use the account, the member can simply write a check. The member may write checks as the money is needed or write out one check for the entire amount and close the account. The account will continue to earn interest as long as any balance is maintained in the account.

### 3. Check

Payment will be made by check only to a guardian or attorney-in-fact. This option is not available to the member.

## WHO WILL RECEIVE THE TSGLI PAYMENT

The TSGLI payment will be made directly to the member. If the member is incompetent, payment will be made to the guardian or attorney-in-fact under the appropriate letters of guardianship, conservatorship, or a power of attorney.

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.

\* 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.



# INSTRUCTIONS FOR COMPLETING THE FORM

**Social Security Number** (pages 4 through 13) – The service member, guardian, or attorney-in-fact must complete the service member’s Social Security Number in the upper right corner on each of these pages.

**PART A** (pages 4 through 6) – **Member’s Identifying Information and Authorization** - to be completed by the member, guardian or attorney-in-fact.

**Section 1 – Service Member Information**-Complete the identifying information for the member who is requesting TSGLI benefits.

**Section 2– Guardian or Attorney-in-fact Information**

The guardian or attorney-in-fact should complete this section if he or she is going to receive payment on behalf of the member or if the member is incapable of signing the form. If this section is completed, the guardian or attorney-in-fact must attach one of the following three items: 1. letters of guardianship, 2. letters of conservatorship, or 3. power of attorney.

**Section 3– Payment Information**

Check the box next to one of the three payment methods and follow the instructions below (see page 2 for payment option information).

<b>Electronic Funds Transfer (EFT)</b>	<b>Prudential’s Alliance Account®</b> (not available to guardian or attorney-in-fact).	<b>Check</b> (not available to member).
Fill in all banking information as indicated on the diagram.	Complete the street address to which the check-book should be sent. The checkbook will be sent via overnight delivery and cannot be sent to a PO Box.	The check will be mailed to the guardian or attorney-in-fact.

**Note:** If a member does not indicate a payment method the TSGLI benefit will be paid through Prudential’s Alliance Account®. If a guardian or attorney-in-fact does not select a payment method, the TSGLI benefit will be paid by check.

**Section 4 – Signature**

The member, guardian, or attorney-in-fact must sign section 4. If the guardian or attorney-in-fact completes this section, they must also indicate their authority to act on behalf of the member (e.g. guardian, conservator, etc.).

**Section 5 – Authorization to Speak With Third Party**

The member, guardian, or attorney-in-fact must complete and sign section 5 if someone other than the member, guardian or attorney-in-fact will speak with OSGLI and/or the branch of service about the TSGLI claim.

**Section 6 – Authorization to Release Information**-The member, guardian, or attorney-in-fact must complete and sign section 6.

**PART B** (pages 7 through 9) – **Medical Professional’s Statement** – to be completed by the Attending Medical Professional **ONLY**

**Section 1 – Patient and Injury Information**

Complete the patient’s name and the date and diagnosis of the patient’s injuries. If the patient is deceased, insert the date, time and cause of death.

**Sections 2 through 10 – Losses Suffered by the Patient**

Complete the information about each loss being claimed by the patient. Check yes or no in each section to indicate if that particular loss is being claimed. If the member is claiming inability to perform activities of daily living, complete the ADL Questionnaire on pages 10 and 11.

**Section 11 – Medical Professional’s Comments**

Complete any additional information about the patient’s injuries. When a narrative description is required, please be complete and concise.

**Section 12 – Medical Professional’s Information**-Fill in identifying information.

**Section 13 – Medical Professional’s Signature**

Indicate whether the medical statement was completed based on observation of the patient’s loss or review of the patient’s medical records. Sign and date the medical statement.

**ADL Questionnaire** – Complete the questionnaire as instructed, if applicable.

**PART C** (pages 12 through 13)– **Certification by Branch of Service** – to be completed by the branch of service TSGLI certifying official **ONLY**

**Section 1 – Traumatic Event Information**

Complete the information about the traumatic event that caused the member’s injury and loss. If the service member is deceased, please submit a copy of the Report of Casualty (DD-1300) or death certificate and Form SGLV-8286, indicating the SGLI beneficiaries.

**Section 2 – Certification by Branch of Service**

Check yes or no to certify that the member’s injuries and resulting loss as well as the event that caused the member’s loss qualifies under 38 CFR 9.20. If the member does not qualify for payment, indicate the reason by checking the appropriate box and provide any explanation necessary in the comments box.

**Note:** If the member does not qualify because the member had declined SGLI coverage, please submit a copy of the Form SGLV-8286 indicating the declination.

**Sections 3 and 4 – Certifying Signature/Additional Comments**

Complete the identifying information, sign and date the certification, and provide any additional comments as necessary.

**CLAIM FOR TRAUMATIC INJURY PROTECTION (TSGLI) PAYMENT**



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**PART A - Member's Identifying Information and Authorization - to be completed by the member, guardian or attorney-in-fact.**

**1 Service member Information**

First Name	MI	Last Name
<input type="text"/>	<input type="text"/>	<input type="text"/>
Social Security Number	Date of Birth (MM DD YYYY)	Gender
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Male
		<input type="checkbox"/> Female
Branch of Service	<input type="checkbox"/> Active Duty	Telephone
<input type="text"/>	<input type="checkbox"/> Reserves	<input type="text"/>
	<input type="checkbox"/> National Guard	<input type="text"/>
Address of Record (number and street)	Apartment (if any)	
<input type="text"/>	<input type="text"/>	
City	State	ZIP Code
<input type="text"/>	<input type="text"/>	<input type="text"/>
E-mail Address		
<input type="text"/>		

**2 Guardian or Attorney-in-fact 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.

If a guardian or an Attorney-in-fact will receive payment, please complete the following:

First Name	MI	Last Name
<input type="text"/>	<input type="text"/>	<input type="text"/>
Mailing Address (number and street)	Apartment (if any)	
<input type="text"/>	<input type="text"/>	
City	State	ZIP Code
<input type="text"/>	<input type="text"/>	<input type="text"/>
Telephone Number	Fax Number	
<input type="text"/>	<input type="text"/>	

**3 Payment Information**  
(Please select only **one** of the three methods)

**Payment Option 1 - Electronic Funds Transfer (EFT)** To have the payment deposited directly into your bank account, provide the banking information below. A sample check is provided to help you locate the bank routing and bank account numbers.

Bank Routing Number	Bank Account Number	<input type="checkbox"/> Checking
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Savings
Bank Name	Bank Phone Number	
<input type="text"/>	<input type="text"/>	
First Name	MI	Last Name
<input type="text"/>	<input type="text"/>	<input type="text"/>

Customer's Name  
Street Address  
City, State, Zip

Check No. 1234

Sample Check

PAY TO THE ORDER OF \_\_\_\_\_ \$

Dollars

Bank Name  
Street Address  
City, State, Zip

⚡ 223207349 ⚡      00123012201234⚡      1234

**Bank Routing Number      Bank Account Number      Check Number (not needed)**

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.

**CLAIM FOR TRAUMATIC INJURY PROTECTION (TSGLI) PAYMENT**







Service member's Last Name

Grid for Service member's Last Name

Service member's Social Security Number

Grid for Service member's Social Security Number

PART B - Medical Professional's Statement - to be completed by the attending medical professional, which includes: a licensed physician, optometrist, nurse practitioner, registered nurse or physician assistant acting within the scope of his/her practice. Fill in information about each loss being claimed by the patient. Check yes or no in each section to indicate if that particular loss is being claimed. If the member is claiming inability to perform activities of daily living, complete the ADL Questionnaire on pages 10 and 11.

1 Patient and Injury Information

First Name, MI, Last Name

Date of Injury (MM DD YYYY) What loss listed below is the patient claiming?

If patient is deceased, please provide:

Date of Death (MM DD YYYY) Time of Death (A.M./P.M.) Cause of Death

2 Loss of Limbs or Digits

Is this claim for loss of limbs or digits? Yes No

If yes, please indicate the following:

Right hand at or above wrist, Right foot at or above ankle, Right thumb at or above the metacarpophalangeal joint, Index finger of right hand at or above the metacarpophalangeal joint, Left hand at or above wrist, Left foot at or above ankle, Left thumb at or above the metacarpophalangeal joint, Index finger of left hand at or above the metacarpophalangeal joint

3 Loss of Vision

Is this claim for loss of vision? Yes No

If yes, please indicate the following:

Best corrected visual acuity Date of Observation (MM DD YYYY) Right Eye Left Eye Visual Field for right eye (degrees) Visual Field for left eye (degrees)

From what date has the visual acuity recorded above existed?

Right Eye (MM DD YYYY) Left Eye (MM DD YYYY)

If patient has suffered the anatomical loss of one or both eyes, give the date this occurred:

Right Eye (MM DD YYYY) Left Eye (MM DD YYYY)

In your medical opinion is the patient's loss of vision clinically stable and unlikely to improve? Yes No

4 Loss of Speech

Is this claim for loss of speech? Yes No

If yes, please indicate the following:

Date of onset (MM DD YYYY)

Can the patient speak by voice or by whisper through normal organs of speech, (esophageal speech and/or artificial appliances are not considered normal organs of speech)?

Yes No

In your medical opinion is the patient's loss of speech clinically stable and unlikely to improve?

Yes No

CLAIM FOR TRAUMATIC INJURY PROTECTION (TSGLI) PAYMENT



Service member's Last Name

Grid for last name

Service member's Social Security Number

Grid for social security number

PART B - Medical Professional's Statement (cont) to be completed by the attending medical professional, which includes: a licensed physician, optometrist, nurse practitioner, registered nurse or physician assistant acting within the scope of his/her practice.

5 Loss of Hearing

Is this claim for loss of hearing? Yes No If yes, comments required in Block 11.

If yes, please indicate the following:

Hearing acuity - measured via pure tone audiometry by air conduction (without amplification device)

Date of observation (MM DD YYYY)

Grid for date of observation

Hearing acuity table for 500 Hz, 1000 Hz, 2000 Hz, and Average across Right and Left ears in db.

From what date has the hearing acuity recorded above existed?

Right Ear (MM DD YYYY)

Left Ear (MM DD YYYY)

Grids for start dates of hearing loss

In your medical opinion is the patient's loss of hearing clinically stable and unlikely to improve? Yes No

6 Paralysis

Is this claim for paralysis? Yes No If yes, comments required in Block 11.

If yes, please indicate the following:

Type of Paralysis:

Date of onset of paralysis (MM DD YYYY)

Options for Hemiplegia, Quadriplegia, Paraplegia and date of onset grid

In your medical opinion is the patient's paralysis clinically stable and irreversible? Yes No

7 Burns

Is this claim for burns? Yes No

If yes, please indicate the following:

Does the patient have third degree or worse burns to the:

Face? No Yes - Please indicate percentage of face affected

Body? No Yes - Please indicate percentage of body affected

8 Coma

Is this claim for coma? Yes No

If yes, please indicate the following:

Date of onset of coma (MM DD YYYY)

Grid for date of onset of coma

Duration of coma Less than 15 Days 15-29 Days 30-59 Days 60-89 Days 90 Days or more

Please classify severity of brain injury using Glasgow Coma Score at 15 Days 30 Days 60 Days 90 Days

9 Traumatic Brain Injuries

Is this claim for traumatic brain injury? Yes No

If yes, please indicate the following:

Did the traumatic brain injury render the patient completely dependent upon another person to perform at least two activities of daily living (bathing, maintaining continence, dressing, eating, toileting, and transferring)?

Yes No

If yes, please complete the ADL questionnaire at the end of Part B on pages 10 and 11 to document the inability to perform activities of daily living as a result of traumatic brain injuries.

10 Other Traumatic Injuries

Is this claim for traumatic injuries other than those listed above in items 1 through 9?

Yes No

If yes, please indicate the following:

Did the patient's injuries render the patient completely dependent upon another person to perform at least two activities of daily living (bathing, maintaining continence, dressing, eating, toileting, and transferring)?

Yes No

If yes, please complete the ADL questionnaire at the end of Part B on pages 10 and 11 to document the inability to perform activities of daily living as a result of traumatic brain injuries.



Service member's Last Name

Grid for Service member's Last Name

Service member's Social Security Number

Grid for Service member's Social Security Number

PART B - Medical Professional's Statement (con't) to be completed by the attending medical professional, which includes: a licensed physician, optometrist, nurse practitioner, registered nurse or physician assistant acting within the scope of his/her practice. For all sections except the signature block, please type or print legibly.

11 Medical Professional's Comments

Use this block to provide any additional information about the patient's injuries.

Large empty box for Medical Professional's Comments

12 Medical Professional's Information

Name of Attending Medical Professional (Please Print)

Grids for First Name, MI, and Last Name

Grids for Medical Professional's Address (number and street) and Suite

Grids for City, State, and ZIP Code

Grids for Telephone Number and Fax Number

Grid for E-mail Address

If civilian medical professional, please complete:

Text box for Specialty

Grids for License Number and State of License

If military medical professional, please complete:

Text boxes for Rank and Branch of Service

13 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.

Grids for 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)

CLAIM FOR TRAUMATIC INJURY PROTECTION (TSGLI) PAYMENT





Service member's Last Name

Grid for last name

Service member's Social Security Number

Grid for social security number

Is this claim for inability to Eat?

Yes No If yes, please indicate the following

Form for inability to eat with 5 numbered questions and date fields.

Is this claim for inability to Toilet?

Yes No If yes, please indicate the following

Form for inability to toilet with 5 numbered questions and date fields.

Is this claim for inability to Transfer?

Yes No If yes, please indicate the following

Form for inability to transfer with 4 numbered questions and date fields.

I have examined the patient and/or reviewed pertinent medical evidence. Based on this examination/review, I certify that this patient was unable to perform the activity(ies) of daily living indicated above.

Name of Attending Medical Professional (please print)

Medical Professional's Signature

Date Signed

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)

REMINDER: Attach copies of any medical records that support this claim.





Service member's Social Security Number

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**PART C - Certification by Branch of Service** - to be completed by the branch of service TSGLI certifying official

**4 Additional Comments**  
(if any)

**CLAIM FOR TRAUMATIC INJURY PROTECTION (TSGLI) PAYMENT**

