of insurance in force on the life of the individual shall remain at a constant level until the principal amount of the mortgage loan which is basis for establishing the amount of insurance is reduced to $200,000, or to the amount of the reduced maximum amount of insurance selected by the individual, at which time the amount of insurance in force on his or her life shall be reduced in accordance with the schedule for the reduction of the principal of the mortgage loan, and whether or not the scheduled payments are timely made.

(c) Subject to the $200,000 maximum amount of insurance, and to the reduced maximum amount of insurance selected by the eligible individual, 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 individual. Where an individual 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, 2101, 2101A, 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; 82 FR 48631, Oct. 19, 2017]

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

Sec.

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) 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.

(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; 85 FR 14802, Mar. 16, 2020]

§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 2-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 Veterans' Group Life Insurance premium must be received by the administrative office within 1 year following termination of SGLI coverage.

(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.

(5) Pursuant to 38 U.S.C. 1977(a)(3), former members under the age of 60 can elect to increase their Veterans' Group Life Insurance coverage by $25,000, up to the existing Servicemembers' Group Life Insurance maximum. The insured's first opportunity to elect to increase coverage is on the one-year Veterans' Group Life Insurance coverage anniversary date. Thereafter, the insured could elect to increase coverage on the five-year anniversary date of the first VGLI coverage increase election opportunity and subsequently every five years from the anniversary date of the insured's last VGLI coverage increase election opportunity. Increases of less than $25,000 are only available when existing Veterans' Group Life Insurance coverage is within less than $25,000 of the Servicemembers' Group Life Insurance maximum and any increases of less than $25,000 must be only in the amount needed to bring the insurance coverage up to the statutory maximum allowable amount of Servicemembers' Group Life Insurance. The eligible former members must apply for the increased coverage through the administrative office, within 120 days of invitation prior to the initial one-year anniversary date or within 120 days prior to each subsequent five-year coverage anniversary date from the first VGLI coverage increase election opportunity. The increased coverage will be effective from the anniversary date immediately following the election.

(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.

(f)(1) If an application, initial premium, or evidence of insurability (as the case may be) has not been received by the administrative office within the time limits set forth in paragraph (c) of this section, 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 210 days following termination of duty, except that evidence of insurability is not required during the initial 330 days following termination of duty.

(2) Paragraph (f)(1) of this section shall not apply to an application or initial premium received after December 11, 2021.

(g) Except as provided in § 9.24, the effective date of enrollment, re-enrollment, or an increase in coverage under 38 U.S.C. 1967(a)(1) shall be the date the uniformed service receives an application and proof of the insurable spouse's good health:

(1) For an insurable spouse who was eligible for coverage under 38 U.S.C. 1967(a)(1)(A)(ii) or (C)(ii) but was not so insured or was insured at a reduced rate and who became a member; and

(2) For a member-spouse covered under 38 U.S.C. 1967(a)(1)(A)(i) and who was also eligible for coverage under 38 U.S.C. 1967(a)(1)(A)(ii) or (C)(ii) but who was not so insured or was insured at a reduced amount by reason of an election made by a member.

(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; 79 FR 44299, July 31, 2014; 83 FR 65528, Dec. 21, 2018; 85 FR 35563, June 11, 2020; 85 FR 78559, Nov. 27, 2020; 86 FR 30543, June 9, 2021]

§ 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 2 years 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; 79 FR 44299, July 31, 2014]

§ 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 *traveltime* 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.

(f) *How do you apply for an Accelerated Benefit?* (1) You can obtain an application form by writing the Office of Servicemembers' Group Life Insurance, 80 Livingston Avenue, Roseland, New Jersey 07068–1733; calling the Office of Servicemembers' Group Life Insurance toll-free at 1–800–419–1473; 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, 80 Livingston Avenue, Roseland, New Jersey 07068–1733.

(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; 79 FR 44299, July 31, 2014]

§ 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 damage to a living being occurring on or after October 7, 2001, caused by:

(i) Application of an external force;

(ii) Application of violence or chemical, biological, or radiological weapons;

(iii) Accidental ingestion of a contaminated substance;

(iv) Exposure to low environmental temperatures, excessive heat, or documented non-penetrating blast waves; or

(v) An insect bite or sting or animal bite.

(2) 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) The term traumatic injury includes anaphylactic shock directly caused by an insect bite or sting or animal bite.

(4) 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 November 30, 2005. (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 results directly from a traumatic injury and from no other cause.

(i) A scheduled loss does not result directly from a traumatic injury and from no other cause if a pre-existing illness, condition, or disease or a post-service injury substantially contributed to the loss.

(ii) A scheduled loss results directly from a traumatic injury and no other cause if the loss is caused by a medical or surgical procedure used to treat the traumatic injury.

(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 § 9.21(c) within two years of the traumatic injury.

(i) If a loss with a required time period milestone begins but is not completed within two years of the traumatic injury, the loss would nonetheless qualify for TSGLI if the requisite time period of loss continues uninterrupted and concludes after the end of the two-year period.

(ii) If a required time period for a loss is satisfied before the end of the two-year period and a member suffers another period of loss after expiration of the two-year time limit, the member is not entitled to TSGLI for this time period of loss.

(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 § 9.21(c) if directly caused by a traumatic injury and from no other cause. 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, unless the diagnostic procedure or medical or surgical treatment is necessary to treat a traumatic injury;

(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 an act that clearly violated a penal law classifying such an act as 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 section and § 9.21—

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

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

(iii) 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.

(iv) The term *external force* means a sudden or violent impact from a source outside of the body that causes an unexpected impact and is independent of routine body motions such as twisting, lifting, bending, pushing, or pulling.

(v) The term *ingestion* means to take into the gastrointestinal tract by means of the mouth.

(vi) The term *medical professional* means a licensed practitioner of the healing arts acting within the scope of his or her practice, including, *e.g.*, a licensed physician, optometrist, nurse practitioner, registered nurse, physician assistant, or audiologist.

(vii) The term *medically incapacitated* means an individual who has been determined by a medical professional to

be physically or mentally impaired by physical disability, mental illness, mental deficiency, advanced age, chronic use of drugs or alcohol, or other causes that prevent sufficient understanding or capacity to manage his or her own affairs competently.

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

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

(f) *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 and sign Part A of the TSGLI Benefits Form and submit evidence substantiating the member's traumatic injury and resulting loss. A medical professional must complete and sign Part B of the Application for TSGLI Benefits Form.

(ii) If a medical professional certifies in Part B of the Application for TSGLI Benefits Form that a member is unable to sign Part A of the Form because the member is medically incapacitated, the Form must be signed by one of the following: 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 (§9.21(c)(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 (§9.21(c)(20)), 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 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.

(g) *How will the uniformed service decide a TSGLI claim?* (1) 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 a member was insured under Servicemembers' Group Life Insurance at the time of the traumatic injury and whether the member sustained a qualifying traumatic injury and qualifying loss.

(2) The uniformed service office may request additional evidence from the member if the record does not contain sufficient evidence to decide the member's claim.

(3) The uniformed service office shall consider all medical and lay evidence of record, including all evidence provided by the member, and determine its probative value. When there is an approximate balance of positive and negative evidence regarding any issue material to the determination of TSGLI benefits, the uniformed service shall give the benefit of the doubt to the member.

(4) 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, and all

negative decisions shall include a statement of the basis for the decision and a summary of the evidence considered.

(h) *How does a member or beneficiary appeal an adverse eligibility determination?* (1) Each uniformed service has a three-tiered appeal process. The first tier of appeal is called a reconsideration, followed by a second-level appeal and then a third-level appeal. A member, beneficiary, or other person eligible to submit a claim under paragraph (f)(1)(ii) or (iii) may submit an appeal using the appeal process of the uniformed service that issued the original decision.

(i) *Reconsideration.* (A) Reconsideration of an eligibility determination, such as whether the loss occurred within 730 days of the traumatic injury, whether the member was insured under Servicemembers' Group Life Insurance when the traumatic injury was sustained, or whether the injury was self-inflicted or whether a loss of hearing was total and permanent, is initiated by filing, with the office of the uniformed service identified in the eligibility decision within one year of the date of a denial of eligibility, a written notice of appeal that identifies the issues for which reconsideration is sought.

(B) The uniformed service TSGLI office will review the claim, including evidence submitted with the notice of appeal by or on behalf of the member that was not previously part of the record before the uniformed service, and issue a decision on the claim.

(ii) *Second-level appeal.* (A) A second-level appeal of the reconsideration decision is initiated by filing, with the second-level appeal office of the uniformed service within one year of the date of the reconsideration decision, a written notice of appeal that identifies the issues being appealed.

(B) The uniformed service second-level appeal office will review the claim, including evidence submitted with the notice of appeal by or on behalf of the member that was not previously part of the record before the uniformed service, and issue a decision on the claim.

(iii) *Third-level appeal.* (A) A third-level review of the second-level uniformed service appeal office is initiated by filing, with the third-level appeal office of the uniformed service within one year of the date of the decision by the second-level appeal office of the uniformed service, a written notice of appeal that identifies the issues being appealed.

(B) The uniformed service third-level appeal office will review the claim, including evidence submitted with the notice of appeal by or on behalf of the member that was not previously part of the record before the uniformed service, and issue a decision on the claim.

(2) If a timely notice of appeal seeking reconsideration of the initial decision by the uniformed service or seeking review of the decision by the second-level uniformed service appeal office is not filed, the initial decision by the uniformed service or the decision by the second-level uniformed service appeal office, respectively, shall become final, and the claim will not thereafter be readjudicated or allowed except as provided in paragraph (h)(3).

(3) New and material evidence. (i) If a member, beneficiary, or other person eligible to submit a claim under paragraph (f)(1)(ii) or (iii) submits new and material evidence with respect to a claim that has been finally disallowed as provided in paragraph (h)(2), the uniformed service office will consider the evidence, determine its probative value, and readjudicate the claim. New and material evidence is evidence that was not previously part of the record before the uniformed service, is not cumulative or redundant of evidence of record at the time of the prior decision and is likely to have a substantial effect on the outcome.

(ii) A decision finding that new and material evidence was not submitted may be appealed in accordance with paragraph (h)(1).

(4) Nothing in this section precludes a member from pursuing legal remedies under 38 U.S.C. 1975 and 38 CFR 9.13. However, if a member files suit in U.S. district court after an adverse initial decision on a TSGLI claim by a uniformed service, the member may not file an appeal pursuant to paragraph (h)(1) if the lawsuit is pending before a

U.S. district court, a U.S. court of appeals, or the U.S. Supreme Court or the time for appeal or filing a petition for a writ of certiorari has not expired. If a member files suit in U.S. district court after filing an appeal pursuant to paragraph (h)(1), the appeal will be stayed if the lawsuit is pending before a U.S. district court, a U.S. court of appeals, or the U.S. Supreme Court or the time for appeal or filing a petition for a writ of certiorari has not expired.

(i) *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 38 U.S.C. 1980A except under the following circumstances:

(A) If a member has been determined by a medical professional, in Part B of the Application for TSGLI Benefits Form, to be medically incapacitated, the member's guardian or, or if there is no guardian, the member's agent or attorney acting under a valid Power of Attorney will be paid the benefit on behalf of the member.

(B) 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.

(C) 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).

(j) 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; 79 FR 44299, July 31, 2014; 88 FR 15910, Mar. 15, 2023]

§ 9.21 Schedule of Losses.

(a) Definitions. For purposes of the Schedule of Losses in paragraph (c)—

(1) The term *accommodating equipment* means tools or supplies that enable a member to perform an activity of daily living without the assistance of another person, including, but not limited to, a wheelchair; walker or cane; reminder applications; Velcro clothing or slip-on shoes; grabber or reach extender; raised toilet seat; wash basin; shower chair; or shower or tub modifications such as wheelchair access or no-step access, grab-bar or handle.

(2) The term *adaptive behavior* means compensating skills that allow a member to perform an activity of daily living without the assistance of another person.

(3) 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.

(4) The term *assistance from another person* means that a member, even while using accommodating equipment or adaptive behavior, is nonetheless unable to perform an activity of daily living unless another person physically supports the member, is needed to be within arm's reach of the member to provide assistance because the member's ability fluctuates, or provides oral instructions to the member while the member attempts to perform the activity of daily living.

(5) The term *avulsion* means a forcible detachment or tearing of bone and/or tissue due to a penetrating or crush injury.

(6) The term *consecutive* means to follow in uninterrupted succession.

(7) The term *discontinuity defect* means the absence of bone and/or tissue from its normal bodily location, which interrupts the physical consistency of the face and impacts at least one of the following functions: mastication, swallowing, vision, speech, smell, or taste.

(8) The term *hospitalization* means admission to a ''hospital'' as defined in 42 U.S.C. 1395x(e) or ''skilled nursing facility'' as defined in 42 U.S.C. 1395i–3(a).

(9) The term *inability to carry out activities of daily living* means the inability to perform at least two of the six following functions without assistance from another person, even while using accommodating equipment or adaptive behavior, as documented by a medical professional.

(i) *Bathing* means washing, while in a bathtub or shower or using a sponge bath, at least three of the six following regions of the body in its entirety: Head and neck, back, front torso, pelvis (including the buttocks), arms, or legs.

(ii) *Continence* means complete control of bowel and bladder functions or management of a catheter or colostomy bag, if present.

(iii) *Dressing* means obtaining clothes and shoes from a closet or drawers and putting on the clothing and shoes, excluding tying shoelaces or use of belts, buttons, or zippers.

(iv) *Eating* means moving food from a plate to the mouth or receiving nutrition via a feeding tube or intravenously but does not mean preparing or cutting food or obtaining liquid nourishment through a straw or cup.

(v) *Toileting* means getting on and off the toilet; taking clothes off before toileting or putting clothes on after toileting; cleaning organs of excretion after toileting; or using a bedpan or urinal.

(vi) *Transferring* means moving in and out of a bed or chair.

(10) The term *permanent* means clinically stable and reasonably certain to continue throughout the lifetime of the member.

(11) The term *therapeutic trip* means an approved pass, by the member's attending physician or nurse practitioner, to leave a hospital as defined in 42 U.S.C. 1395x(e) or ''skilled nursing facility'' as defined in 42 U.S.C. 1395i–3(a), accompanied or unaccompanied by hospital or facility staff, as part of a member's treatment plan and with which the member is able to return without having to be readmitted to the hospital or facility.

(b)(1) For losses listed in paragraphs (c)(1) through (19) of this section—

(i) Except where noted otherwise, multiple losses resulting from a single traumatic event may be combined for purposes of a single payment.

(ii) The total payment amount may not exceed $100,000 for losses resulting from a single traumatic event.

(2) For losses listed in paragraphs (c)(20) and (21) of this section—

(i) Payments may not be made in addition to payments for losses under paragraphs (c)(1) through (19); instead, the higher amount will be paid.

(ii) The total payment amount may not exceed $100,000 for losses resulting from a single traumatic event.

(3) Required period of consecutive days of loss. For losses in paragraphs (c)(17) through (18) and (20) through (21)—

(i) A period of consecutive days of loss that is interrupted by a day or more during which the criteria for the scheduled loss are not satisfied will not be added together with a subsequent period of consecutive days of loss. The counting of consecutive days starts over at the end of any period in which the criteria for a loss are not satisfied.

(ii) A required period of consecutive days will be satisfied if a loss begins within two years of a traumatic injury and continues without interruption after the end of the two-year period. A subsequent period of consecutive days of a scheduled loss will be satisfied if it follows uninterrupted immediately after an initial period of consecutive days of loss that ended after expiration of the two-year period.

(c) *Schedule of Losses.* (1) *Total and permanent loss of sight* is:

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

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

(iii) Anatomical loss of the eye.

(iv) The amount payable for the loss of each eye is $50,000.

(2) *Total and permanent loss of hearing* is:

(i) 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 via pure tone audiometry by air conduction, without amplification device.

(ii) The amount payable for loss of one ear is $25,000. The amount payable for the loss of both ears is $100,000.

(3) *Total and permanent loss of speech* is:

(i) 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.

(ii) The amount payable for the loss of speech is $50,000.

(4) *Quadriplegia* is:

(i) Total and permanent loss of voluntary movement of all four limbs resulting from damage to the spinal cord, associated nerves, or brain.

(ii) The amount payable for quadriplegia is $100,000.

(5) *Hemiplegia* is:

(i) Total and permanent loss of voluntary movement of the upper and lower limbs on one side of the body from damage to the spinal cord, associated nerves, or brain.

(ii) The amount payable for hemiplegia is $100,000.

(6) *Paraplegia* is:

(i) Total and permanent loss of voluntary movement of both lower limbs resulting from damage to the spinal cord, associated nerves, or brain.

(ii) The amount payable for paraplegia is $100,000.

(7) *Uniplegia* is:

(i) Total and permanent loss of voluntary movement of one limb resulting from damage to the spinal cord, associated nerves, or brain.

(ii) The amount payable for the loss of each limb is $50,000.

(iii) Payment for uniplegia of arm cannot be combined with loss 9 or 10 for the same arm. The higher payment for uniplegia or loss 14 will be made for the same arm. Payment for uniplegia of leg cannot be combined with loss 11 or 12 for the same leg. The higher payment for uniplegia or loss 13 will be made for the same leg. The higher payment for uniplegia or loss 15 will be made for the same leg.

(8) *Burns* is: (i) 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.

(ii) The amount payable for burns is $100,000.

(9) *Amputation of a hand at or above the wrist:* (i) The amount payable for the loss of each hand is $50,000.

(ii) Payment for amputation of hand cannot be combined with payment for loss 7 or 10 for the same hand. The higher payment for amputation of hand or loss 14 will be made 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:* (i) The amount payable for the loss of each hand is $50,000.

(ii) Payment for amputation of 4 fingers on 1 hand or thumb alone cannot be combined with payment for loss 7 or 9 for the same hand. The higher payment for amputation of 4 fingers on 1 hand or thumb alone or loss 14 will be made for the same hand. 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:* (i) The amount payable for the loss of each foot is $50,000.

(ii) Payment for amputation of foot cannot be combined with loss 7 or 12 for the same foot. The higher payment for amputation of foot or Loss 13 will be made for the same foot. The higher payment for amputation of foot or Loss 15 will be made for the same foot.

(12) *Amputation at or above the metatarsophalangeal joints of all toes on 1 foot:* (i) The amount payable for the loss of each foot is $50,000.

(ii) Payment for amputation of all toes including the big toe on 1 foot cannot be combined with loss 7 or 11 for the same foot. The higher payment for amputation of all toes including the big toe on 1 foot or loss 13 will be made for the same foot. The higher payment for amputation of all toes including the big toe on 1 foot or loss 15 will be made 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:* (i) The amount payable for the loss of each foot is $25,000.

(ii) The higher payment for amputation of big toe only, or other 4 toes on

1 foot, or loss 7 will be made for the same foot. The higher payment for amputation of big toe only, or other 4 toes on 1 foot, or loss 11 will be made for the same foot. The higher payment for amputation of big toe only, or other 4 toes on 1 foot, or loss 12 will be made for the same foot. The higher payment for amputation of big toe only, or other 4 toes on 1 foot, or loss 15 will be made for the same foot.

(14) *Limb reconstruction of arm (for each arm):* (i) A surgeon must certify that a member had surgery to treat at least one of the following injuries to a limb:

(A) Bony injury requiring bone grafting to re-establish stability and enable mobility of the limb;

(B) Soft tissue defect requiring grafting/flap reconstruction to reestablish stability;

(C) Vascular injury requiring vascular reconstruction to restore blood flow and support bone and soft tissue regeneration; or

(D) Nerve injury requiring nerve reconstruction to allow for motor and sensory restoration and muscle reenervation.

(ii) The amount payable for losses involving 1 of the 4 listed surgeries is $25,000. The amount payable for losses involving 2 or more of the 4 listed surgeries is $50,000.

(iii) The higher payment for limb reconstruction of arm or loss 7 will be made for the same arm. The higher payment for limb reconstruction of arm or loss 9 will be made for the same arm. The higher payment for limb reconstruction of arm or loss 10 will be made for the same arm.

(15) *Limb reconstruction of leg (for each leg):* (i) A surgeon must certify that a member had at least one of the following injuries to a limb requiring the identified surgery for the same limb:

(A) Bony injury requiring bone grafting to re-establish stability and enable mobility of the limb;

(B) Soft tissue defect requiring grafting/flap reconstruction to reestablish stability;

(C) Vascular injury requiring vascular reconstruction to restore blood flow and support bone and soft tissue regeneration; or

(D) Nerve injury requiring nerve reconstruction to allow for motor and sensory restoration and muscle reenervation.

(ii) The amount payable for losses involving 1 of the 4 listed surgeries is $25,000. The amount payable for losses involving 2 or more of the 4 listed surgeries is $50,000.

(iii) The higher payment for limb reconstruction of leg or loss 7 will be made for the same leg. The higher payment for limb reconstruction of leg or loss 11 will be made for the same leg. The higher payment for limb reconstruction of leg or loss 12 will be made for the same leg. The higher payment for limb reconstruction of leg or loss 13 will be made for the same leg.

(16) *Facial reconstruction:* (i) A surgeon must certify that a member had surgery to correct a traumatic avulsion of the face or jaw that caused a discontinuity defect to one or more of the following facial areas:

(A) Surgery to correct discontinuity loss involving bone loss of the upper or lower jaw—the amount payable for this loss is $75,000;

(B) Surgery to correct discontinuity loss involving cartilage or tissue loss of 50% or more of the cartilaginous nose—the amount payable for this loss is $50,000;

(C) Surgery to correct discontinuity loss involving tissue loss of 50% or more of the upper or lower lip—the amount payable for loss of one lip is $50,000, and the amount payable for loss of both lips is $75,000;

(D) Surgery to correct discontinuity loss involving bone loss of 30% or more of the periorbita—the amount payable for loss of each eye is $25,000;

(E) Surgery to correct discontinuity loss involving loss of bone or tissue of 50% or more of any of the following facial subunits: Forehead, temple, zygomatic, mandibular, infraorbital, or chin—the amount payable for each facial subunit is $25,000.

(ii) Losses due to facial reconstruction may be combined with each other, but the maximum benefit for facial reconstruction may not exceed $75,000.

(iii) Any injury or combination of losses under facial reconstruction may be combined with other losses in § 9.21(c)(1)–(19) 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.

(iv) Bone grafts for teeth implants alone do not meet the loss standard for facial reconstruction from jaw surgery.

(17) *Coma (8 or less on Glasgow Coma Scale) AND/OR Traumatic Brain Injury resulting in inability to perform at least 2 activities of daily living (ADL):* (i) The amount payable at the 15th consecutive day of ADL loss is $25,000.

(ii) The amount payable at the 30th consecutive day of ADL loss is an additional $25,000.

(iii) The amount payable at the 60th consecutive day of ADL loss is an additional $25,000.

(iv) The amount payable at the 90th consecutive day of ADL loss is an additional $25,000.

(v) Duration of coma and inability to perform ADLs include 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:* (i) The amount payable at the 15th consecutive day of hospitalization is $25,000.

(ii) Payment for hospitalization may only replace the first ADL milestone in loss 17. Payment will be made for 15-day hospitalization, coma, or the first ADL milestone, whichever occurs earlier. Once payment has been made for the first payment milestone in loss 17 for coma or ADL, there are no additional payments for subsequent 15-day hospitalization due to the same traumatic injury. To receive an additional ADL payment amount under loss 17 after payment for hospitalization in the first payment milestone, the member must reach the next payment milestones of 30, 60, or 90 consecutive days.

(iii) Duration of hospitalization includes the dates on which member is transported from the injury site to a hospital as defined in 42 U.S.C. 1395x(e) or skilled nursing facility as defined in 42 U.S.C. 1395i–3(a), admitted to the hospital or facility, transferred between a hospital or facility, leaves the hospital or facility for a therapeutic trip, and discharged from the hospital or facility.

(iv) In cases where a member is hospitalized for 15 consecutive days for a diagnostic assessment for a mental illness and/or brain or neurologic disorder, and the assessment determines the member has a mental illness or brain or neurologic disorder, and not TBI, this loss is not payable because the loss was due to illness or disease and is excluded from payment. If a member is hospitalized for 15 consecutive days for a diagnostic assessment to determine whether the member has TBI and is diagnosed with TBI, TBI and PTSD, or PTSD and not TBI, the loss is payable for $25,000. If a member is hospitalized for 15 consecutive days for a diagnostic assessment to determine whether the member has PTSD and is diagnosed with TBI or TBI and PTSD, the loss is payable for $25,000.

(19) *Genitourinary losses:* (i) Amputation of the glans penis or any portion of the shaft of the penis above glans penis (*i.e.*, closer to the body) or damage to the glans penis or shaft of the penis that requires reconstructive surgery—the amount payable for this loss is $50,000.

(ii) Permanent damage to the glans penis or shaft of the penis that results in complete loss of the ability to perform sexual intercourse—the amount payable for this loss is $50,000.

(iii) Amputation of or damage to a testicle that requires testicular salvage, reconstructive surgery, or both—the amount payable for this loss is $25,000.

(iv) Amputation of or damage to both testicles that requires testicular salvage, reconstructive surgery, or both—the amount payable for this loss is $50,000.

(v) Permanent damage to both testicles requiring hormonal replacement therapy—the amount payable for this loss is $50,000.

(vi) Complete or partial amputation of the vulva, uterus, or vaginal canal or damage to the vulva, uterus, or vaginal canal that requires reconstructive surgery—the amount payable for this loss is $50,000.

(vii) Permanent damage to the vulva or vaginal canal that results in complete loss of the ability to perform sexual intercourse—the amount payable for this loss is $50,000.

(viii) Amputation of an ovary or damage to an ovary that requires ovarian salvage, reconstructive surgery, or both—the amount payable for this loss is $25,000.

(ix) Amputation of both ovaries or damage to both ovaries that requires ovarian salvage, reconstructive surgery, or both—the amount payable for this loss is $50,000.

(x) Permanent damage to both ovaries requiring hormonal replacement therapy—the amount payable for this loss is $50,000.

(xi) Permanent damage to the urethra, ureter(s), both kidneys, bladder, or urethral sphincter muscle(s) that requires urinary diversion and/or hemodialysis—the amount payable for this loss is $50,000.

(xii) Losses due to genitourinary injuries may be combined with each other, but the maximum benefit for genitourinary losses may not exceed $50,000.

(xiii) Any genitourinary loss may be combined with other injuries listed in § 9.21(b)(1)–(18) and treated as one loss, provided that at 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):* (i) The amount payable at the 15th consecutive day of ADL loss is $25,000.

(ii) The amount payable at the 30th consecutive day of ADL loss is an additional $25,000.

(iii) The amount payable at the 60th consecutive day of ADL loss is an additional $25,000.

(iv) The amount payable at the 90th consecutive day of ADL loss is an additional $25,000.

(v) Duration of inability to perform ADL includes the date of the onset of inability to perform ADL and the first date on which member is able to perform ADL.

(21) *Hospitalization due to traumatic injury other than traumatic brain injury:* (i) The amount payable at 15th consecutive day of ADL loss is $25,000.

(ii) Payment for hospitalization may only replace the first ADL milestone in loss 20. Payment will be made for 15-day hospitalization or the first ADL milestone, whichever occurs earlier. Once payment has been made for the first payment milestone in loss 20, there are no additional payments for subsequent 15-day hospitalization due to the same traumatic injury. To receive an additional ADL payment amount under loss 20 after payment for hospitalization in the first payment milestone, the member must reach the next payment milestones of 60, 90, or 120 consecutive days.

(iii) Duration of hospitalization includes the dates on which member is transported from the injury site to a hospital as defined in 42 U.S.C. 1395x(e) or skilled nursing facility as defined in 42 U.S.C. 1395i–3(a), admitted to the hospital or facility, transferred between a hospital or facility, leaves the hospital or facility for a therapeutic trip, and discharged from the hospital or facility.

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

[88 FR 15912, Mar. 15, 2023]

§ 9.22 VA's access to records maintained by the insurer, reinsurer(s), and their successors.

(a) In order to perform oversight responsibilities designed to protect the legal and financial rights of the Government and persons affected by the activities of the Department of Veterans Affairs and its agents and to ensure that the policy and the related program benefits and services are managed effectively and efficiently as required by law, the Secretary of Veterans Affairs shall have complete and unrestricted access to the records of any insurer, reinsurer(s), and their successors with respect to the policy and related benefit programs or services that are derived from the policy. This access includes access to:

(1) Any records relating to the operation and administration of benefit programs derived from the policy, which are considered to be Federal records created under the policy;

(2) Records related to the organization, functions, policies, decisions, procedures, and essential transactions, including financial information, of the insurer, reinsurer(s), and their successors; and

(3) Records of individuals insured under the policy or utilizing other related program benefits and services or who may be entitled to benefits derived through the Servicemembers' and Veterans' Group Life Insurance programs, including personally identifiable information concerning such individuals and their beneficiaries.

(b) Complete access to these records shall include the right to have the originals of such records sent to the Secretary of Veterans Affairs or a representative of the Secretary at the Secretary's direction. The records shall be available in either hard copy or readable electronic media. At the Secretary's option, copies may be provided in lieu of originals where allowed by the Federal Records Act, 44 U.S.C. chapter 31.

[79 FR 48072, Aug. 15, 2014. Redesignated at 88 FR 15912, Mar. 15, 2023]

§ 9.23 Submission of certain applications and forms affecting entitlement to Servicemembers' Group Life Insurance and Veterans' Group Life Insurance.

(a)(1) For purposes of this section, the terms *in writing* and *written* mean an intentional recording of words in visual form and include:

(i) Hard-copy applications and forms containing a person's name or mark written or made by that person; and

(ii) Applications and forms submitted through a VA approved electronic means that include an electronic or digital signature that identifies and authenticates a particular person as the source of the electronic message and indicates such person's approval of the information submitted through such means.

(2) With regard to the following actions, applications or forms that satisfy the definition in paragraph (a)(1) of this section will be deemed to satisfy the requirement in the referenced statutes that an application, election, or beneficiary designation be ''in writing'' or ''written'':

(i) Decline Servicemembers' Group Life Insurance for the member or Family Servicemembers' Group Life Insurance for the member's insurable spouse (38 U.S.C. 1967(a)(2)(A) or (B));

(ii) Insure the member under Servicemembers' Group Life Insurance or the member's spouse under Family Servicemembers' Group Life Insurance in an amount less than the maximum amount of such insurance (38 U.S.C. 1967(a)(3)(B));

(iii) Restore or increase coverage under Servicemembers' Group Life Insurance for the member or under Family Servicemembers' Group Life Insurance for the member's insurable spouse (38 U.S.C. 1967(c));

(iv) Designate one or more beneficiaries for the member's Servicemembers' Group Life Insurance or former member's Veterans' Group Life Insurance (38 U.S.C. 1970(a)); and

(v) Increase the amount of coverage under Veterans' Group Life Insurance (38 U.S.C. 1977(a)(3)).

(b) Applications or forms that satisfy the definition in paragraph (a)(1) of this section may be utilized to—

(1) Apply for Veterans' Group Life Insurance; and

(2) Reinstate Veterans' Group Life Insurance.

[83 FR 10623, Mar. 12, 2018. Redesignated at 88 FR 15912, Mar. 15, 2023]

§ 9.24 Insurable dependents who become eligible members, and eligible members who marry eligible members.

(a) A Servicemembers' Group Life Insurance-covered member (member) who marries another Servicemembers' Group Life Insurance eligible member (member spouse) after January 1, 2013, or is married to a person who becomes a Servicemembers' Group Life Insurance eligible member after January 1, 2013, shall receive Family Servicemembers' Group Life Insurance spousal coverage at the statutory maximum amount or a lesser amount, or receive increased existing spousal coverage on their member spouse, upon an election of such coverage if made within 240 days following the member's marriage to another member, or the member's spouse entering service, without having to provide proof of the member spouse's good health. If a member does not elect coverage for a member spouse within 240 days following the member's marriage to another member, or the member's spouse

entering service, then the member may still receive spousal coverage at the statutory maximum amount or a lesser amount, or increase existing spousal coverage, by applying and submitting proof of the member spouse's good health.

(b) A spouse shall remain eligible to be covered by any existing Family Servicemembers' Group Life Insurance spousal coverage without the member electing such coverage or applying for such coverage with proof of the member spouse's good health in a case where the spouse is enrolled in coverage under 38 U.S.C. 1967(a)(1)(A)(ii) or (C)(ii) prior to becoming a member married to another member.

(c) A member's spouse who was insured under the member's Family Servicemembers' Group Life Insurance at the time the spouse separates from service will continue to be covered under the spousal Family Servicemembers' Group Life Insurance carried while in service, and the member will not need to elect such coverage. If a member seeks to enroll a former member spouse who did not have such spousal insurance coverage when the former member spouse separates from service, or seeks to increase existing spousal coverage on their former member spouse, the member shall receive such spousal coverage on their former member spouse, upon an election of such coverage if made within 240 days following the former member spouse's separation from service, without having to provide proof of the former member spouse's good health. If a member does not elect coverage for a former member spouse within 240 days following the former member spouse's separation from service, then the member may still receive spousal coverage at the statutory maximum amount or a lesser amount, or increase existing spousal coverage, by applying and submitting proof of the former member spouse's good health.

(d) After January 1, 2013, an insurable child who is a member at the time a parent's Servicemembers' Group Life Insurance coverage commences is not eligible for automatic dependent coverage under 38 U.S.C. 1967(a)(1)(A)(ii) or (C)(ii). Dependent coverage in effect for an insurable child prior to becoming a member shall remain in effect so long as the child remains an insurable dependent. If an insurable child was not covered prior to becoming a member, the child cannot be covered under 38 U.S.C. 1967(a)(1)(A)(ii) or (C)(ii) after the child becomes a member.

[85 FR 78559, Nov. 27, 2020]

PART 10—ADJUSTED COMPENSATION

ADJUSTED COMPENSATION; GENERAL

Sec.