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CHAPTER I. HISTORY AND JURISDICTION

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SUBCHAPTER I. HISTORY

1.01 AGE RESTRICTION ON WAIVER

Prior to January 1, 1965, under NSLI (National Service Life Insurance), an insured must have become totally disabled prior to his or her 60th birthday to be eligible for a disability waiver of premiums. On and after the date, the total disability must occur prior to his or her 65th birthday. Therefore, when total disability occurs after age 60, premiums which became due prior to January 1, 1965 are not eligible to be waived.

1.02 TOTAL DISABILITY INCOME PROVISION FOR NSLI

The first TDIP Total Disability Income Provision) for NSLI became available on August 1, 1946. It provided payment to the insured of $5 a month for each $1 ,000 of insurance should the insured become totally disabled prior to his or her 60th birthday or the anniversary date of the policy nearest the insured's 60th birthday, whichever was later. On November 1, 1958 a new TDIP became available. It provided payment to the insured of $10 a month for each $1,000 of insurance should he or she become totally disabled prior to his or her 60th birthday. On January 1, 1965, still another TDIP became available. It provided payment to the insured of $10 a month for each $1 ,000 of insurance should total disability occur prior to his or her 65th birthday. As each new rider became available, issues of the old rider were not allowed; however, an old rider, previously issued, could be retained.

1.03 TOTAL DISABILITY PROVISION FOR USGLI

The first Total Disability Provision for USGLI (United States Government Life Insurance) became available on May 29, 1928. It provided payment to the insured of $5.75 a month for each $ 1 ,000 of insurance should he or she become totally disabled. Protection was provided by the provision for the life of the policy. On July 3, 1930, a new TDP became available. It provided payment to the insured of $5.75 a month for each $1 ,000 of insurance should total disability occur prior to his or her 65th birthday. When the new rider became available, issue of the old rider was not allowed. However, an old rider, previously issued, could be retained.

1.04 TOTAL PERMANENT DISABILITY

The TPD (total permanent disability) provision is an integral part of all plans of USGLI except the special endowment at age 96. It is included in policies on extended insurance and policies surrendered for reduced paid-up insurance. When an insured is considered totally and permanently disabled, the policy matures and the insured receives payment of $5.75 a month for each $1,000 of net insurance. Net insurance is the gross amount of insurance minus indebtedness. The monthly payments are payable to the insured, if the insured remains totally and permanently disabled, for life with 240 months guaranteed. The insured may request the payments be held in abeyance. Under this condition, the payments are held by the VA with a payment being added each month. The insured may request payment of the accumulated monthly payments held in abeyance at any time. These payments, including those held in abeyance, reduce the face amount of insurance. Should the insured recover without having received 240 monthly payments, the policy may be revived in a reduced amount (this is referred to as a rerated policy). The amount of insurance revived is the present value of the unpaid guaranteed monthly

payments. Should the insured recover after receiving 240 or more monthly payments, there is no insurance available to be revived. Should the insured die before receiving 240 monthly payments, the present value of the unpaid guaranteed monthly payments is payable to the designated beneficiary. Any payments held in abeyance at the time of death are payable to the beneficiary in a lump sum. Interest is not paid on payments held in abeyance and the insured is notified of this. If the insured dies after receiving 240 or more payments, there is no insurance payable to the beneficiary. The insured may qualify for more than one period of TPD. While payments under the basic contract reduce the amount of insurance remaining, payments under the TDP do not reduce the amount of the rider.

1.05 CLAIM FOR TDIP BENEFITS

Originally, a claim for TDIP benefits could only be made by the insured. Later, this was changed to provide that application could be made by the beneficiary, administrator of the estate, or next of kin, if it could be established that the insured's failure to file a claim was due to circumstances beyond the insured's control. When the change was first made, the beneficiary was required to submit the claim within 6 months after the death of the insured. Later, the time period was changed to 1 year.

1.06 ESTABLISHMENT OF DISABILITY INSURANCE BENEFITS FOLDER

During World War II and the years immediately following, claims for waiver of premiums were filed in a DIC (disability insurance claims) folder, which was identified by the claim number. At that time, the insurance folder was not combined with the DIC folder. A copy of the waiver award was placed in the insurance folder. [ ] At a later date, about 1950, the file containing a claim for waiver was combined with the insurance file and a DIB (disability insurance benefits) folder (green) was established under the insurance number. [During August 1976, the establishment of the DIB folder (green) was discontinued. All disability insurance benefits material is now filed on the right side of the insurance folder.

NOTE: When the DIB folder still exists, continue to use for filing disability insurance benefits material

1.07 DISABILITY DECISIONS

During World War II and the years immediately following, the decision as to total disability was prepared by a Decision Writer, and the award or denial was prepared by an Adjudicator under the supervision of an Attorney Reviewer. At a later date, about 1950, the procedure was changed so that the combined decision and award was prepared by a Junior Legal Member and approved by a Senior Legal Member. Decisions was written in a narrative form until May 27, 1964, at which time a short form decision was inaugurated. Signatures required for decisions have varied over the years, with a progressive relaxation toward requiring fewer approvals by supervisory personnel. For many years it was necessary to list every period of 5-year level premium term insurance covered by the award or by the allegation of total disability, but with the introduction of the computer system only the latest period of term insurance has been carried on the award.

1.08 EXTRA HAZARD DECISIONS

Extra hazard decisions were originally made by a committee. They were in narrative form and were separate from the decision as to total disability. A stamped imprint was placed on the reverse of the award to indicate the extra hazard decision. Later the narrative form, with a stamped imprint, was changed to a short form with a

stamped imprint. Subsequent to that, the committee on extra hazards for disability insurance claims was terminated and the decision on extra hazard was made by the Authorizer where he or she made a decision on total disability. The decision on extra hazard was shown with an X in the proper block under the heading "Extra Hazard Determination," on VA Form 29-1565-3, Decision Disability Insurance Benefits, and the stamp imprint was not needed. When the extra hazard was difficult to determine, an explanation was entered on the form. All decisions of extra hazard must be reviewed by a Senior Authorizer or higher authority, when it is held that the disability was due to the extra hazard of service.

1.09 EXTRA HAZARD CRITERIA

In the early years the criterion as to whether a disability was due to the extra hazard of service was whether the disability was incurred in the performance of duty. During 1963, the criterion was changed to emphasize that a disability should be held traceable to the extra hazard of service only when it was caused by the performance of duty and when the disability occurred under circumstances which do not usually happen in civilian life. It was also emphasized that disabilities which occur or reappear after separation from service should not be held traceable to the extra hazard of service unless the causal connection was completely clear.

1.10 CONTROL OF PENDING CLAIMS

Prior to June 3, 1968, an abstract card was prepared for each claim, and control was maintained by the use of paper diaries. On and after June 3, 1968, the record keeping and diary control has been under the computer system, except for USGLI contracts matured by a finding of TPD and matured endowment policies with TDIP riders in force at maturity. Paper diaries are also used for control purposes in cases where claims for disability insurance benefits are pending and the insurance account is not on the master tape such as in lapsed cases which have been purged, and in death cases when action on a claim for the insurance death proceeds has been completed and a claim for waiver of premiums is still pending. In both of these situations the tapes have been purged and there is no control under the computer system.

SUBCHAPTER 2. JURISDICTION

1.11 JURISDICTION OF CHIEF, INSURANCE PROGRAM MANAGEMENT DIVISION, VA CENTER, PHILADELPHIA

The Office of the Chief, Insurance Program Management Division is responsible for the development of policies and technical standards with reference to claims for disability insurance benefits. The Chief, Insurance Operations Division, VA center, St. Paul and VA center, Philadelphia, will refer all questions as to the proper applications of approved policies and technical standards to the Office of the Chief, Insurance Program Management Division (290), VA Center, Philadelphia.

1.12 CASES OVER WHICH INSURANCE PROGRAM MANAGEMENT DIVISION HAS JURISDICTION

Insurance Program Management Division (290) has jurisdiction over the following types of cases:

a. Unusual or complex cases when an advisory opinion is requested by Insurance Operations Division, VA Center, Philadelphia or VA Center, St. Paul.

b. When an administrative review is requested by a service organization representative.

c. When a case is in litigation and where, prior to judgment, reconsideration is requested by the Department of Justice or the Office of the General Counsel.

d. Cases in which judgments have been rendered in favor of the Government when further claim is made with reference of a total and permanent disability or with reference to the veterans' condition as found at the time of the judgment.

e. Litigated cases in which initial award action is required pursuant to judgment.

f. Any case in which there is a conflict with another VA rating agency as to whether or not the insured has suffered the permanent loss of use of a member, or of an eye, or the organic loss of speech, or the total loss of hearing.

g. Any case involving a conflict between a tentative or actual finding that the insured is not totally disabled, and a VA rating board decision that the insured was individually unemployable under code 18.

h. Cases involving the question of fraud where there is the possibility that the veteran's mental condition makes it questionable whether the insured understood the nature of his or her action, and in cases where there is the possibility that not withstanding a finding of fraud, insurance may be issued as H insurance.

i. Cases in which the insured suffers from a high degree of disability and has disappeared under circumstances which make it probable that he or she is dead, although the evidence is not sufficiently definite to make a finding of death.

j. Claims filed by insureds who are or have been employed by the center maintaining his or her insurance records.

1.13 JURISDICTION OF VA CENTERS

The Insurance Claims Section in the Insurance Operations Division, VA Center, Philadelphia and VA Center, St. Paul are responsible for performing the following functions:

a. Jurisdiction over claims for total disability and total disability income benefits under Government life insurance, this includes original decisions continuing, granting or denying benefits and review decisions terminating benefits.

b. Determination of whether disability on which the benefits are granted is due to extra hazards of service (38 U.S.C. 721 and 757).

c. Decisions on the question of fraud involving living veterans in connection with the procurement or reinstatement of insurance, whether the question arises prior or subsequent to the filing of claims for disability insurance benefits except in those cases where the veteran's mental condition makes it questionable whether he comprehended the nature of his or her action, and in death cases when claims for disability insurance benefits are adjudicated prior to the adjudication of the claims for death insurance benefits.

d. Decisions on questions of mental competency in connection with disability claims, loan applications, cash surrender, paid-up insurance.

e. Preparation of amended or supplemental awards based on new and material evidence or clear and unmistakable error.

f. Certifying appeals to the Board of Veterans Appeals.

g. Total disability determinations in connection with conversion to an endowment plan, change of plan, cash surrenders, loans and paid-up insurance.

h. Claims filed under 38 U.S.C. 712(d).

i. Determination of whether an insured possessed testamentary capacity at the time he or she executed a change of beneficiary designation. These cases will be referred to the Insurance Claims Section from the Insurance Death Claims Section.

1.14 EXCLUSIVE JURISDICTION OF THE INSURANCE CLAIMS SECTION, VA CENTER, PHILADELPHIA

The following types of cases are exclusively adjudicated in the Philadelphia Office.

a. All USGLI (K), Yearly Renewable Term (T), and Automatic Insurance.

b. Accounts where War Risk Term and/or USGLI are involved.

c. Accounts where premiums are deducted from employers' payroll.

d. Accounts where premiums are deducted from VA benefits. (Deduction from benefits accounts.)

e. Accounts where premiums are paid by allotment from service or retired pay or waived under 38 U.S.C. 724.

f. [(Deleted by change 2.)]

CONTENTS

CHAPTER 2. PRELIMINARY DEVELOPMENT OF CLAIMS

CONTENTS-Continued

PARAGRAPH PAGE

SUBCHAPTER 4. MEDICAL EVIDENCE

A. Issue Affected: M29-l, Part III, Chapters 2 and 4.

B. Purpose: To revise and add certain paragraphs to identify valid informal claims, to establish adjudicative procedure for decision as to acceptability of valid informal claims and to clarify criteria for timeliness of filing claims.

C. Text: 1. Delete pages 2-1, 2-2, 2-3 and 2-4 and substitute as follows:

Chapter 2 - Preliminary Development of Claims

Subchapter l - Claim, Formal and Informal

2.01 Definition of Claim

a. Any communication from the insured or anyone representing him or her, whether by letter, form, or any other writing, which indicates an intent to file claim for disability insurance benefits will be accepted as a claim.

b. The claim may be on a form prescribed by the VA (formal claim) or not (informal claim). There is no difference in the effect of a formal or informal claim. An informal claim has all the attributes of a formal claim and the same adjudicative procedure must follow.

c. Whenever the word "claim" is used, it means a formal or informal claim.

d. The intent to file may be either expressed or implied. Any person acting on the insured's behalf, including a VA employee, will be considered the insured's representative.

e. As an example of implied intent, consider the VA Form 9-l7 which may be submitted by a VA employee to ascertain the status of insurance. The purpose of the form is to ascertain if the vet is on waiver or if a claim for waiver has been filed. We may imply the intent to file a claim if one has not been filed and the Form 9-l7 would, therefore, be accepted as an informal claim. The same is true of VA Form 27-4358, Request for Insurance Information.

2.

f. Another example. If an application for reinstatement is rejected because of disability, the application indicated an intent to restore insurance protection under any available section of law and thus may be considered implied intent to file for waiver and 80 is a valid claim.

g. Another such situation is when an application for RH insurance shows a significant amount of service-connected disability and the RH is disapproved because

of nonpayment of premiums, the application for insurance will be considered a claim for premium waiver.

h. If it is determined that a communication or anything else does not constitute a claim, see Chapter 4 for discussion of extenuating circumstances.

i. Neither Title 38, Code of Federal Regulations, Sections 3.150 through 3. 160, dealing with claims, nor Title 38, United States Code Sections 3001 through 3003 apply to insurance.

2.02 Necessity for Claim

a. The law requires the filing of a claim as a prerequisite for granting disability insurance benefits (premium waiver and/or total disability income).

b. A claim after death for insurance benefits is a claim for waiver of premiums if necessary to mature the insurance.

2.03 Unsigned Claims

The absence of a signature does not invalidate a claim if the insured prepared or caused a claim to be prepared. If the insured did not sign the claim, appropriate development should be undertaken to determine if he or she prepared or authorized the action.

2.04 Abandonment of Claim

a. Once a valid claim has been received, it may not be abandoned in the absence of clear evidence establishing such fact. Generally, it would take positive evidence, such as request for withdrawal of claim, to dispose of the claim.

b. If requested evidence is not received, the claim will be denied or disallowed for failure to prosecute, under applicable adjudicative procedure.

Subchapter 2 - Claims Adjudication

2.05 Adjudication Procedure Upon Receipt of Material Which May Not Be A Valid Claim

a. When material is received in the Insurance Claims Section which may be an informal claim, information will be secured to determine if insurance was issued. If so, the Claims Examiner will make a determination as shown on the attached exhibit as to whether the material constitutes a valid claim.

b. If it is determined that a valid claim has been filed, it will be set up as a pending claim in the same manner as if Form 29-357 had been filed.

c. Any needed evidence will be requested. The insured will not be requested to file Form 29-357 as a claim. However, the 29-357 may be used in part or in entirety to secure needed evidence. If in entirety, the designation as a claim will be deleted.

d. When material is received in the Insurance Claims Section, which, if overlooked, may later constitute extenuating circumstances, Form 29-357 and covering letter will be forwarded. When we have thus discharged our responsibility to notify the veteran, the material will not be used in the future to constitute extenuating circumstances.

2.06 Premature Claim

a. When less than six months have elapsed since the alleged beginning date of total disability and the claim is not accompanied by sufficient medical evidence to establish a beginning date of total disability, the medical and/or industrial evidence to determine this date will be developed immediately. When evidence indicates the onset of total disability from a date earlier than alleged, the development should include the earlier period. Both in the situations

4.

mentioned above, and in cases where the evidence is sufficient to establish a beginning date of disability and six months have not elapsed since that date, Form Letter 29-580 will be released informing the insured that action will be taken on the claim at the end of the six month period. The appropriate input document, VA Form 29-5395c, Waiver Diary Action, should be prepared with the message PRMCL and the callup date on VA Form 29-5886b changed to the date at the end of the six month period.

2. Page 4-5: Delete "c" and "d" and substitute the following:

c. When a claim is filed subsequent to August l, 1947, waiver of premiums be coining due more than one year prior to the receipt of claim in the VA may not be granted in the absence of satisfactory evidence of circumstances beyond the insured's control which prevented his or her making timely claim.

A. Change: M29-1, Part HI, Chapter 2, Subchapter 6. This advance manual change will clarify that waiver of premiums on RH insurance issued under 38 U.S.C. 722(a) may be granted pursuant to the provisions of 38 U.S.C. 712 and such waiver shall not be denied on the grounds that the service-connected disability became total prior to the effective date of the insurance or that the insurance is not in force for six months under premium paying conditions.

B. Procedure: Page 2-4, delete subparagraph 2.06(b) and substitute the following:

b. When a claim is received on Service Disabled Veterans Insurance (RH) and the evidence is not sufficient to establish that the disability has been total for six consecutive months, Form Letter 29-580 will be released informing the insured that action will be taken on the claim at the end of the six month period. The appropriate input document, VA Form 29-5895c, Waiver Diary Action, should be prepared with the message PRMCL and the callup date on VA Form 29-5886b changed to the date at the end of the six month period. For RH insurance, it is not necessary that the disability begin after the date of application for insurance nor must the policy be in force for six months under premium paying conditions to grant waiver of premiums. The only requirements for waiver on RH policies are that the disability be total for six consecutive months and that the disability begin prior to the insured's 65th birthday.

C. New or Revised Insurance Forms: Form Letter 29-580

ROBERT W. CAREY
Assistant Director for Insurance

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CHAPTER 2. PRELIMINARY DEVELOPMENT OF CLAIMS

SUBCHAPTER I. INFORMAL CLAIM

2.01 PRELIMINARY CLERICAL PROCESSING

The preliminary clerical processing is done by the Administrative Division, as provided in existing instructions.

2.02 RECEIPT OF CORRESPONDENCE BY CLAIMS EXAMINER

When correspondence is received indicating a desire on the part of an insured to file a claim for disability insurance benefits or seeking information about the procedure for filing such a claim, it will be referred to a Claims Examiner. (For definition of a claim see M29-l, pt. I, par. 31.19.) Correspondence will be considered an informal claim (even though there is no specific request for information about filing a claim), when the correspondence indicates that an insured has had or is suffering from an impairment and is under treatment or is unemployed.

2.03 RECEIPT OF REQUEST FOR STATUS FROM VA HOSPITAL OR VETERANS SERVICES DIVISION

A VA Form 29-178, Request for Insurance Status, or VA Form 274358, Request by Chief Attorney for Insurance Information, will be considered an informal claim for benefits in all cases. Parts III and IV of VA Form 29-178 and Part II of VA Form 274348 pertaining to disability insurance benefits will be completed by the Claims Examiner. A photocopy will be filed in the disability insurance benefits folder and the original form will be returned to the originating station.

2.04 CHECK FOR STATUS

If the correspondence contains an alleged or indicated beginning date of total disability, the Claims Examiner will ascertain if insurance was issued and if it was in force on or near the date of total disability by checking the effective date of the policy on the insurance application and/or VA Form 29-5886b, Insurance Record Printout.

2.05 NO RECORD OF INSURANCE

a. [When it is established that] there is no record of [the veteran having] insurance, the general clerk will [return the claim with] a letter to the [claimant attempting] to determine if an application for insurance [has been] submitted. [An alpha file will not be established.]

b. [If the claimant returns the claim with an award letter and] the veteran is ineligible to apply for RH insurance, a letter will be released [explaining] the reason the veteran is not eligible to apply for new insurance. [The award letter and claim will be returned to the claimant.]

2.06 RH INSURANCE NOT APPROVED

When a claim is received with the RH application and the insurance is not yet approved, a waiver diary will not be inserted in the temporary master record. No action will be taken until the RH application is approved and insurance is issued. However, in tentative decision actions taken after medical approval of flee application for RH insurance but before the insurance is issued, a waiver diary will be inserted for control purposes during development of the claim for waiver of premiums.

2.07 RELEASE OF CLAIM FORM

If insurance has been issued, a claim form will be sent with a cover letter containing the requirements for total disability benefits. If the correspondence requesting the claim form contains a request for additional information which is not provided in the covering letters, or if the insurance has lapsed, a letter will be prepared which gives the additional information requested and the date of lapse, when necessary.

2.08 ESTABLISHMENT OF FORMAL CLAIM

If the correspondence contains enough information, upon approval of the supervisor, a pending claim should be set up as provided in existing instructions.

2.09 BEGINNING DATE OF TOTAL DISABILITY ON "J" CONTRACT (VETERANS REOPENED INSURANCE-POLICIES WITH LETTER PREFIX J, JR, JS)

Whenever a new claim on a "J" policy is received, the Claims Examiner will ascertain that the insurance was in force on the date of the alleged disability. If it appears that the insured may have been totally disabled from a date prior to the effective date of the "J" contract, development should be taken to clarify this point. The development will include a request for the claims folder.

2.10 XC-CASE, THIRD PARTY INQUIRY

When the correspondence indicates the insured has died and a third party is inquiring about his or her possible entitlement to disability benefits during his or her lifetime, the appropriate letter will be prepared explaining the criteria for waiver when an insured has died. (See M29-I, pt. I, pars. 31.16d and e, 31.19d, 31 .20b, 31 .35d and 31.38.) If the insurance lapsed prior to death, the date of lapse should be included in the letter. It is particularly important that a claimant be informed that adequate proof of total disability of at least 6-months' duration be of record within 1 year from the date of the insured's death.

SUBCHAPTER 2. FORMAL CLAIM

2.11 ASSOCIATION WITH PROPER RECORDS

a. When VA Form 29-357, [ ] Claim for Disability Insurance Benefits, is received in the Insurance Claims Section, it will be referred to the Claims Examiner with the DIB (disability insurance benefits), and the insurance folder. The name and birth date on the form will be checked against VA Form 29-5886b and original application for insurance to verify that the claim has been associated with the proper records. The address on the claim form will be checked against the record printout and insurance records and any change will be noted.

b. If the discrepancy is not to be clarified, the date of birth recorded on the insurance records at the time the discrepancy is discovered will be retained for subsequent transactions.

c. If the date of birth discrepancy does not change the insurance age, it will not be clarified unless the plan of insurance is Modified Life, or there is a total disability income provision involved, or there is a question of whether total disability commenced before age 65.

d. If the (date of birth] discrepancy is to be clarified, the claims [examiner will release FL 29-286, and insert a diary for 60 days.

e. When the letter is being released due to a possible older age, the difference in premium or reserve calculation required for the letter will be furnished by the Adjustment Claims Clerk. (See M29-l , pt. I, par. 22.03.)

f. If it is necessary to correct the date of birth and the premium, the Adjustment Claims Clerk will make the necessary adjustment and correct the master record. (See M29-1 , pt. I, ch. 22.)

2.12 DATE OF RECEIPT OF CLAIM

The Claims Examiner will check to see that the correct date of receipt of claim is reflected on the record printout and VA Form 29-1565-3, Decision Disability Insurance Benefits. Date of receipt of claim is the date upon which the claim was first received in any VA agency. If the date of receipt of claim is not correctly shown on the insurance record printout, VA Form 29-524, Waiver Diary, should be inserted to make the correction.

2.13 STATUS CHECK

The status of the insurance will be reviewed and any lapses and reinstatements since the alleged beginning date of total disability will be noted on VA Form 29-1565-3, in the right side of the first "Remarks" block.

2.14 INITIAL REVIEW OF CLAIM FORM

If the claim is not accompanied by evidence or if the evidence is not sufficient to establish total disability for the period alleged, the Claims Examiner will request the appropriate evidence. If there is

doubt as to whether additional evidence is necessary, the Authorizer or Senior Authorizer should be consulted.

2.15 UNSIGNED CLAIM

If a claim is unsigned, the Claims Examiner will send an industrial report to the insured. By this procedure a current industrial report is obtained as well as the signature of the insured. The unsigned claim form will be considered an informal claim for purposes of extension of time. See M29-l, part 1, paragraph 31.19, subparagraphs a, c and d, for those persons who may file a valid claim for disability insurance benefits. If a claim fond is unsigned and is accompanied by correspondence signed by or on behalf of the insured, it will not be necessary to obtain a signed VA Form 29-357 [ ] - When a signed claim form is requested, it will be assumed that it will be received and the Claims Examiner will initiate the preliminary development immediately.

2.16 PREMATURE CLAIM

a. When less than 6 months have elapsed since the alleged beginning date of total disability and the claim is not accompanied by sufficient medical evidence to establish a beginning date of total disability, the medical and/or industrial evidence to determine this date will be developed immediately. When evidence indicates the onset of total disability from a date earlier than alleged, the development should include the earlier period. If the evidence is sufficient to establish a beginning date of disability and 6 months have not elapsed since the date, the Claims Examiner will refer the case to an Authorizer or a Senior Authorizer.

b. When a claim is received on Service-Disabled Veterans Insurance (RH) and file evidence is sufficient to establish a beginning date and 6 months have not elapsed since the effective date of the insurance, FL 29-580 will be released informing the insured that action will be taken the claim at the end of the 6-month period. The appropriate input document, VA Form 29-5895c, Waiver Diary Action, should be prepared with the message PRMCL and the callup date on VA Form 29-5886b changed to the date at the end of the 6-month period. In cases involving RH term plans, the Claims Examiner should take special care not to set up a claim as premature on the basis of the effective date of the policy shown on the record printout alone. The effective date of the policy shown on the original application should be checked to determine if the insurance has been in force for 6 months.

2.17 CLAIMS THAT APPEAR READY FOR DECISION

If the claim form contains sufficient evidence to prepare an award, the Claims Examiner will refer the case to the Authorizer or Senior Authorizer (see ch. 4).

2.18 DEDUCTION FROM BENEFITS CASES AT VA CENTER, ST. PAUL

If a claim has been received in the St. Paul VA center requesting waiver of premiums on an RH policy and an insurance deduction authorization or allotment is of record, the claim for waiver will be mailed to the Philadelphia VA center.

SUBCHAPTER 3. ESTABLISHMENT OF TOTAL DISABILITY

2.19 REQUIREMENTS TO ESTABLISH

In order to establish total disability it will be necessary to obtain evidence which will show:

a. That the insured is prevented from following a substantially gainful occupation by a physical or mental condition.

b. The period of the time during which this condition prevented him or her from following such occupation.

2.20 AVOID DUPLICATION OF EVIDENCE

While both the medical and industrial aspects of the case should be developed simultaneously, an attempt should be made to avoid duplicating evidence that was submitted with the claim.

2.21 DILATED LETTER

While most evidence will be obtained through appropriate form letters, care should be taken to ensure that the form letter being used will obtain the evidence that is desired. If there is a doubt as to whether a form letter will be sufficient for the evidence desired, a dictated letter will be used.

SUBCHAPTER 4. MEDICAL EVIDENCE

2.22 AMOUNT NEEDED

The medical evidence should be sufficient to show the existence of a disabling condition from the time total disability is alleged to have commenced through the present time or, if total disability is ended, through the period of total disability. It is not necessary to document the entire period of disability if the veteran is suffering from a chronic severe condition.

2.23 VA AND MILITARY HOSPITAL REPORTS

Whenever possible, evidence of treatment in VA or military hospitals should be obtained first in preference to reports from private doctors or hospitals. The request for VA or military hospital records should be made on the appropriate form letters. They should specify the period for which evidence is desired. In obtaining medical information, the primary purpose is to ascertain objective medical findings. These can be obtained from inpatient rather than outpatient reports. The outpatient rents are of limited value in ascertaining the nature and extent of the disabling condition and should be avoided on initial development, unless there is no record of any other treatment. If application has been made for compensation or pension benefits and it appears that the VA and service medical record may be of record in the claims folder, the folder should be requested from the regional office.

2.24 PRIVATE MEDICAL REPORTS-NOTIFICATION OF CONTACTS TO VETERAN

If there is no record of any VA or service treatment, reports may be requested from private doctors or hospitals. It should be kept in mind that hospital reports will tend to be more comprehensive than private medical reports. The requests for this information should specify the period of treatment necessary. A request to a private doctor or hospital should contain a notation that the claim form signed by the insured authorized the release of information. If information is being sought from private doctors, hospitals or employers, a form letter should be sent to the insured, listing those contacted. The letter should also ask the insured to urge a prompt reply from the concerned parties.

2.25 REQUEST FOR EXAMINATION

a. A VA examination should ordinarily not be requested at the time of the initial development. An examination should not be requested to determine current total disability until reports of all pertinent medical treatment have been obtained and reviewed. If, on the basis of these reports, a determination cannot be made as to whether the insured is currently totally disabled, an examination may be requested.

b. If the Claims Examiner determines an examination is necessary, written advice of the Medical Consultant must be obtained. In addition, the Medical Consultant will be consulted as to the specific examinations and tests that may be necessary on each individual case. This information will be requested on VA Form 29-482, Request for Medical Opinion.

2.26 DEVELOPMENT OF BEGINNING DATE OF TOTAL DISABILITY

In some cases an insured will allege total disability from a date which had no relevance for purposes of making a finding of total disability, such as the commencing date of his pension or compensation award. In such cases where the evidence indicates that total disability may have commenced prior to the date alleged, the initial development should cover the entire period of apparent disability.

SUBCHAPTER 5. INDUSTRIAL EVIDENCE

2.27 DETERMINING THE NEED FOR ADDITIONAL INFORMATION

The question of whether additional industrial evidence should be obtained to verify the last day of substantially gainful employment is dependent upon the facts in each individual case. If the evidence on the claims form indicates a disability which appears to be severe and continuous from the date alleged and such disability is documented by medical evidence of record or can be documented by obtaining reports of treatment shown on the claim form, it is not necessary to obtain additional employment evidence. When the ending date of employment is not given, is unclear, or when it appears that disability may have commenced before the last date of employment, clarifying information should be obtained. When it appears that gainful employment may have been engaged in after the alleged date of disability, the nature of this employment should be developed.

2.28 SELF EMPLOYMENT

When the evidence indicates self-employment, part time employment or when there is an indication that the employment may not have been competitive, additional evidence must be obtained. In this regard see M29-1, part I, paragraphs 31.12, 31.13 and 31.15.

2.29 TOTAL DISABILITY ALLEGED NEAR 65TH BIRTHDAY

When total disability is alleged from a period within several days of the insured's 65th birthday, it will be necessary to obtain precise information as to the last day the insured worked in a substantial and gainful capacity and whether his physical condition prior to his or her 65th birthday prevented him or her from carrying out any substantially gainful occupation.

SUBCHAPTER 6. REQUEST FOR CLAIM FOLDER

2.30 RECEIPT OF CLAIMS FOLDER WITH WAIVER CLAIM

If the claim folder is received with the claim the case will be referred to an Authorizer or a Senior Authorizer.

2.31 WHEN CLAIMS FOLDER SHOULD BE REQUESTED

If the claim folder does not accompany the claim and the evidence of record is not sufficient to support a finding of total disability, the claim folder will be requested, if it appears that it may contain pertinent evidence. The request will be made on VA Form 07-7216a, Request For and/or Notice of Transfer of Veterans Records. If the claim folder is requested, attempts to obtain additional evidence from either VA or private medical reports should be withheld until it is determined that such evidence is not already of record in the claim folder.

SUBCHAPTER 7. FRAUD INDICATED AT INITIAL DEVELOPMENT

2.32 DEVELOPMENT FOR FRAUD

The Claims Examiner will have the responsibility for reviewing the insurance file at the time of initial development for any indication of possible fraud. If, in his or her opinion, the possibility of fraud exists, the case will be referred to the Authorizer or Senior Authorizer.

SUBCHAPTER 8. INPUT DOCUMENTS

2.33 PREPARATION OF INPUTS

a. VA Form 29-5895a, Pending Transaction Input Card, or VA Form 29-8526, Pending Transaction, will be used to maintain on-tape control of a case, if necessary, when a claim form has been released to the insured. A 30-day diary is standard with the message 357c.

b. VA Form 29-5895c, Waiver Diary Action, will be used to insert the message PRMCL to change the callup date to the end of the 6-month period.

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CHAPTER 3. DEVELOPMENT OF ORIGINAL CLAIMS

SUBCHAPTER 2. CLAIMS FOLDER

SUBCHAPTER 3. MEDICAL INFORMATION

SUBCHAPTER 4. INDUSTRIAL INFORMATION

CONTENTS CONTINUED

DEVELOPMENT OF ORIGINAL CLAIMS

A. Change: M29-l, Part III, Chapter 3.

B. Procedure: Insert the following after Paragraph 3.04b:

c. The VA Form 21-6796, Rating Decision, usually describes the disease or injury which the veteran has claimed is causing his/her disability for insurance benefits and the findings. Also, at times the VA Form 21-6796 includes dates of treatment, examination or hospitalization which are useful in establishing the beginning date of total or total permanent disability.

d. When the VA Form 21-6796 contains sufficient information, it will be acceptable as evidence in support of a claim and used whenever possible as a basis for an immediate favorable decision. It must be signed by one or more members of the rating board. No claim should be medically denied based solely on the evidence in a rating decision.

New-or Revised
Insurance Forms: None w

Assistant Director for Insurance

DISTRIBUTION:

335/29 - 60
310/291 - 50
310/290 - 45
Library - l

CHAPTER 3. DEVELOPMENT OF ORIGINAL CLAIMS

SUBCHAPTER 1. GENERAL

3.01 REVIEW EVIDENCE AND DETERMINE ACTION

When evidence requested on initial development is received, it will be attached to the DIB (disability insurance benefits) file and referred to the Authorizer or Senior Authorizer. He or she will review the evidence and prepare a decision at the earliest possible date. He or she will request evidence when necessary when appropriate for instructional purposes, have the Claims Examiner request this formation.

___

SUBCHAPTER 2. CLAIMS FOLDER

3.02 BRIEF OF CLAIMS FOLDER

The Authorizer or Senior Authorizer will be responsible for reviewing the claims folder when it is received. A brief of facts will be prepared noting the information in the file which is pertinent to the claim. When necessary, photocopies of important evidence may be made and [filed with the brief on the right side of the insurance folder, or in the DIB folder if still in use.]

3.03 OBTAIN CLAIMS FOLDER IN POSSIBLE FRAUD

In all cases when there is a question of possible fraud, the claims folder will be obtained.

3.04 RATINGS AND SUMMARIES

a. If a rating or a summary of treatment for a specific period of time is desired, it should be requested by the appropriate form, addressed to the regional office where the claims folder is located, rather than requesting the entire claims folder for review.

b. If the claims folder and an abstract of VA outpatient treatment is needed, the request should be made on the same form with the address and period of VA outpatient treatment given.

SUBCHAPTER 3. MEDICAL INFORMATION

3.05 INCOMPLETE REPORTS

When an incomplete report has been received from a private doctor or hospital, a letter requesting the information which had been omitted will be sent to the source if, in the opinion of the Authorizer or Senior Authorizer, it is necessary for the adjudication of the claim.

CORRECTED COPY

3.06 INSUFFICIENT REPORTS

If medical evidence requested on the initial development is not sufficient for the purpose of establishing total disability and it appears that such evidence can only be obtained from private medical sources, it will be requested. The request should include any specific information that is desired by the adjudicator at the time the report is released. A letter will be sent to the insured, listing the names of the private doctors or hospitals being contacted.

3.07 REQUEST FOR FEE

When a private doctor or hospital requests a fee in connection with the preparation of a report, a letter will be sent informing him or her that the VA is not allocated funds to pay for such reports.

3.08 SECOND REQUEST

If no reply is received to requests for medical evidence from VA and military hospitals or private sources, it will be requested again with the notation *Second Request.* In cases concerning private medical reports, the insured will be notified of the second request for information and reminded that it is his or her responsibility to provide proof of disability in support of his or her claim.

3.09 VA EXAMINATION

a. If it is determined that a VA examination is necessary on a new claim, the request should be made by an Authorizer or Senior Authorizer. The Authorizer or Senior Authorizer will request a written concurrence from flee Medical Consultant. The Medical Consultant may suggest the specific examination and tests needed. In most cases, an examination will not be necessary if one has been conducted within the past 90 days. Upon receipt of the Medical Consultant's written approval, the examination will be requested on the appropriate form and routed to the regional office in the jurisdiction where the veteran resides.

b. The veteran's insurance file number, claim number, social security number and current address should be on the appropriate form. If there is no folder or if the claims folder is located in a regional office other than that in which the examination is to be conducted, these facts should be shown on the form.

c. The form should also contain a statement to the effect that if the insured does not report for the examination, or request a new appointment within 30 days, the form should be returned to the Insurance Center. If the insured fails to report, a letter will be sent advising him or her that an examination is necessary to reach a decision on the claim and if he or she does not request another appointment within 30 days, a decision will be made on the evidence of record. If the insured indicates a desire to report for an examination, another form will be sent to the regional office stating the insured is now willing to report for an examination. If the veteran does not report for this examination and the evidence is not sufficient to establish total disability for any period, the claim will be the evidence of record and the insured will be informed of the reason for the denial in a letter. If the evidence establishes total disability for a limited period, a decision will be prepared setting forth the dates of disability for the known and established period and granting or denying benefits accordingly. The veteran will be informed that total disability has been

found for the period that is known and established by the evidence of record and that a finding of continuous total disability cannot be made as he or she failed to report for an examination. The insured will be informed of the right to appeal and that the claim will be reconsidered if there is an indication of a desire to report for an examination.

3-2

7. A survey was conducted by Michael Dinney on Requests for Disability Exams (1570).

Recommendations: (We should follow them)

l. That the Insurance Division give the VARO working on the exam, 90 days in which to complete the exam.

2. Supervisors are to give training in processing disability exams and routing of ~9~~57~~~ as indicated in M-29, Part III, Par. 2.25 and VAC Circular 00-76-5.

3. In following up on the 1570, we should make a n FTS call to the Regional Office who has the jurisdiction of the case. We should make the call to VSD.

4. There were several suggestions given on how to make sure the VARO received our request. The decision is outlined as follows:

a. Make a paper diary for two weeks after you send the 1570, which will be handled by Bob Jones.

b. Call the VARO to make sure they have received the request. (Call the Veterans Services Division). If they have received the request, O.K.
If they have not received our request, see if they will take our request over the phone; if they will not, we must send another 1570.

c. This process of the Disability Exam should be given 90 days to be worked out,

d. When calling to make sure they received our request, see if you can get a date that the Exam is scheduled for. If you get that date, diary the case for a reasonable amount of time for the VARO to complete the paperwork and return it to us (about 30 days later).

FIELD EXAMINATION REQUEST

ORIGINATING OFFICE SOCIAL SECURITY NO. VA FILE NO./~$~ * ~ DATE Of REQUEST

VAROIC (310~297A)

NAME Of VETERAN

Chief, Insurance Claim Division
PO BOX 8079
PHILA., PA 19101
Director (27)

NAME Of CLAIMANT (above)

ADDRESS Of CLAIMANT

___

A
FACTS TO BE ESTABLISHED

In accordance with M 29-1 Part III, Chapter 5, Paragraph 5.11 a field Examination is required for the purpose of determining whether inured is still totally disabled for insurance purposes.

2. The insured has been found totally disabled since_____ because of _____

3. The insured has failed to respond to two employment-medical questionnaires. The law requires that the administrator periodically review the insured's continued entitlement to waiver of premiums.

4. Therefore, it is requested that a field examination be conducted to include the following:

a. Is the insured now working?

b. Has he worked in the past year?

c. Does he have plans for returning to work?

d. Is he attending school?

a. Has he been hospitalized or received medical attention during the past year?

5. If any of the above require detailed explanation furnish complete data for our use the examiner should furnish his impression as to the insured's mental stability including any symptomatology present.

6. It is suggested that the insured be interview, and if necessary, next of kin, neighbors, acquaintances, or persons in the business community, in order to couple your report. Your findings May give this office the information or evidence needed to finalize our adjudication.

7. The claim file is located at VA Regional Office.___, which is your jurisdiction.

JOSEPH MCCANN
Insurance Operations Division

3.10 OBSERVATION AND EVALUATION

If necessary, an insured may be hospitalized for purposes of observation. A request for such hospitalization will have the written concurrence of the Medical Consultant. The letter requesting the

hospitalization should be addressed to the Veterans Services Officer having jurisdiction over the insured's current address. The letter should specify the reason for requesting the hospitalization and the specific information that is desired.

3.11 ADVISORY OPINION BY MEDICAL CONSULTANT

The Authorizer or Senior Authorizer may request a written opinion from the Medical Consultant on the appropriate form as to what effect an insured's disability or disabilities will have upon his or her ability to pursue gainful employment. He or she may also request information about the effect of a particular condition on a person or request an interpretation of the results of medical tests. When there is a question as to the sufficiency of the medical findings, the Medical Consultant may be asked to give an opinion. If necessary, he or she may advise as to what further evidence should be obtained and if a VA examination is necessary, he or she should note the specific examinations and tests that are necessary. It should be remembered that any opinion by the Medical Consultant is advisory only. The final responsibility in making the determination of total disability rests with the Authorizer or Senior Authorizer. This is true in all cases even though in some situations, such as when there is a question of whether or not the insured has suffered the permanent loss of use of a member under 38 U.S.C. 714, the medical opinion will be given extra weight.

3.12 BEST EVIDENCE

In evaluating the extent and degree of any impairment, the *best evidence* is that obtained from hospitals or private medical doctors and current examination reports. In cases where this type of evidence is not available or is not sufficient on which to base a decision, lay affidavits may be requested from private parties who have knowledge of the insured's condition. These affidavits should include the relationship of the party to the insured during the period for which he or she is attempting to describe his or her condition. They should state how the insured's condition affected his or her daily activities, the type of subjective complaints the insured had and any symptoms which were visible to the party making the affidavit. When evidence contained in these affidavits is contradicted by the medical evidence of record, the weight that can be given them will be minimal. In cases where there is no medical evidence for the period involved, the value of the affidavit will depend upon the character of the affidavit his or her ability to have observed the insured and the extent to which he or she is capable of discerning the insured's condition or employment.

3.13 CIVIL SERVICE RETIREMENT RECORDS

a. When an insured has been retired from the Federal Civil Service due to disability, the medical evidence of record in connection with his or her retirement may be obtained by writing to the Bureau of Retirement and Insurance, Attention: Medical Division, Disability Retirement Section, U.S. Civil Service Commission, Washington, D.C. 20415.

b. The request should include the place of employment, starting and ending dates of employment, and the civil service retirement number of the insured. If the civil service annuitant number is unknown, include his or her social security number.

3.14 SOCIAL SECURITY MEDICAL RECORDS

Medical evidence which has been obtained by the Social Security Administration in connection with a claim by the insured for disability benefits from that agency, may be obtained when necessary. This evidence should only be requested when it is not possible to obtain it from any other medical source. It may be obtained from the Division of Benefits Services, Bureau of Disability Insurance, Social Security Administration, Baltimore, Maryland 21241 - The request should include the insured's social security number. If it is unknown, include any other identify the specific reports which are desired and contain a statement that the insured has authorized the release of this information.

3.15 SERVICE MEDICAL RECORDS

When service medical records including Retirement Board Proceedings and Records for Philippines Accounts are necessary in the adjudication of a claim, they will be requested. The types of records that may be obtained and the instructions for completing the request from may be found in MP-1, Part II, chapter 12 and appendixes. When the insured is discharged from service and there is a claim number of record, the claims folder should be reviewed first in an attempt to obtain this information.

3.16 FIELD INVESTIGATION

a. When a field investigation is necessary to fully develop medical and/or industrial aspects of a case, it will be requested on VA Form 27-3537a, Field Examination Request. The request should state the facts in the case, cite the evidence that is necessary and where the evidence may be obtained. It will be addressed to the Director of the regional office or center having jurisdiction of the area in which the insured was treated or employed, for the attention of the Veterans Services Officer. All requests will be signed by the Chief, Insurance Claims Section.

b. When it is necessary to conduct a field investigation in a foreign country where a VA regional office or center is not maintained, it will be requested in the form of a letter addressed to the Office of Special Consular Service, Department of State, Washington, D.C. 20521, Attention: Federal Benefits Section. The letter will contain necessary identification information and will set forth the facts to be established. The letter will also request that the proper consular officer be instructed to secure the desired information.

3.17 RESIDENT OF PHILIPPINES

When a claim is received from a veteran residing in the Philippines, requests for the specific medical reports or a VA examination will be directed to the Manila regional office. The claims folder can be obtained from the Manila regional office or Veterans Benefits Office.

SUBCHAPTER 4. INDUSTRIAL INFORMATION

3.18 RETAIL CREDIT

Services of the Retail Credit Corporation may be used when necessary.

VETERANS ADMINISTRATION
CENTER

WISSAHICKON AVE. AND MANHEIM ST.
P.0. Box 8079
PHILADELPHIA, PA. 19101

Attached is a consent statement signed by the claimant described below for disclosure to the Veterans Administration, the record of earnings, including the names and addresses of employers, for the quarters indicated.

This information is needed in connection with an initial claim for Government Life Insurance disability benefits.

R. MELZER
chief, Insurance Division
Enclosure

¶ NAME (First middle, last)

2 SOCIAL SECURITY NUMBER

3 DATE OF BIRTH (Month, day.year)

4 PLACE OF BIRTH

5 FATHER S NAME (First. middle, last)

6 MOTHER'S MAIDEN NAME (First, Middle, Last)

Period

Through

FL 29-723
MAR 1977

"To care for him who shall have borne the battle and for his widow and his orphan. "-ABRAHAM LINCOLN

VETERANS ADMINISTRATION
CENTER

J.

WISSAHICKON AVENUE AND MANHEIM STREET
P.0. Box 8079

it..

PHILADELPHIA, PA. 19101

Your claim for disability insurance benefits on your Government Life Insurance is being reviewed.

Additional information from the Social Security Administration as shown below is needed to support your claim.

However, the Social Security Administration will not release this information without your authorization. Please sign t e consent statement below and return it to this office. This information will be used in determining your eligibility for the maximum benefits allowed by law.

Permission for the release of this information is voluntary. No penalty will be imposed for failure to respond. However, the decision as to entitlement for the benefit you are claiming must then be made on the basis of the available evidence of record. This may result in delay of your claim or complete disallowance. Failure to provide information in connection with this claim will have no detrimental effect on any other benefit to which you are entitled.

Chief, Insurance Operations

CONSENT STATEMENT

I hereby authorize the Social Security Administration to disclose to the Veterans Administration the record (by quarters) of my places of employment, employer's addresses, and corresponding earnings for the period through

SOCIAL SECURITY NUMBER

DATE 0F **BIRTH (Month,** day, year)

SIGNATURE (Do not *print)*

NL 2~-724
MAR ¶~77

"To care for him who shall have borne the battle, and for, his widow, and his orphan. "-ABRAHAM LINCOLN

3.19 NEED FOR INDUSTRIAL INFORMATION

The determination of the last date on which the insured was able to follow a substantially gainful occupation is necessary to a finding of total disability and every effort should be made to determine such date as exactly as possible. When a decision is written, there should be evidence within 90 days of the decision that the insured continues to be employed. If there is evidence of continuing unemployment within 90 days and the evidence indicates the claimant may have returned to work since the date of the report, a current employment report should be obtained before preparing a decision.

3.20 METHOD OF REQUESTING INFORMATION

When additional industrial information is desired from an insured's employer, it will be requested by the appropriate form letter. When specific information about an insured's industrial activities are desired, a dictated letter may be sent to the employer.

3.21 TOTAL DISABILITY PRIOR TO FORMAL TERMINATION OF EMPLOYMENT

If an insured is unable to perform work due to illness for an extended period of time prior to formal termination of employment, he or she may be considered totally disabled during the period of those absences. If absence from work was due to illness for a substantial amount of time prior to treatment, it may be necessary to contact the employer and determine if the insured was able to perform normal duties without special assistance during the period he or she was able to return to work. The Authorizer should keep in mind that many times an insured will fail to claim total disability for a period during which he or she was unable to perform duties because of sickness prior to the actual termination of employment.

3.22 SOCIAL SECURITY REPORT OF EARNINGS

[a.] When all efforts to obtain adequate and accurate employment information from the veteran, his/her employers, or from other sources have been unsuccessful, [an FL 29-723] may be [sent] to the Social Security Administration, [ ] requesting quarterly earnings information. [Such correspondence will be kept to a minimum.

b. the FL 29-723, to be acceptable by the Social Security Administration, must be accompanied by a signed consent statement from the insured authorizing the Social Security Administration to disclose the needed information to the VA. (Xerox copy of the signed VA Form 29-357, Claim for Disability Insurance Benefits, is *not* acceptable.)

c. An FL 29-724 will be sent to the insured requesting authorization for disclosure of such information.

d. A VA Form 29-5895a or 29-8526, Transaction Type 008, will be used to insert a nonfreeze diary, with a 15-day callup date.

e. When the FL 29-724 is returned signed by the insured, it will be attached to the FL 29-723 and addressed to the Social Security Administration, Bureau of Data Processing, General Policies Staff (2-E-3), Dogwood East, Baltimore, MD 21235.

f. Remove the FL 29-723, 15-day diary and insert a nonfreeze diary for the FL 29-724 with-a 45-day callup date.]

3.23 SOCIAL SERVICE REPORT

A social service report may be requested when a detailed study of the daily activities of an insured is deemed necessary to make a determination as to whether total disability exists. The request will be in letter form prepared by the Authorizer or Senior Authorizer and addressed to the Director of the appropriate regional office or center, attention, Veterans Services Officer. The letter should explain the fact situation which creates the need for such a request and the specific information and contacts that are desired. The request should be concurred in by the Medical Consultant and the section chief.

SUBCHAPTER 5. CLAIM FOR BENEFITS ON AN N CONTRACT

3.24 REQUEST PHOTOCOPY OF PREMIUM RECORD CARD

When a claim for disability benefits is received and the only insurance issued was under an N- prefixed policy, the initial development will consist of a request for a photocopy of the VA Form 9-361 , Premium Record Card (discontinued), from the PC (Records Processing Center), St. Louis. The request will be made on VA Form 29-5714, Requisition-Photocopy/Folder Request-Temporary Charge Card. The premium record card shows the status of the account, and the date of lapse of the insurance can be determined from it. The premium record card also contains a notation if any waiver of premiums was awarded in the past and ilk date of termination of such an award.

3.25 DATE CLAIMED AFTER LAPSE

a. If total disability is claimed from a date after the insurance has lapsed, the claim will be disallowed without a decision and the claimant will be informed of the decision by a letter that will not include the appeal paragraph.

b. In making this decision, the provisions of VA Regulation 3407.3 (A) and (B) should be taken into consideration. If the insured became totally disabled in the second or in the first few days of the third month following lapse, the 61-days allowed eligible policyholders is, extended to the next business day of this period ended on a Saturday, Sunday or legal holiday.

c. If VA Regulation 3407.3 (B) does not apply and any of the insured's policies have, prior to lapse, accrued dividends, not then payable, and total disability has commenced before the anniversary date or if there were amounts due and payable to the insured on the date the insurance lapsed (end of the grace period for the unpaid premiums), determine if these amounts are equal to or exceed the monthly premiums due at lapse and thereafter under VA Regulation 3407.3 (A).

d. The provisions of the amended regulations may be applied if, on the commencing date of total disability, the insurance is in force under the extended term insurance provision (VA Regulations 3105 and 3429) and a policy loan was outstanding on the date of lapse or a dividend deposit balance was included in the cash value as determined at time of lapse.

e. If accrued dividends under amended VA Regulation 3407.3 (A) (I) and/or amounts due and payable under amended VA Regulation 3407.3 (A) (2) exist in connection will more than one policy of the same veteran and one or more policies lapsed prior to date of commencement of total disability, the amounts available will be related first to the policy or policies on which they arose if such policy or policies are lapsed. Any amount available under VA Regulation 3407.3 (A) (1) or (2) which is not required to place in force the policy upon which it

arose or which is insufficient to place in force the policy upon which it arose, may be combined with similar amounts available on any other policy whenever the total of such amounts is sufficient to place another policy in force.

f. When more than one policy is involved and credits are not needed or are insufficient to revive the policies) which the credits arose, the credits will be used insofar as they are sufficient to revive the policy or policies which the most insurance is payable.

g. No total disability income provision will be considered in force under this regulation unless it lapsed at the same time as the life insurance contract and both the life insurance and TDIP can be considered in force through the same date and benefits are payable under the total disability income provision. An exception will be a paid-in-full limited pay contract on which TDIP premiums continue to be due and payable.

h. When a TDIP lapsed at the same time as the life insurance, the premium for the provision will be considered separately in determining if the amounts available are equal to or in excess of the monthly premiums which have become die. In such a case if the amounts available are sufficient, both the life insurance and the provision will be revived. If the amounts are insufficient for that purpose, they will be

applied to revive the policy or policies providing the greatest life insurance and total disability benefit in total disability cases.

i. Accrued dividends and/or credits on any policy of National Service or United States Government Life Insurance held by the policyholder may be considered for the purpose of the amended regulation.

j. If none of the foregoing adjustments apply, determine if there were circumstances surrounding the lapse of the insurance or the subsequently rejected or disapproved reinstatement application which might form the basis for possible administrative adjustment. when it is believed circumstances of this type exist, the file and a statement of the facts should be submitted for consideration through proper channels.

k. If the insurance can be found in force, a memorandum or worksheet detailing the adjustment and the authority will be prepared and included in the insurance folder.

l. Accrued dividends or amounts due and payable prior to the last day of coverage, which cannot be used to place the insurance in force to the date of commencement of total disability, should be reported together with any other credits for disposition under existing procedures.

m. If it appears that the month of lapse and any later month could be considered paid if the date of commencement of total disability fell therein or within the following grace period, the report of status should include the statement-For disability purposes the lapse date shown can be advanced.

n. In such cases if the insurance Claim Section finds that total disability commenced when the insurance was lapsed according to the status report, it will return the file to the Policy Service Section. A covering memorandum will indicate the commencement date of total disability and request a decision as to the last monthly premium which could be considered paid under any authority.

o. Upon receipt of such a case, the Policy Service Section will cause the same action to be taken as in a death case and return the case to the Insurance Claim Section with a statement that the account can or cannot be found in force on the commencement date shown. A copy of the memorandum, including details and authority will be included in the insurance folder. When an award is made any necessary collection will be effected from the amounts payable to the insured or, alternately, liens will be established if necessary.

p. When it is possible to consider insurance in force to date of death or date of commencement of total disability, the master record will be updated (established if necessary) in the same way that the account would be adjusted if the amounts available or liens were applied in the regular course of business.

q. When the delimiting date for any application for the issuance, reinstatement, change or waiver of a Government life insurance contract, or any adjustment authority connected therewith, falls on a Saturday, Sunday or legal holiday, the time period will be extended to include the following workday. This basically reflects the amendment to VA Regulations 3031 and 3412.

r. The adjustments described herein for NSLI (National Service Life Insurance) are equally applicable for the revival of USGLI (U.S. Government Life Insurance). The amended regulations governing USGLI will be used as the authority for comparable adjustments. In the application of these adjustment authorities to USGLI accounts, whenever the words "Total Disability" appear, the words "Total Permanent Disability" are also implied.

3.26 DATE CLAIMED PRIOR TO LAPSE

If total disability is alleged from a date prior to the date of lapse, development will be undertaken to establish a definite period of disability. Since the N folders are not available for review, a dummy folder will be established.

3.27 REQUEST OF CLAIMS FILE

In cases in which it is necessary to establish a definite period of total disability, the claims folder will be reviewed. The necessary medical and industrial evidence to establish the period of disability will be obtained. Reports of medical treatment alleged in the distant past will be hard to obtain at times and a determination of total disability may have to be made on the basis of the evidence of record.

SUBCHAPTER 6. CORRESPONDENCE

3.28 CORRESPONDENCE ATTACHED WHILE CASE IS UNDERGOING ADJUDICATION

Correspondence concerning adjudication will be answered promptly and completely. If *NAN* (no answer necessary), it will be indicated by writing NAN on the correspondence. When mail requiring action by another service or division is attached to the folder while undergoing adjudication, action on the claim will be expedited.

3.29 CORRESPONDENCE WITH THE DEPARTMENT OF STATE AND PERSONS OUTSIDE THE CONTINENTAL LIMITS OF THE UNITED STATES

Correspondence within the subject categories will be processed as prescribed in VA Manual MP-1, part II, chapters 5,6 and 10.

3.30 FILING MATERIAL IN PROPER FOLDERS

All material relating to disability insurance claims except that which requires authentication or release will be filed on the [the right side of the insurance folder or in the DIB folder [if still in use]

CONTENTS

CHAPTER 4. ORIGINAL DECISIONS-NSLI

CHAPTER 4. ORIGINAL DECISIONS NSLI

4.01 RESPONSIBILITY OF PERSONNEL AS TO TYPES OF CASES

Except as modified hereafter, the Authorizer will have responsibility as to claims involving waiver of premiums only. The Senior Authorizer will have responsibility as to claims involving the total disability income provision.

4.02 FORMAT

a. Most decisions are written in memorandum style. A narrative decision will be written when judgment dictates that a recitation of the evidence is necessary to clarify the reason for the decision. A narrative decision may be written if necessary for training purposes, or as deemed advisable by the section chief.

b. Narrative decisions will be written in cases involving the renewal of N insurance, or in death cases when a favorable award is written which has the effect of maturing a lapsed policy. Also, a narrative decision will be written when judgment dictates that a recitation of the evidence is necessary to clarify the reason for the decision.

c. The narrative decision will when practicable, set forth the medical and industrial evidence in chronological order. Employment evidence will set forth such details as the hours worked per week, amount of earnings, time lost due to illness, any special supervision received in cases involving sheltered employment, and the reason for termination of work. Medical evidence will show the dates of treatment or hospitalization, objective findings and diagnosis, and when pertinent, the history, complaints and prognosis.

d. When necessary, there will be a separate paragraph as to timely filing of claim if it is an issue, or is responsible for the granting or denying of benefits. When necessary to explain the decision, there will be a separate paragraph giving the Authorizer's evaluation of the evidence and the basis for the decision.

4.03 EVALUATION OF THE EVIDENCE

a. In all cases, it will be necessary for the Authorizer to evaluate the medical and industrial evidence to determine how it effects the insured's ability to continuously follow a substantially gainful occupation. See M29-1, Part I, paragraphs 31.01, 31.l0 and 31.11.

b. Although medical reports are basic in claims work and close attention should be paid to the doctor's report of the insured's complaints, symptoms, findings, diagnosis and prognosis, the decision as to whether or not the insured is totally disabled should not be based upon the reporting doctor's opinion but should be based upon the Authorizer's analysis of the medical and industrial evidence and how it affects the work abilities of the particular insured. The doctor's opinion as to the extent of impairment is important but the decision as to ability to continuously follow a substantially gainful occupation is an administrative one and should be made by the Authorizer.

4.04 PREPARATION OF VA FORM 29-1565-3, DECISION DISABILITY INSURANCE BENEFITS

a. In the remainder of this chapter, the items will be discussed basically in the order in which the VA Form 29-1565-3 is to be completed.

Item	Entry Required
Claim No.	The C-number will be added to the form if it is available. If it is unknown, unknown will be shown in the item. If an incorrect number is shown, line through this and enter the correct claim number.
Date Received	The decision writer will verify that the date of receipt of claim shown on the machine produced VA Form 29-1565-3 is correct, if not, will amend the form accordingly. A notation as to the fact of informal claim and date received will be made if applicable.
Insurance File No.	Enter insurance file prefix and number.
Diary Control	Will be completed by inserting a 0 in VA Form 29-8313, Disability Benefits Questionnaire, is to be released. En ter a "3" if the form will not be released such as in a stat utory case. If there is a denial or disallowance, this item will be left blank.
Policy No.	Enter policy prefix and numbers on which the VA Form 29-1565-3 is being prepared.
Name of Insured	Insured's name.

Date of Birth	Check date shown on original insurance application and VA Form 29-357c (See ch. 2, par. 2.11.)
Method of Premium Payment	Insert one of the following codes: 0-Paid through premium-paying period. 1-Not in force. 2-Reduced paid-up. 3-Deduction from benefits. 4-Extended insurance. 5-Section 712 waiver. 6-Allotment. 7-Section 724 waiver (term). 8-Payroll deduction. 9-Direct pay.
C-File Examined	Complete appropriate box to show if the claims file was reviewed with the current claim.
Claim Filed By	Complete item to show who signed the form.
Total Disab. Alleged	Insert the date of alleged total or total and permanent disability as shown on the claim. include closed alleged periods if necessary.
Amount Insurance TDIP Effective Date	If these items have been completed by the system, no action is necessary unless some adjustment is made on the RPO (record printout) received with the VA Form 29-1565-3.

Item	Entry Required
Plan	Enter appropriate plan code. 1-Ordinary life. 2-20 payment life. 3-30 payment life. 4-20 Year Endowment. 5-Endowment at Age 60. (6-Endowment at Age 65. NSLI 7-5-LPT. 8-Mod Life at Age 65. 8-Mod Life at Age 70. 9-Reduced Mod Life at Age 65. 9-Reduced Mod Life at Age 70. -Replacement of the Mod Life 5-Endowment at Age 96 6- Endowment at Age 96 USGLI w/Waiver Rider

Age	Enter age of insured as of the effective date of contract.
TDIP Benefits	Indicate whether rider is $5 or $10.
TDIP Type	Enter appropriate TDIP Type 1-to age 60 2-to age 65 3-to age 65 (premiums continued until age 65 although the basic policy is paid up before).
Monthly Premium Rate Insurance TDIP	If these items have been completed by the system, no action is necessary unless some adjustment is made on the RPO received with the VA Form 29-1565-3.
Premiums Paid to Insurance TDIP	In all active cases, the (mo., day, yr.) *premiums paid to* blocks, will be machine printed. Where the account has lapsed, the actual lapse date will be entered. The date the extended insurance expires will be noted in the first *Remarks* block.
Disallowance of Claim Is Based on Decision	(1) Check the appropriate block to show if disallowed on the basis of a decision. State in the benefits awarded item that the claim is disallowed and the reason for disallowance. It is not necessary to write a memorandum or narrative decision to reach a finding as to total disability and the decision paragraph at the bottom of the form need not be completed. A decision on fraud must be made. (2) A case will be considered a disallowance as distinguished from a denial, when a certified letter is not sent to the insured or applicant. Essentially, a disallowance can be used when a claim shows on its face that there is no entitlement.

Item	Entry Required
Disallowance of Claim Is Based on Decision (Con.)	(3) The Claims Examiner may prepare and sign without other written

concurrence, the following types of disallowances not involving death cases or total disability income provision:

(a) When the insurance has lapsed, whether or not it is in force under extended insurance and there is no medical or other evidence of record to suggest the existence of a serious impairment at, or close to, the date of lapse and the insured alleged a date of onset of total disability subsequent to, and not close to, the date of lapse.

4% (b) When the claimant alleges a date of onset of total disability long after his or her 65th birthday and there is no medical or other evidence of record to suggest the existence of a serious impairment at or prior to the 65th birthday.

(c) When the claim indicates that the insured has returned to duty or to work within less than 6 months.

(d) When the insured alleges and the evidence of record indicates the o disability prior to the effective date of the insurance, except in cases invol insurance issued under 38 U.S.C. 722, or insurance reinstated or replaced under 38 U.S.C. 781.

(e) When waiver has already been granted as previously requested so that the current claim is a duplicate claim.

(9) When a claim has been filed and an application for insurance has been rejected so that no insurance has been issued.

(g) When there is no record of Government life insurance having been issued to the claimant.

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(4) The Authorizer or Senior Authorizer in their areas of responsibility will process other disallowance's. In addition to the type of claims mentioned above, they may prepare disallowance's when:

(a) Total disability is alleged and indicated after an endowment policy has matured.

(b) A limited payment life policy has been paid up.

(c) The supporting evidence clearly establishes that the insured has returned to work of a substantially gainful nature.

Item	Entry Required
Disallowance of Claim Is Based on Decision (Con.)	(d) Death occurs within 6 months of the effective date of an active RH policy. (e) In a death case, claim is submitted by someone who has no interest in the case as defined in M29-1, part l, paragraph 31.38.
Total or Total Permanent Disability Found From To	Insert the commenci disability. Complete if the awa closed period. Leave blank if an open awa Enter the date for the intermediate review. the date indic system will release VA Form 29-8313, D Benefits Questionnai purpose of the interm review is to determir ensured has returned substantially gainful employment.

_____

b. Section 602(n), of the National Service Life Insurance Act provided that when a claim was filed on or prior to August 1, 1947 , waiver could be granted for premiums becoming due within 5 years prior to receipt of a claim. When a claim is made prior to August 1, 1947, a waiver of premiums can be waived up to 5 years prior to the date of inability to file claim without having to investigate grounds for extension.

c. When claim is filed after August I, 1947, and the insured's failure to file claim on time was *not* due to circumstances beyond his or her control, or due to the failure of the VA Insurance Service to properly advise him or her of his or her right to file claim, 38 U.S.C. 712, prevents the waiving of any premium becoming due more than 1 year prior to receipt of claim. If there was an informal claim prior to the receipt of the formal claim, the 1-year period will be computed from the date of the informal claim. An informal claim does not cease to be such merely because the insured does not file formal claim within a certain period.

d. When the insured's failure to file claim on time is found to be due to circumstances beyond his or her control, or to be due to the incomplete action by the VA Insurance Service in failing to tell the insured of his or her right to file claim and the period of inability or date of incomplete action arose within 1 year subsequent to the first premium becoming due after total disability began, a completely favorable award may be written.

e. In instances when failure to file claim on time partially limits the award, the effective date of waiver will be computed by first determining the period of inability with the 1-year period prior to receipt of claim plus the period of inability which continued before and up to the 1-year period, and then computing a period of time prior to 1-year period which is equal to the total period of inability. The first premium becoming due on or after the beginning date of the 1-year period plus the period of inability will be the effective date of waiver.

f. When total disability is alleged or found more than 1 year prior to receipt of claim, except in special cases such as an RH policy when the effective date is within 1 year from the receipt of claim, a finding will be made as to timely filing of claim and will be entered on VA Form 29-1565-3 in the *Failure To File Claim Timely Excused* item. If there is a complete denial of any extension, or if there is a finding of inability from the beginning date of disability, the appropriate blocks will be marked. If there is a partial grant of this benefit, the date inserted after From will be the date from which inability has been established.

g. A finding that the insured's failure to file timely is not excused requires only the signature of an Authorizer. A finding that the insured's failure to timely file is excused in whole or in part requires the signature Supervisor

I

h. Any competent insured who has been requested two successive times to submit evidence or to state when he or she can report for medical examination and fails to do so without adequate explanation within 30 days from the date of the letter, or who fails to appear for an examination which is indispensable to a determination as to the existence or continuation of total disability, will be considered to have failed to cooperate. The finding of total disability will be based upon the evidence of record. If the evidence of record shows total disability for less than 6 months, the claim will be denied for that reason. If there is no evidence to support a finding of total disability for any period, the denial decision will be that the insured was not totally disabled.

Item	Entry Required
Premiums Waived Commencing Date	(1) When a favorable award is made, it will not be necessary to show earlier term periods of the insurance contract, even though the beginning date of the award is prior to the effective die of the term period on the VA Form 29-1565-3. (2) When a claim has been filed on time or an extension allowing completely favorable action

has been granted or the insured's failure to file timely claim was due to incomplete action by the VA, beginning date for waiver will be the date of the first monthly premium becoming due on or after the beginning date of total disability.

(3) An exception to this rule is when total disability commenced between the insured's 60th and 65th birthday. No premiums may be waived prior to January 1, l965.

(4) Waiver of premiums on permanent plans of insurance issued or reinstated under 38 U.S.C. 781 will be effective as to the premium due date in the month in which application for insurance is made, or commencing with the effective date of issue or reinstatement, whichever is the later.

(5) Waiver of premiums on RH insurance issued under 38 U.S.C. 722(a) may be granted pursuant to the provisions of 38 U.S.C. 712 and such waiver may not be denied on the ground that the service-disconnected disability became total prior to the effective date of the insurance. Unless otherwise barred, the beginning date of waiver would be the effective date of the policy. However, in order that there may be entitlement to waiver of premiums under 38 U.S.C. 712, total disability must be found to exist for 6 or more consecutive months after the date of application for, or the effective date of the insurance whichever is the later.

(6) Waiver of premiums on statutory awards are exempt from this 6-month rule. When the insurance under this section is granted with a retroactive effective date, the total disability must exist for 6 or more consecutive months from the premium due date in the month in which application is made. In those cases 2. Page 4-

5: Delete "c" and "d" and substitute the following :

c. When a claim is filed subsequent to August l, 1947, waiver of premiums becoming due more than one

5. year prior to the receipt of claim in the VA may not be granted in the absence of satisfactory evidence of circumstances beyond the insured's control which prevented his or her making timely claim,

M29-l, Part III
Advance Manual Change -

(1) Similarly, with timely applications filed by beneficiaries after the death of an insured, waiver of premiums becoming due more than one year prior to death may not be waived unless the Insureds failure to timely file claim was due to circumstances beyond his or her control. Circumstances or conditions which may permit, although not necessarily require a finding that the insured was prevented by circumstances beyond his or her control from filing a timely claim, may include mental or physical disability of such severe degree as to render the insured incapable of taking care of his or her affairs with reasonable prudence (physical disability which does not preclude the insured from directing another to act

for him (e.g. blindness, loss of hands) does not constitute circumstances beyond control); beleaguerment; besiegement and involuntary isolation; or when there are other unusual and extenuating circumstances which are a reasonable cause of the insured's failure to make timely application. Generally, the lack of knowledge of the nature of his or her disability is not to be regarded as a circum- stance beyond the insured's control. However, there are exceptions to this general rule. If the insured did not know that he or she was suffering from a deadly insidious disease until the terminal phase became apparent, the failure to timely file claim will be excused. If the insured lacks knowledge of the nature of his or her disability and does not realize how disabled he or she is, but tries unsuccessfully to work at a detriment to his or her health, the failure to timely file claim will be excused. If any VA Insurance activity receives information in writing that discloses the existence of severe disabilities and potential entitlement to disability insurance benefits and fails to apprise the insured of his or her probable rights to the benefits, such failure is deemed an incomplete action by the VA and, as such, constitutes extenuating circumstances that will excuse the failure to timely file claim. When circumstances beyond the control of the insured excusing the failure to file timely are found, waiver of premiums will be effective during the period of one year prior to the filing date plus the period during which he or she was prevented from filing.

(2) The appointment of a guardian does not change the problem with respect to timely filing of claim. Even though the guardian may neglect for years to file a claim on behalf of the insured, the test remains whether or not the insured was prevented from filing claim on time due to circumstances beyond his or her control.

d. Extenuating circumstances differ from an informal claim in that there is no intent, expressed or implied, to file claim for disability insurance benefits. The following are some examples of what will constitute extenuating circumstances unless action is taken by the VA to notify the veteran of possible waiver rights:

(a) Claim filed with Service Department;
(b) VA Form 29-4347 - Notification of incompetency or Appointment of Fiduciary;
(c) DD 214- Discharge shown as disability;
(d) Conversion application by guardian;
(e) Writing of any kind showing evidence of significant degree of disability.

(l) The following are some examples of what will not constitute extenuating circumstances or circumstances beyond the insured's control:

(a) Lack of knowledge;
(b) Not furnished copy of policy;
(c) Poor in English language - illiterate;
(d) Mail alleged not to have reached veteran;
(e) Evidence of alcoholism;
(f) Letter stating, "premium is late because 1 ~a~~~~ worked."

(2) When the insured's failure to file claim on time is found to be due to circumstances beyond his or her control, or to be due to the incomplete action by the VA Insurance Service in failing to tell the insured of his or her right to file claim and the period of inability or date of incomplete action arose

within one year subsequent to the first premium becoming due after total disability began, a completely favorable award may be written.

M29-1, Part III
Advance Manual Change No. 2-84 January 6, 1984

Chapter 4. Original Decisions - NSLI

A. Change: M29-1, Part III, Chapter 4, Subchapter 4. This advance manual change will clarify that waiver of premiums on RH insurance issued under 38 U.S.C. 722(a) may be granted pursuant to the provisions of 38 U.S.C. 712 and such waiver shall not be denied on the grounds that the service-connected disability became total prior to the effective date of the insurance or that the insurance is not in force for six months under premium paying conditions.

B. Procedure: 1. Page 4-5, delete under "Entry Required", (d).

2. Page 4-6, delete under " Required", (5) and substitute the following:

Waiver of premiums on RH insurance issued under 38 U.S.C. 722(a) may be granted pursuant to the provisions of 38 U.S.C. 712 and such waiver shall not be denied on the grounds that the service-connected disability became total prior to the effective date of the insurance or that the insurance is not in force for six months under premium paying conditions.

3. Page 4-6, delete under "Entry Required". (6).

C. New or Revised Insurance Forms: None

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Item Entry Required

Premiums Waived
Commencing Date (Con.)

when a waiver is granted on an RH policy because of a service-connected disability which preexisted the effective date of the policy, a statement will be added in the benefits award block immediately below the dates of the award as follows "38 U.S.C. 722(a)."

(7) When an insured is not entitled to a waiver on an RS policy because total disability began prior to the effective date and he or she drops the RS policy for RH insurance and the total disability is due to a service-connected disability which has continued for 6 or more consecutive months, he or she will be immediately entitled to waiver on the RH policy even though 6 months may not have expired from the effective date of the RH policy.

(8) When an applicants request for RH insurance has been withheld solely because it was not accompanied by the proper tender of money and assuming that waiver of premiums is otherwise in order, a favorable award of waiver of premiums may be granted, other action taken as indicated in this chapter, and then the file sent to the Medical Determination Section.

Premiums Waived
Next Premium After
Termination

(9) When total disability is found for a limited period, the ending date of waiver will be the last day of the premium month in which total disability ceases.

(10) When total disability continues to include the premium due date of the insurance month, the waiver will end the last day of that premium month.

(11) When insurance was made effective the 31st day of the month, the last day of each succeeding month will be the due date of the premium for that month regardless of whether it is a 28- 29- or 30-day month. Example: When waiver began on May 31 and the insured ceased to be totally disabled on April l 5, the last day of the waiver award would be April 29.

(12) When insurance is made effective February 28th, the monthly premium due date thereafter is the 28th and not the last day of the month. Example: When waiver began on February 28, and total disability ceased on December 15, the ending date of waiver will be December 27.

(13) Establishing of the ending date of a limited period of waiver to agree with the ending of the period of total disability is permissible not withstanding that a continuing award of waiver previously granted under another contract in the

same case may have been terminated, as of a date subsequent to the insurance month in

Item	Entry Required
Premiums Waived Next Premium After Termination (Con.)	which total disability ceased. An exception to this rule will exist when there is a specific claim under two contracts and the insured has reason to believe that he or she would be entitled to waiver on both contracts but when action on one contract was delayed. When necessary, a supplemental decision will be written to show the exact ending date of total disability.
Benefits Awarded Commencing Date	(l) Since the first payment is due on the 1st day of the 7th consecutive month of total disability, it is necessary that the insured be totally disabled for 6 months and 1 day in order to meet the minimum requirements of total disability for this benefit. Payments cannot begin earlier than 6 months prior to the receipt of required proof (due proof) as explained in M29-1, part l, paragraphs 31.34 and 31.35. (2) If the insured was prevented from filing claim at an earlier date due to his or her mental incompetency and provided a claim is filed during the period of mental incompetency or within 6 months thereafter, the date of receipt of required proof will be determined on the same basis as though the claim had been filed at the time the insured first became mentally incapable of filing a claim. (3) If required proof was already of record at the time the insured first became unable to file claim, the payment of benefits may not relate back more than 6 months prior to receipt of required proof. If the claim is not filed until more than 6 months after recovery from the mental capacity, the strict limitation of the required proof will apply. When required proof of a continuous total disability for 6 or more months is contained in the records of a VA hospital or service hospital or a non-service hospital when the insured was admitted as a VA patient, required proof of total disability will be regarded as having been received as of the date the claim for disability insurance benefits was filed, provided such records show existence of total disability for a period of at least 6 months as of the date of the claim. When the insured suffers from a

statutory total disability, there is no required proof limitation and the total disability income payments will begin on the 1st day of the 7th consecutive month of total disability. Reference is again made to M29-1, Part 1 paragraph 31.35.

(4) When a valid claim is filed by the beneficiary after the death of the insured, the monthly income payments may relate back to a date not exceeding 6 months prior to the insured's death. 4 ,

Chapter 4 - Original Decisions - NSLI

A. Change: - M29-1, Part III, Chapter 4. This advance manual change is required to clarify the procedure for determining the commencing dates of Total Disability Income payments. It is issued in conjunction with Advance Manual Change No. 10-83 for M29-1, Part I, paragraph 31.36.

B. Procedure: Paragraph 4.04, page 4-8, subparagraph (3), delete the fourth sentence. Add the following sentence to subparagraphs (4) and (5):

Reference is made to M29-1, Part I, paragraph 31.36.

C. New or Revised Insurance Forms: None

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Assistant Director for Insurance

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Item	Entry Required
Benefits Awarded	(5) However, in those cases in which the insured suffered from a statutory total disability, the beginning date of the first payment will be the 1st day of the 7th consecutive month after statutory requirements have been met.
Commencing Date (Con.)	(6) When it has been determined that the insured became totally disabled on a date prior to the effective date of issue or reinstatement of a total disability income provision under 38 U.S.C. 781 and other requirements are met, payments will commence the first monthly anniversary date of total disability following the date of issue of a reinstatement but in no event more than 6 months prior to receipt of required proof if statutory disability is not involved. (7) In those cases involving the total disability income provision when a favorable award is written more than 1 year after the beginning date of total disability as found by the decision, a finding will be made in the *Date Due Proof Received* item on VA Fond 29.1565-3 to indicate when due proof or required proof was received. See M29-1, Part I, paragraph 31.35. (8) The *Mo. Payment (TDIP)* block of the VA Form 29-1565-3 will also be completed when there is a favorable award. (9) It is not necessary to make any statement in the final decision paragraph that total disability has also been found under 38 U.S.C. 715. [(10) When the award date is more than 18 months, the award must be processed off tape].

i. An award of total disability income payments may be made to the insured, his or her court-appointed fiduciary when there is a certification from the Veterans Services Officer within the last 12 months, or his or her legal custodian, as appropriate. The appointment of a legal custodian by the Veterans Services Officer will not be questioned unless obviously in error. An award of total disability income-payments may not be made to a spouse payee. In those cases in which the Insurance Claims Section has found the insured to be incompetent, but the Veterans Services Officer has determined that the money may be paid directly to the insured, the case will be processed as though the insured were competent.

Item	Entry Required
Benefits Awarded Ending Date	The ending date of disability income payments will be the day prior to the due date of the next monthly in stallment following the date upon which total disability ceased.

When disability income payments are due on flee 31st day of the monthly, the date of termination will be the day prior to the last day of the month, regardless of whether it is a 28-, 29-, 30-or 31-day month.

Item	Entry Required
Extra Hazard Determination	A decision as to extra hazards is necessary in connection with an award of waiver of premiums on participating insurance such as N or V. The "Extra Hazard Determina tion" block will be marked "not due" or "due" as appropriate. It is not necessary in connection with a waiver on a non-participating policy such as H, RS, W, RH, J, JR or JS and an O will be marked above the "Not Due" check box. A finding that a decision is due to the extra hazards of service, or a reversal of a prior extra hazards decision requires the signature of the Authorizer and Senior Authorizer.
Severity Code	Insert one of the following:

Code		
0	Statutory	None
1	Monthly	Every Month
2	Quarterly	Every 3 Months
3	Semiannually	Every 6 Months
4	Three-Quarterly	Every 9 Months
5	Annually	Every I 2 Months
6	Sesquiannaully	Every 18 Months
7	Biennially	Every 24 Months
8	Triennially	Every 36 Months
9	No Mail	None (RPO generated on anni versary of TD effective date.) See "Review Date" listed below.

Review Date	(1) The review date will be a future date which would be the most appropriate time to review the case again upon the basis of then current industrial and medical evidence. The severity code and followup date are dependent upon the review date and they will be set with reference to a date when

it would be most appropriate to review the case solely upon the evidence of record. The followup date will ordinarily be midway between the date of writing the decision and the review date.

(2) The Authorizer may deviate from the general rule when assigning severity codes and review dates as each case is adjudicated on its own merit.

Disability Classification Code Primary and Secondary

(l) [Complete] only [the] primary disability classi fication code, [except when the] diary [message is EVID6MOS or PRMCL; then enter 0000 in the] "Sec ondary Disability Code" [block].

ORIGINAL DECISIONS - NSLI REVIEW DECISIONS - NSLI - WAIVER DIARIES

A. Change: M29-l, Part III, Chapters 4, 5 and 7.

B. Procedure:

l. Page 4-5, paragraph 4.04a, Item - Follow-Up Date under Entry Required delete the last subparagraph beginning with "Date" in its entirety and substitute the following:

Enter the date for the first intermediate review. On the date indicated, the system will release VA Form 29-8313, Disability Benefits Questionnaire. The purpose of the intermediate review is to determine if the insured has returned to substantially gainful employment.

2. Page 4-10, paragraph 4.04 i, Item - Severity Code under Entry Required delete "See Review Date listed below" and substitute the following:

(l) The Severity Code determines the interval at which the system will release VA Form 29-8313. The adjudicator has the option of setting the Severity Code based on the evidence in each case.

(a) A short interval between intermediate reviews (SC 1,2,3) should be set when there is a strong likelihood that the insured will return to substantially gainful employment.

(b) A more moderate interval between intermediate reviews (SC 4,5,6) should be set if there is reasonable likelihood that the insured will return to substantially gainful employment.

(c) A longer interval between intermediate reviews (SC 7,8) should be set if there is little likelihood that the insured will return to substantially gainful employment.

A no mail code (SC 9) should be used if there is only remote likelihood that the insured will return to substantially gainful employment.

Item	Entry Required
	(2) [ ] In statutory disabilities pursuant to the provisions of 38 U.S.C. 714 and 758, the code representing the effect rather than the cause will be reflected in the "Primary" block.
Policy No. Excluded	The policy prefix and the last three digits of the policy number of the policy to be excluded will be inserted.
Life Fund	Code is taken from the prefix of the policy not to be mistakenly taken from the file number prefix.

	V	5	K
2	RS	6	W
3	RH	7	J
4	H		

Mos. Not Due [for Refund]	The number of months not paid between lapse and rein statement.
Action Code	Item will be completed by inserting the appropriate codes as follows: 1-If there is a continuing waiver. 4 %-If there is an award for a closed period 4-If the action is being done manually. 5-If action completed by the system and FL 29-9a is suppressed.
Mo. Payment (TDIP) Mo. Payment (T&P)	These figures will be calculated and inserted by the Senior Authorizer making this award.
Batch No.	Filled in by ADP.
Remarks	Any remarks or instructions to the Adjustment Clerk If the claim is a partial denial enter "Denied" or "Dis allowed" (show alleged total disability date) (followed by reason for denial or disallowance).

Insured Represented	Indicate whether or not represented. If so, furnish the name of the organization.
Authenticated By	The Adjustment Clerk will verify the figures.
Date	Insert date authenticated.

j. The summary of evidence will ordinarily be limited to the date or dates of total or total permanent disability, the finding on fraud and on timely filing of claim and due proof, if pertinent.

Item	Entry Required
Principle Diagnosis(es) Employment Terminated First Treatment	These blocks will not be completed.
Principle Occupation(s)	The insured's occupation and the source of information will be shown.
Educational Background	The insured's highest level of education will be indi cated, including the source of information.
Date Due Proof Received	Insert the earliest date of receipt of such evidence in the VA, if applicable.
Failure To File Claim Timely Excused	Fill in the proper square indicating whether failure to file claim timely is excused and if, from what date.
Fraud Found	Indicate whether fraud is found.
Statutory Req. Met	(1) Refer to M29-l, part l, paragraph 31.02 for definition of statutory disability. When the question of statutory total disability is not involved, that item will be marked *N/A.* When the question of statutory total disability is involved but it is found that the requirements are not met, the item will be marked *not met* and the severity code, followup date and review date will be such as the Authorizer deems appropriate. When it is - determined that the requirements of statutory total disability have been met, the "Followup Date" and "Review Date" items will be marked "None", the "Severity

	Code" will be marked O and the "Action Code" and "Diary Control" character items will be marked 3. When the evidence of record is not sufficient to make such a determination, "deferred" will be inserted in the item "Statutory Req. Met."
	(2) In cases in which the loss of use of members or organs is involved, the Authorizer or Senior Authorizer will secure a written opinion of the medical consultant as to whether the insured's disability meets the statutory total disability requirements. The consultant's statement will be filed in the DIB folder. The Authorizer or Senior Authorizer will refer the decision to the assistant section chief for final approval.
Competency Information	(I) The Authorizer or Senior Authorizer will complete the applicable check box. If competency is not an issue, "NIA" will be inserted. Reference is made to M29-l, part I, paragraph 31.39. Whenever the Authorizer or Senior Authorizer is unable to make a' determination of competency at the time the award is prepared because of insufficient evidence, the "Competency Deferred" box will be checked. The Adjustment Clerk will insert a pending transaction for the unearned premiums and credits along with a frozen diary with the message

Item	Entry Required
Competency Information (Con.)	*Competency Deferred.* When development of compe tency or incompetency is completed, whoever made the original decision will line out the entry deferring compe tency and make the proper entry. The Authorizer or Senior Authorizer may make a finding of competency without any cosigners.
	(2) If there has been a prior court or rating board determination of incompetency and current evidence does not contradict the prior rating, the Authorizer may continue that rating of incompetency without a cosigner. An initial rating of incompetency or a finding of competency after prior court or rating board or Insurance Claims Section finding of incompetency, will require the signature of the Senior Authorizer.

(3) When the Insurance Claims Section makes an initial determination of incompetency, the Authorizer will prepare a VA Form 21-592, Request for Appointment of Fiduciary, Custodian or Guardian, in entirety, except for item 24, Amount of Accrued Benefits Due, and forward to the Adjustment Clerk to complete the block and take other necessary action. In those cases where there is evidence of an appointed fiduciary or evidence of an institutional award but there is no certification from a Veterans Services Officer within the past 12 months, the Adjustment Clerk will complete VA Form 29-505 "Request for Information", which will be sent to the Veterans Services Officer for a current certification.

(4) In those cases when the Insurance Claims Section has found the insured to be incompetent, but the Veterans Services Officer has determined that the money may be paid directly to the insured, the case will be processed as though the insured was competent.

Item	Entry Required
2d Remarks Block	When necessary a statement will be added to this block in the following instances: (a) When an award has been made on one policy and action deferred on a second because of possible fraud. (b) When an award is made pursuant to a reversal by the Board of Veterans Appeals. (c) Make an explanatory statement when the beginning date of waiver is limited pursuant to PL 88-364. (d) Make explanatory statement when an award is made pursuant to 38 U.S.C. 781.

Item	Entry Required
2d Remarks Block (Con.)	(e) Make such other remarks necessary to explain the action taken.

k. Whenever an Authorizer or Senior Authorizer makes a decision awarding insurance benefits and defers action on any element, such as possible earlier beginning date of total disability, extension of time,

or an extra hazard determination, the person who made the initial decision will be responsible for completion of the deferred element as soon as possible.

Item	Entry Required
Decision Paragraph	The decision paragraph will be completed to show: (l) A beginning date of total disability or that it is continuing. (2) A closed period of total disability. (3) That total disability does not exist.
Signature of Authorizer	(l) The Claims Examiner may sign a disallowance of a claim without any concurring signature. (See Disallowance of Claim Is Based on Decision). He or she may sign a favorable award of statutory total disability which is based upon the anatomical loss of two members without any concurring signature, except that the section chief or designee must sign if the insured's failure to timely file claim is excused, and Senior Authorizer must also sign if due to the hazards of service, or if there is an initial finding of incompetency. (2) The Authorizer will sign disallowances involving waiver only cases other than those types of cases specifically assigned to the Claims Examiner and will handle all types of disallowances if Claims Examiners are not present. A decision of denial involving waiver only will be signed by the Authorizer and the Senior Authorizer. (3) A favorable award of waiver of premiums will be signed by the Authorizer without concurring signatures, except (a) That the signature of the section chief or designee is required if it is held that the insured's failure to file timely claim was due to circumstances beyond his or her control, if a prior decision is reversed upon the basis of clear and unmistakable error, or if there is a revival of *N* insurance or favorable action is taken in a lapsed death case. (b) The signature of a Senior Authorizer is required when there is no prior court or rating board determination of incompetency and the decision holds that the Insured is incompetent, or there is a prior court or rating

(b) Invalid transaction-the folder will be withdrawn and the case referred to the Chief, Insurance Claims Section; e.g., How Paid .

(c) The VA Form 29-1565-3 which contains incomplete or erroneous Information. VA Form 298524, Waiver Diary, transaction type 078, will be prepared after the folder has been withdrawn and the original VA Form 29-1565-3 corrected.

(3) Rejects involving VA Form 29-462, Authorization for Insurance Payments, received from the Finance activity will have instructions attached. Rejects related to the erroneous or Incomplete preparation of VA Form 29-462 will be referred to the Adjustment Claims Clerk with instructions for their correction from the Finance activity. Reference will be made to MP-6, part III, supplement No. 2.5, for clarification of the instructions, if required.

e. If all information is correct, the Adjustment Claims Clerk will Initial the VA Form 4-5851 under the amount of the check to be released and file the form in the insurance folder. *NOTE: If the amount of monies dose not correspond to the information given on the VA Form 29-1565-3, the Chief, Finance activity will immediately be contacted by telephone to suspend any Future payments.*

Item	Entry Required
Signature of Authorizer (Con.)	board or Insurance Claims Section decision that the in sured was incompetent and the present decision holds that he or she is competent, and where the finding is that the disability is due to extra hazards of service, or there is a reversal of a prior extra hazards decision. A decision will not require the concurring signature of a Senior Authorizer merely because it is "unfavorable" due to its being a partial denial of the insured's claim.
Approval Date	The approval date will be inserted by the last signatory.
Signature of Senior Authorizer	The Senior Authorizer may disallow, deny or grant awards involving the total disability income provision without concurring signatures except as noted hereafter. A revival of a lapsed death case, or a finding that the insured's failure to timely file claim was due to circum stances beyond his or her control, or a reversal of a prior decision on the basis of clear and unmistakable error, will require the signature of the section chief or designee. A concurring signature of some other Senior Authorizer is required (1) Where there is no prior court or rating board determination of incompetency and the decision holds that the insured was incompetent, and the present decision holds that he or she is competent; and (2) When the finding is that the disability was due to the extra hazards of service, or there is a reversal of a prior extra hazards decision. In those cases involving waiver of premiums only which may be assigned to the Senior Authorizer, the requirements as to concurring signatures are governed by this section.
Signature of Section Chief	The signature of the section chief or designee is needed when it is determined that the insured's failure to file timely claim was due to circumstances beyond his or her control, when a prior decision is reversed on the basis of clear and unmistakable error, when there is a revival of N insurance, or favorable action is taken on a lapsed death case.

4.05 PARTIAL DENIAL

A decision will be regarded as a partial denial and therefore subject to appellate review if it denies at least 1 month's benefits either at the beginning or at the end of the period of total disability to which the insured or his or her representative alleged entitlement. A decision finding a closed period went the insured alleged continuing entitlement will not be considered a partial denial if the ending date of total l disability is subsequent to the date upon which the claim was signed. The fact that payment of total disability income benefits is limited by the due proof limitation does not, in itself, require the case to be considered a partial denial.

4.06 AMENDED AWARDS

a. When an amended award must be made in order to change the period of the award, it may be necessary to complete a new VA Form 29-1565-3 in longhand.

b. When the amended award is to reopen a previously closed award, the new VA Form 29-1565-3 will show in the award item "Amend: Prev.: Awd Term (date)"; the date shown will be the ending date of the previous award. A line will be drawn across the award box immediately below the foregoing phrase. The new award of continuing or closed period benefits will be shown immediately below the line. When the previous award is reopened and a continuing waiver is granted, a statement will be inserted in the top remarks area of the VA Form 29-1 565-3 to the effect "Waiver of premiums continuous from (date) the beginning date of the original award."

c. When the amended award is to change the beginning or ending dates of total disability, the new VA Form 29-1565-3 will show in the award item "Amend: Prev. Awd. Canc. (date)"; the date of cancellation will be the date of the previous award which is being canceled. A line will be drawn across the award box immediately below the foregoing phrase. The new award of continuing or closed period waiver will be shown immediately below the line.

d. When it is necessary to correct an award which has previously been authorized under an incorrect insurance number, it will be necessary to prepare a stop waiver terminating the award as of the effective date on the erroneously issued insurance. In those cases in which it is appropriate, the award on the new issue of insurance will include a statement immediately below the waiver award to the effect "Subject to prior refund under (FURNISH POLICY NUMBER)."

4.07 CONTROL OF INSURANCE AWARD PAYMENTS

a. A copy of VA Form 29-I 0, Transmittal List of Award Actions, will be made and maintained as a control log for establishment and resumption of insurance award payments.

b. The Control Clerk will retain a copy of the VA Form 29-1565-3 in a 5-workday suspense file.

c. Upon receipt of VA Form 4-5851, Insurance Award Statement, from the Finance activity, the Control Clerk will associate it with the corresponding VA Form 29-I 565-3 and forward the forms to the Adjustment Claims Clerk.

d. If VA Form 4-5851 is not received from the Finance activity within 5 workdays, the Control Clerk will prepare VA Form 4-8602, Insurance Awards Multiple Record Printout Request, for each VA Form 29-1565-3 in the suspense file at the end of the diary period.

(1) Upon receipt of VA Form 4-456, Insurance Award Record Printout, the Control Clerk will forward it to the Adjustment Claims Clerk for review.

(2) If reject cards are received from the Finance activity, the Control Clerk will refer them to the Adjustment Claims Clerk for processing. There are three major categories of rejects involving VA Form 29-1565-3. Reference will be made to MP-6, part II, supplement No. 1.4, containing the reason codes which facilitate the processing of rejects. The three categories are:

(a) No programming exists-the inputs will be prepared manually; e.g., 3-policy case.

CONTENTS

CHAPTER 5. REVIEW DECISIONS-NSLI

CONTENTS

CHAPTER 5. REVIEW DECISIONS-NSLI

4. Page 5-1, paragraph 5.02, delete paragraph 5.02 in its entirety; insert the following:

5.02 REGULAR REVIEW - PURPOSE

a. The purpose of the Regular Review is to determine if continued entitlement to disability insurance benefits is justified. The date of the first Regular Review is determined by the adjudicator at the time the original decision is prepared.

b. In conducting the Regular Review, the adjudicator assesses the evidence of record to determine if the insured has returned to substantially gainful employment or if the disability has improved sufficiently to permit return to substantially gainful employment.

5.03 REGULAR REVIEW - PROCEDURE

a. VA Form 29-83l3 will be prepared by the system when the Regular Review date is reached. It will bear the legend "Regular Review". when the form is received, it will be associated with the folder and routed to the Claims Examiner for adjudication.

b. if no reply is received within 45 days, a follow- up RPO (Record Printout) will be generated with the reason code Reg. Rev. The RPO and folder will be forwarded to the Claims Examiner and the failure to cooperate procedure will be followed. (Refer to par. 5.11)

4. Page 5-1, paragraph 5.02, delete paragraph 5.02 in its entirety; insert the following:

5.02 REGULAR REVIEW - PURPOSE

a. The purpose of the Regular Review is to determine if continued entitlement to disability insurance benefits is justified. The date of the first Regular Review is determined by the adjudicator at the time the original decision is prepared.

b. In conducting the Regular Review, the adjudicator assesses the evidence of record to determine if the insured has returned to substantially gainful employment or if the disability has improved sufficiently to permit return to substantially gainful employment.

5.03 REGULAR REVIEW - PROCEDURE

a. VA Form 29-8313 will be prepared by the system when the Regular Review date is reached. It will bear the legend "Regular Review". When the form is received, it will be associated with the folder and routed to the Claims Examiner for adjudication.

b. If no reply is received within 45 days, a follow- up RPO (Record Printout) will be generated with the reason code Reg. Rev. The RPO and folder will be forwarded to the Claims Examiner and the failure to cooperate procedure will be followed. (Refer to par. 5.11)

CHAPTER 5. REVIEW DECISIONS-NSLI

SUBCHAPTER I. TYPES OF REVIEWS

5.01 INTERMEDIATE REVIEW-PURPOSE AND PROCEDURE

The primary purpose of the intermediate review is to check the industrial status of the insured. All intermediate review VA Forms 29-8313, Disability Benefits Questionnaire, received will be referred directly to the Insurance Claims Section without the folders. The General Clerk will review the forms, checking to see that lines 1 through [4] of Part I are answered "No" and that the forms are signed and dated. If all answers are "No", the forms will be reported for disposal. [ ] VA Form 29.589c [Waiver Diary Action] with transaction type 078, will be prepared to change the diary date. The diary control character will be Shown as a "0" which will trigger the release of VA Form 29-8313 at a future date. (See MP-6, pt. 11, supp. No. 2.2, for further instructions on the preparation of VA Form 29-5895c.) When VA form 29-8313 is received with one of the first three questions of Part I checked "Yes," without line 1 of Part I com pleted, or and there is no written signature of-the insured on the envelope, the General Clerk will route the VA Form 29-8313 to the Claims Examiner who will determine if the folder is necessary for review. If forms indicate possible substantial employment the examiner will request the folder by submitting VA Form 23-5713, Folder Charge Card. When a VA Form 29-8313 is received at the time of an intermediate review unsigned and the envelope bears the written signature of insured it will be attached to the folder and processed as if the form were signed.

5.02 REGULAR REVIEW-PURPOSE AND PROCEDURE

a. The purpose of the regular review is:

(1) To determine if continued entitlement to disability insurance benefits is justified by the industrial and medical evidence of record.

(2) To set a future date of review or to terminate benefits in the event it is found that an insured is no longer totally disabled.

b. VA Form 29-8313 will be prepared by the system when the regular review date is reached. The VA Form 29-8313 will bear the legend "Regular Review." If no reply is received within 45 days, a followup RPO (record printout) will be generated with the reason code *Reg. Rev.*

c. The RPO and folder will be forwarded to the Claims Examiner and a Second Request will be initiated. The second form will be conspicuously noted "Second Request" and released clerically by the "Claims Examiner." In cases involving guardianship, a copy of the VA Form 29-8313 will also be sent to the Veterans Services Officer of the appropriate VA regional office. The RPO will be noted to show the action taken, dated and filed in the DIB (disability insurance benefits) folder. No action will be taken to change the diary at this time since a repetitive RPO will be generated in 45 days. Upon receipt of the second RPO, the folder will be obtained and referred to the Authorizer for review. The Claims Examiners are responsible for the development of evidence in connection with review decisions, except in cases involving TDIP (total disability income provision) benefits or in cases assigned by the Unit Supervisor to the Authorizers and Senior Authorizers for review decisions. When VA Form 29-8313 is received at the time of regular review, both the VA Form 29--8313 and RPO will be associated with the folder and routed to the Claims Examiner for adjudication. The date of the next review will be determined by the medical record and employment history. The determination must be made on flee basis of the facts in each individual case.

SUBCHAPTER 2. BENEFITS TO BE CONTINUED

5.03 PROCEDURE

If benefits are to be continued, a VA Form 29-808b, Review Decision of Disability Insurance Claims, will be prepared in longhand by the Claims Examiner. At the time of the initial review of VA Form 29-8313, items 1 through 4 of VA Form 29-808b will be completed. Item 5A, Remarks, can be left blank unless it is felt that an explanation is necessary. "Doc 4" will be annotated in item 5A and then after every subsequent review indicating that VA Form 29-8524 [, Waiver Diary,] will be prepared to change the diary control character and advance the review date. The severity code will initially be shown above item 5B and then after every subsequent review. Item 5B, Date of Next Review, will reflect the future review date. Item 5C, Approved By, will bear the signature of the Claims Examiner and title. Item 5E will show the date of review. Whenever continuance of an award is authorized on VA Form 29-808b, destroy all intermediate VA Forms 29-8313's that may be filed in the folder.

(b) Line 4, sentence 4, delete and insert the following:

"Doc 12" or "Doc 04?t will be annotated in item 5A and then after every subsequent review indicating that the scanner input portion of the VA Form 29-8313 or VA Form 29-8525, Waiver Diary, will be prepared to change the diary control character and advance the review date. RPO's will be Diary, will be prepared to change the diary control character and advance the review date.

When a statutory determination has been deferred as to whether the loss may be considered permanent, a review will be made at a time deemed appropriate. If necessary, reviews will be made at appropriate intervals until it is determined that there is no reasonable doubt as to permanency. When it is so determined, the Authorizer or Senior Authorizer will line through the word "deferred" in the item entitled "Statutory Req. Met" on VA Form 29-1565-3 [Decision Disability Insurance

Benefits,] and will show either the date when statutory total disability requirements are met or the entry "Not Met," followed by Authorizer's initials and date. If the findings of statutory total disability results in the granting of additional benefits, an amended award will be prepared. When a finding of statutory total disability was not deferred at the time of the original decision awarding insurance benefits and it is later determined that the insured is statutory totally disabled, the Authorizer or Senior Authorizer with the concurrence of the Section Chief or designee will authorize decision of statutory total disability on VA Form 29-808b showing in the appropriate "Remarks" item a statement 19 the effect that the evidence of record establishes that the insured's disability meets the statutory total disability requirements. In arriving at the decision, the Authorizer will secure a written opinion from the Medical Consultant as to whether the insured has suffered the permanent loss of use of members or organs. At this time, VA Form 29-8524 Doc 4, will be prepared to insert the statutory code as the primary disability classification code and the changing of the diary control character to 3 and the severity code to "0."

5.06 INDUSTRIAL REVIEW

a. When the insured suffers from impairments which are so severe in degree and so chronic or progressively deteriorating in nature that there is reasonable certainly that he or she will remain totally disabled, the case will be termed "Industrial Review." Age and length of the period of total disability are factors to be considered in deciding if the case is to be marked "Industrial Review." If a case meets "Industrial Review" criteria, it will not

thereafter be necessary to review the case other than as interim or clerical review. A case may be made "Industrial Review" either as an original or as a review decision.

b. The following are guidelines to be used in determining if a case should be marked "Industrial Review." The guidelines are not to be applied automatically. The types of cases which may properly be considered for classification as "industrial Review" are:

(l) Those cases in which the insured has been totally disabled for 10 or more years.

(2) Those cases in which the insured has been totally disabled for 5 or more years and is over age 60.

(3) Those cases in which the insured suffers from severe impairments of such chronic or progressively deteriorating nature that there is reasonable certainty that the insured will not improve and must be considered totally disabled if the insured is not, in fact, continuously following a substantially gainful occupation.

c. When the Authorizer or Senior Authorizer considers the case to come within one of these classifications, he or she will write "industrial Review" in the Remarks item of VA Form 29-1565-3, set the review date for the end of the 19th year of total disability or at the end of the premium-paying period, whichever is earlier, and will indicate a severity code 7 calling for interim or clerical review every 2 years. In review cases, "industrial Review" will be stamped on the VA Form 29-808b in items 5A through 10A whenever appropriate. it must be remembered that these cases will not be placed in this category automatically. If development, medical or

otherwise, is indicated at this review, such development will be taken as in any other regular review.

5.07 ANNIVERSARY OF THE 19TH YEAR OF TOTAL DISABILITY

On the anniversary of the 19th year of total disability, an RPO will be generated with the Reason Code STAREV (statutory review is the next callup). At this time, the Claims Examiner will review the insurance DIB folder ensuring that all is in order to becoming a 20-year case. The Claims Examiner will:

a. Verify the date of total disability on the VA Forms 29-1565-3 and 29-808b and the RPO for correctness.

b. See that there is no evidence of employment.

c. VA Form 29-8524, transaction type 078, will be prepared to change the callup date to the end of the 20-year period.

5.08 ANNIVERSARY OF THE 20TH YEAR OF TOTAL DISABILITY

On the anniversary of the 20th year of total disability, an RPO will be generated with the Reason Code STAREV and the message "Statutory" in the callup date field. The insurance DIB folder will be reviewed by the Claims Examiner ensuring that the beginning date of total disability is correct. The RPO will be initiated, dated and filed in the right side of the insurance folder or in the DIB folder if still in use and returned to file. (See M29-1, pt. I, ch. 31, par. 31.32.)

SUBCHAPTER 3. BENEFITS TERMINATED

5.09 RETURN TO GAINFUL EMPLOYMENT

Whenever a VA Form 29-8313 is received which shows that the insured has returned to full-time employment, provided the possibility of statutory disability is not involved, the Claims Examiner will take the necessary action to terminate the award immediately. in cases in which TDIP (total disability income [provisions]) payments are involved, the Senior Authorizer will terminate the award.

5.10 MEDICAL

a. When there is a continuing award in effect and a review decision is rendered finding the insured no longer totally disabled for insurance purposes on the basis of evidence received subsequent to the date of the prior decision, the award will be terminated. (See M29-l, pt. I, ch. 31, par. 31.27.)

b. A finding of recovery from total disability may be based on industrial and/or medical evidence. When the finding of recovery is based on medical evidence alone, the medical evidence of record must be recent enough so that it establishes that the insured is presently capable of continuous substantially gainful employment.

5.11 FAILURE TO COOPERATE

Whenever an insured fails to reply to two employment questionnaires and neither request is returned by the Postal Service authorities as undeliverable, the Claims Examiner will refer the case to the Authorizer for a determination of termination of benefits on the basis of failure to cooperate. When the disabling condition is not mental, awards will be terminated when an insured fails to respond to two requests for employment information. Any deviation from this will require supervisory approval. When an employment questionnaire is returned unclaimed and there is an indication that the insured has disappeared, another VA Form 29-8313, conspicuously marked "Second Request," will be released to the latest address of record. Letters returned unclaimed should be filed with the envelopes on the right side of the insurance folder! DIB folder if still in use. The case will be diaried for a 45-day callup. If at the end of the 45 days no answer is received to the second request, the award will be terminated. If the insured's disability is of a mental or emotional nature, or if there are any other circumstances which would indicate that the insured might not be able to act in a responsible manner, additional development besides a second request VA Form 29-8313 (a copy being sent to the Veterans Services Officer) will be undertaken. The additional development could include a letter to the spouse or relative, Retail Credit Corporation report, Postal Service inquiries. In guardianship cases when no answer is received to a second request, a letter should be written to the Veterans Services Officer seeking assistance in getting a reply to the requests for employment reports. When total disability income provision payment is involved, the Insurance Awards Unit will be notified to stop payment if mail is returned unclaimed.

5.12 END OF PREMIUM-PAYING PERIOD

[a.] Continuing awards of waiver of premiums on 20-payment life, 30-payment life and endowment policies [will be terminated as the premium-paying period ends.]

[b. No intermediate or regular review of the insured's continued entitlement to waiver of premiums will be established for a date within 6 months of the date a policy reaches the end of the premium-paying period or matures.

c. When it is determined that no further review is required because the policy becomes paid up or matures, the waiver diary callup date and review date will be changed to the due date l month after the premium-paying period ends.

NOTE: The above is not applicable when there is one or more additional policies which will remain on waiver or the insured is receiving TDIP benefits.]

5.13 PREPARATION OF FORMS

a. The Claims Examiner, Authorizer, or Senior Authorizer when appropriate, will complete VA Form 29-1568, Review Decision-Termination, as follows:

		Self explanatory.
2.	Insurance File No.	Self explanatory.
3.	Name of Insured	Self explanatory.
	Correspondence and Symbol	Self explanatory.
5A.	Policy No.	Self explanatory.
5C.	Effective Date of Termination	Insert the day prior to the date of the next premium due following preparation date of this form. Refer to M29-l, part I, paragraph 31.27.
6.	Reason for Action	No longer totally disabled or failure to cooperate.
9.	C-File Examined	Self explanatory.
10.	Date of Birth	Self explanatory.
11.	Insured Representative	Indicate *Yes* or *No.* If *Yes,* name of organization.
13.	The decision is that the insured is shown to have recovered the ability to follow a substantially gainful occupation.	When continuing awards are terminated because of the insured's failure to cooperate, the decision should so state as follows: *The decision is that the insured has failed to submit and there is not of record, evidence to establish that the insured continues to be totally disabled.* (See M29-1, pt. I, par. 31.29.
14.	Approval Date	Date action is completed.
15.	Signature of Authorizer and/or Senior Authorizer	Self explanatory-type name in bottom of item.
16.	Signature of Section Chief	Self explanatory-type name in bottom of item.

b. When the reason for action is no longer totally disabled, the Claims Examiner or Authorizer, when appropriate, will prepare VA FL 29-22. The Claims Examiner will terminate the waiver when the termination is based on a return to full-time gainful employment or active duty. The Authorizer will terminate the waiver when termination is based on medical evidence which shows the insured has recovered the ability to return to full-time gainful employment.

c. When premiums were previously paid:

(1) Direct-the first block will be checked.

(2) By deduction from benefits-the second block will be checked informing the veteran that the deductions will be resumed. (The Adjustment Claims Clerk will prepare VA Form 29-5926, Request for DFB Action, input, generating a request to DPC Hines to resume deductions.)

(3) By deductions from retired or active service pay-the first block will be checked and a postscript, If you are receiving retired or active service pay and wish to pay future premiums by monthly Class N deduction from your pay, please let us know at once, will be added.

d. When the reason for action is failure to cooperate, the Authorizer will prepare:

(1) MTST tape U #10-if the veteran pays premium by direct pay.

(2) MTST tape U#11-if the veteran is paying premium by deduction from benefits.

(3) MTST tape U #12 or 13-if the veteran has a fiduciary.

(4) VA FL 29-351-if the veteran failed to report for an examination.

e. After an original and one copy of VA Form 29-1568 is completed, the insurance folder, VA Form 29-5886b, (RPO) Insurance Record Printout, and termination letter will be forwarded to the General Clerk. The General Clerk will authenticate VA Form 29-1568 and release the termination letter. The General Clerk will route the copy of the VA Form 29-1568 to the Control Clerk for insertion into the control file. The General Clerk will route the insurance folder, original VA Form 29-1568 and RPO to the Adjustment Claims Clerk. The Adjustment Claims Clerk will process the case, prepare the necessary input document and annotate the action taken on the VA Form 29-1568. For example, *VA Form 29-8524* or *VA Form 29-5926.* The Adjustment Claims Clerk will file the VA Form 29-1568 in the insurance folder and route the folder to file.

f. When the input documents are accepted by the system, an RPO reason code DELWA will be generated.

g. Upon receipt of the *DELWA RPO,* the Control Clerk will withdraw the corresponding VA Form 29-1568 from the control file. The RPO will be analyzed to determine that the *how paid code* has been changed from how paid 5 to the appropriate code; the reimbursable control character has been removed, if applicable, and that the next month due is not prior to the waiver termination date.

h. If the RPO shows action has been taken and is correct, the RPO and VA Form 29-1568 will be disposed of in accordance with the Records Control Schedule VB-1.

i. If no DELWA RPO is received by the end of a 2-week period, an RPO will be requested to determine if the corrective action has been taken. If the change has not been made, the General Clerk will refer the RPO and waiver decision copy to the supervisor to expedite action or resolve the problem.

j. If the correct action has not been taken or premiums have not been refunded, the insurance folder will be requested by use of VA Forms 29-5714, Requisition-Photocopy/Folder Request-Temporary Charge Card. Upon receipt of the folder, the Control Clerk will attach the RPO and refer the records to the Adjustment Claims Clerk for corrective action.

k. In termination of cases involving TDIP, the criteria is similar to that of termination of waiver of premium on basic policies. The difference is that the VA Form 29-1568 will include the termination date of the waiver on the TDIP rider and the termination date of the monthly income payments (the monthly payment due date will be included). The annotation DIS will be placed after the policy number on the entries involving TDIP.

l. In termination of a TDIP, when the reason for action is no longer totally disabled, the Senior Authorizer will prepare VA FL 29-317.

m. When premiums were previously paid:

(1) Direct-the first block will be checked.

(2) By deduction from benefits-the second block will be checked informing the veteran that the deductions will be resumed. (The Adjustment Claims Clerk will prepare VA Form 29-5926 input, generating a request to DPC Hines to resume deductions.)

n. By deductions from retired or active service pay-the first block will be checked and a postscript, You should contact your finance officer to reestablish your allotment, will be added.

o. In termination of cases involving TDIP, when the reason for action is failure to cooperate, the Senior Authorizer will prepare one of the appropriate letters:

(1) VA FL 29-351-if the veteran failed to report for an examination.

(2) MTST tape U #10-if the insured previously paid premiums by direct pay.

(3) MTST tape U #11-if the insured previously paid premiums by deduction from benefits.

(4) MTST Tape U #12 or #13-if the insured has a fiduciary.

p. The Senior Authorizer will postscript the pertinent data on TDIP provision payments to the appropriate letter.

q. The Senior Authorizer will prepare and affix VA Form 3230 to the insurance folder with the following instructions on the Adjustment Claims Clerk:

(I) Assign control number.

(2) Suspend payments.

(3) Obtain current VA Form 4-456, Insurance Award Record Printout.

r. After an original and one copy of VA Form 29-1568 is completed, the insurance folder and VA Form

4-456 will be forwarded to the Adjustment Claims Clerk by the Senior Authorizer.

s. The Adjustment Claims Clerk will prepare VA Form 21-8046, Payment Notice (Stop-Suspended-Resume), to suspend the award. Block B will be checked and reason code 02 will be inserted. Block 12, Remarks, will show *Poss NLTD* (Possibly No Longer Totally Disabled). This form will be prepared by one Adjustment Claims Clerk and reviewed by another. A control number will be assigned to the form which will be released through the Control Clerk to notify the Insurance Awards Unit, Operations Section, Finance Division. The form will be noted in red ink, *Return to ICS.* The case will be held by the Adjustment Claims Clerk's desk until the VA Form 21-8046 and a VA Form 4-456 is returned from the Finance Division. When the suspend VA Form 21-8046 with reason code 02 is returned with the VA Form 4-456 award RPO reflecting suspend action, the Adjustment Claims Clerk will send the insurance folder, RPO and VA Form 29-1568 back to the Senior Authorizer for a review of the termination letter.

t. The Senior Authorizer will route all of the material to the General Clerk.

u. The General Clerk will verify the letter and release it. The General Clerk will then route a copy of VA Form 29-1568 to the Control Clerk, forward the insurance folder, RPO's (insurance and awards) and original VA Form 29-1568 to the Adjustment Claims Clerk.

v. The Adjustment Claims Clerk will prepare a second VA Form 21--8046. Block A will be checked and reason code 06 will be inserted. Block 12, Remarks, will show NLTD (No Longer Totally Disabled). The original VA Form 21-8046 showing a control number will be sent to Finance Division through the Control Clerk. The duplicate will be filed in the folder and returned to file.

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CHAPTER 6. ORIGINAL DECISIONS-USGLI AND WRTI

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CHAPTER 6. ORIGINAL DECISIONS-USGLI AND WRTI

SUBCHAPTER I. GENERAL

6.01 RESPONSIBILITY OF PERSONNEL AS TO TYPES OF CASES

a. USGLI cases will be handled as directed in chapter 4, paragraph 4.01, of this manual.

b. WRTI (War Risk Term Insurance) cases will be adjudicated on a specialized basis as directed by the Chief, Insurance Claims Section.

c. Decisions involving death claims are covered in chapter 8.

6.02 EVALUATION OF EVIDENCE

Refer to chapter 4, paragraph 4.03.

SUBCHAPTER 2. TYPES OF DECISIONS-USGLI

6.03 TPD-(TOTAL PERMANENT DISABILITY)

a. Involves a claim for total permanent disability. Upon approval of claim, monthly payments of $5.75 per $1 ,000 coverage are payable. Such a finding matures the contract (making it nonparticipating) and these payments reduce the face amount of the insurance. Refer to M29-1, part I, chapter 32, paragraphs 32.01 through 32.07.

b. Prior to making the award, the Authorizer should advise the insured of the effects of the indebtedness. Refer to M29-l, part I, chapter 32, paragraph 32.05g. The insured should also be informed that if full payments are desired, repayment of the entire loan should be made prior to commencement of award payments.

6.04 TPD (TOTAL PERMANENT DISABILITY)-ABEYANCE

Involves the same criteria as a TPD decision. However, the payments may be held to accumulate by the Veterans Administration at the insured's request. These payments shall accrue no payable interest to the insured or beneficiaries. The insured may make a written request to have payments that are being withheld released to him/her at any time.

6.05 TD (TOTAL DISABILITY)

a. In addition to the total permanent disability benefit provided in the basic contract, a disability income provision may be added to provide income to the insured who becomes totally disabled (while not meeting the requirements for benefits on the basic contract).

b. This rider provides monthly income payments of $5.75 per $1 ,000 coverage. Payments on the rider do not reduce the face value of flu contract.

c. Premiums are waived on basic policy and rider.

d. Dividends remain payable as a finding of total disability does not mature the policy. Refer to M29-I, part I, chapter 32, paragraphs 32.08 through 32.14.

e. The Authorizer must check the policy to see that the TDIP cease field on the IRPO and the TDIP type code on the VA Form 29-1565-3, Decision Disability Insurance Benefits, are correct and agree. There are three codes, explained as follows:

(1) Code 1-when the effective date of the rider and the insurance are different and subsequent to July 3, 1930, the premium on the rider is payable until the insured's 65th birthday.

(2) Code 2-when the effective date of the TDIP rider is prior to July 3, 1930, the additional premium is payable for life.

(3) Code 3-when the effective date of the insurance and the rider are the same and both are effective July 3, 1930 or later, premium payments for the rider cease of the date the insurance becomes Paid-up or at age 65, whichever is earlier. However, protection will continue on the rider until the insured's 65th birthday.

6.06 TOTAL PERMANENT DISABILITY AND TOTAL DISABILITY

a. An insured who has the disability income provision added to his/her policy may file claim for benefits under both the total permanent disability provision of the contract and the disability income rider. If approved, this would result in payments of $5.75 per $1,000 of coverage under each of the above provisions.

b. Refer to M29, part I, chapter 32, paragraph 32.10e, which explains the procedure when an endowment plan matures while the insured is receiving disability benefits.

6.07 SPECIAL ENDOWMENT AT AGE 96-WAIVER

Involves only those Special Endowment at Age 96 policies with the waiver of premium provision which is based on a finding of total permanent disability. No income benefits are payable as the total disability income provision is not available. Dividends remain payable as declared.

SUBCHAPTER 3. TYPES OF DECISIONS-WRTI

6.08 AUTOMATIC INSURANCE

This decision involves insurance benefits to those qualified persons held totally permanently disabled without having applied for insurance. Refer to M29-l, part I, chapter 33, paragraphs 33.01 and 33.05.

6.09 TPD (TOTAL PERMANENT DISABILITY)

Refer to paragraph 6.03.

6.10 RENEWAL OF INSURANCE UNDER SECTION 305, WORLD WAR VETERANS ACT of 1924, AS AMENDED

This decision involves the restoration of lapsed insurance through the use of uncollected compensation. See M29-1, part I, chapter 33, paragraph 33.07.

SUBCHAPTER 4. PREPARATION OF DECISIONS

NOTE: In the remainder of this chapter, the preparation of VA Form 29-1565-3 will be discussed for the various types of decisions outlined previously. The items will be discussed in the order in which the form is to be completed. For simplification, those items not discussed are to be completed as directed in chapter 4, paragraph 4.04.

6.11 TPD (TOTAL PERMANENT DISABILITY)

Item	Entry Required
Diary Ctrl.	Leave blank. Prepare a paper diary VA Form 29-5716b, DIC Diary Card-NSLI-USGLI. Preparation of this form will facilitate the control of the insurance folder at the expiration of the diary date for release of VA Form 29-8313, Disability Benefits Questionnaire. This manual diary is required to control the folder for review pur poses as the K contract matures and comes off the in-force system at the time of a finding of total permanent disability.
Disallowance of Claim is Based on	Check the appropriate block to show if disallowed Decision the basis of a decision. State in the "Benefits Awarded" item that the claim is disallowed and the reason. It is not necessary to write a memorandum or

	narrative decision to reach a finding as to total or total permanent disability, and the decision paragraph at the bottom of the form need not be completed. A decision on fraud must be made.
Premiums Waived-Commencing Date	Leave blank. Premiums are not waived as the contract matures at a finding of TPD. Premiums paid after the contract has matured will be refunded.
Benefits Awarded-Commencing Date	Basic Contract (1) The effective date of the award is the beginning date of such disability, when not limited by due proof. (2) when limited by due proof, the commencing date of the award shall not exceed 6 months prior to receipt

Item	Entry Required
	of due proof. See M29-I, part I, chapter 32, paragraph 32.05.
Benefits Awarded Ending Date	(1) Leave blank if a continuing award. (2) If a closed award, insert ending date.
Statutory Req. Met	Refer to M29-l, part I, chapter 32, paragraphs 32.04 and 32.13, for definition of statutory disability.
Competency Information	Refer to chapter 4, paragraph 4.04j, Competency Information. Subparagraph (4) under "Entry Required" does not apply. Only a court-appointed fiduciary or guardian may file claim. (I) The Authorizer will prepare and sign without other written concurrence, the following types of disallowance: (a) when the claim indicates that the insured has returned to duty or to work. (b) When benefits have already been granted as previously requested so that the current claim is a duplicate.

	(c) when there is no record of Government Life Insurance having been issued to the claimant. (d) Total or total permanent disability is alleged after the expiration of extended insurance. (e) When a claim is withdrawn. (f) when a claim is held to be a disallowance for failure to prosecute.
Date Due Proof Received	Insert the earliest date of receipt of such evidence in the VA. Refer to M29-1, part I, chapter 32, paragraph 32. 05b.

6.12 TPD (TOTAL PERMANENT DISABILITY)-ABEYANCE

Item	Entry Required
Benefits Awarded-Commencing Date	Insert commencing date of award (month-day-year). Beneath this date, insert the caption PAYMENTS WITHHELD INSURED'S P GUEST.

Item	Entry Required
Mo Payment (T&P)	Enter amount of award.
Remarks	Block print-ABEYANCE CASE.
Decision Paragraph	Show the date of total permanent disability. If the award was currently being paid and now payments are to be held in abeyance, insert the caption-PRIOR DECISION AMENDED ACCORDINGLY.
Date Due Proof Received	Insert flu earliest date of receipt of such evidence in the VA. Refer to M29-1, part I, chapter 32, paragraph 32.05b.

6.13 TD (TOTAL DISABILITY)

Item	Entry Required

Premiums Waived-Commencing Date	Basic Contract: Insert the caption-BASIC. Under this caption, insert the commencing date of waiver (month-day-year). Total Disability Provision: Insert the caption-SEC 748. Under this caption insert the commencing date of waiver (month-day-year).
Benefits Awarded-Commencing Date	Basic Contract: Insert the caption-BASIC. Under this caption, insert NO CLAIM ON BASIC CONTRACT. Total Disability Provision: Insert the caption-SEC 748. Under this caption, insert the commencing date of award (month-day-year). Refer to M29-l, part 1, chapter 32, paragraphs 32.11, 32.12,32.13.
Mo. Payment (T&P)	N/A
Date Due Proof Received	Insert the earliest date of receipt of such evidence in the VA. Refer to M29-l, part I, chapter 32, paragraph 32.05b.

6.14 TOTAL PERMANENT DISABILITY AND TOTAL DISABILITY

Item	Entry required
Premiums Waived-Commencing Date	Leave blank.
Benefits Awarded-Commencing Date	Basic Contract: Insert the caption-BASIC. Under this caption, insert the commencing date of TPD (month-day-year). Refer

Item	Entry Required
	to M29-1, part I, chapter 32, paragraph 32.05, for commencing dates of awards.
	Total Disability Provision: Where applicable, insert SEC 748 under this caption, inserting the commencing date of award (month-day. year). Refer to M29-I, part **I,** chapter 32, paragraphs 32.11,32.12,32.13.

Date Due Proof Received	Insert the earliest date of receipt of such evidence in the VA. Refer to M29-1, part I, chapter 32, paragraph 32.05b.

6.15 SPECIAL ENDOWMENT AT AGE 96-WAIVER

Item	Entry Required
Diary Ctrl.	Leave blank.
TDIP Benefits	Leave blank-N/A.
TDIP Type	Leave blank-N/A.
Premiums Waived-Commencing Date	(1) Insert the commencing date of waiver of premiums. Insert below the date the caption-38 U.S.C. 742(c). (2) Waiver will be granted effective with the first monthly premium due after effective date of total permanent disability. (3) If the due date is the first, the first premium to be waived is the following monthly premium. (4) Premiums due more than l year prior to receipt of claim will be waived only if there existed circumstances beyond the insured's control which prevented such claim. (5) Any premiums paid after the effective date of waiver will be refunded.
Premiums Waived- Next Prem. After Termination	(I) If a continuing period of disability, leave blank. (2) If a closed period, enter the last day of the waiver award.
Benefits Awarded-Commencing Date	Not applicable.
Benefits Awarded-Ending Date	Not applicable.

Item	Entry Required

1st Remarks Block	E C96-Premiums waived from due date after date found T&P.
Date Due Proof Received	Insert the earliest date of receipt of such evidence in the VA. Refer to M29-1, part l, chapter 32, paragraph 32.05b.

6.16 PARTIAL DENIAL

Refer to chapter 4, paragraph 4.05.

6.17 AMENDED AWARD

Refer to chapter 4, paragraph 4.06.

SUBCHAPTER 5. REVIEW DECISIONS

6.18 TYPES OF REVIEW-PURPOSE AND PROCEDURE

a. In view of the age of most USGLI policyholders, it must be remembered that the effects of disability on an individual of this age are severe and the chances of return to employment are minimal. This should be kept in mind when scheduling reviews.

b. The purpose of the review is to determine if continued entitlement to disability benefits is justified by the medical and industrial evidence of record.

c. As stated in chapter 5, paragraph 5.01, the intermediate or interim review is made primarily to check on the industrial status of the insured at the midpoint in time from the last regular review to the next. Keeping in mind the advanced age of this group of insureds, the Authorizer should forego the interim review except when circumstances would justify differently. For on-tape cases, this is possible by making the callup date the same as the regular review. For off-tape cases, this is done by making the future regular review date the expiry date of the paper diary.

d. The material outlined (Employment, Deferred Statutory, Industrial Review, Anniversaries of 19th and 20th Years of Disability) in chapter 5 paragraphs 5.04 through 5.08 will apply, except to off-tape cases where references to computerized documents are made.

6.19 PROCEDURE-CONTINUING BENEFITS

a. Benefits to be continued (on-tape contract). The same procedural practice will apply as outlined in chapter 5, paragraph 5.03. Substitute Authorizer where Claims Examiner is indicated.

b. Benefits to be continued (off-tape contract). The above procedure will apply except that VA Form 29- 5716b, DIC-Diary Card-NSLI-USGLI, will be prepared in place of VA Form 29-8524, Waiver Diary *(Doc 4).*

6.20 PROCEDURE-TERMINATION OF TOTAL PERMANENT DISABILITY BENEFITS

a. All income and waiver benefits cease upon the insured's recovery from total permanent disability. Surrender of the policy for the cash value will terminate the total permanent disability benefits only. Payments on the TDIP (Total Disability Income Provision) will continue on the surrendered policy as long as the insured remains totally disabled.

b. A dictated conservation letter will be released by the Senior Authorizer before processing a request for cash surrender. The cash surrender value of the reduced amount of insurance will be furnished by the Adjustment Claims Clerk. The Senior Authorizer will prepare VA Form 29-5716b for callup in 45 days. Refer to M29-I, part l, chapter 32, paragraph 32.07.

c. when the TPD award is terminated because of recovery or cash surrender, the rerated amount of insurance must be inserted on the insurance inforce system master tape.

d. The Senior Authorizer will prepare VA Form 29-1568, Review Decision-Termination, and route it to the

Adjustment Claims Clerk with the insurance folder and the following instructions:

(1)Assign control number.

(2)Suspend payment.

(3)Obtain current VA Form 4456, Insurance Award Record Printout, with the date of last payment.

e. The Adjustment Claims Clerk will prepare VA Form 21-8046, Payment Notice (Stop-Suspend-Resume), in duplicate to suspend the award. Item 4b will be checked and the reason code 02 will be inserted. Item 12, "Remarks." will show "Re-rated TPD." The original will be sent to the Insurance Award Unit, Finance activity; the duplicate filed in the DIB folder. A control number will be assigned to the form which will be released through the Control Clerk. The case will be held on the Adjustment Claims Clerk's desk until the VA Form 21-8046 and a VA Form 4456 are returned from the Finance activity.

(l) When the VA Form 21-8046, with reason code 02, is returned with the VA Form 4456 showing month of suspension of payments, prepare VA Form 9-683, Termination of Permanent and Total Disability Rating, in duplicate and forward the original with the insurance folder to Miscellaneous Accounts and Service Unit for the amount of rerated insurance. A copy will be retained for control purposes.

(2)Upon return of the completed VA Form 9-683, VA Form 21-8046, the Award Record Printout and insurance folder will be sent with flee form to the Senior Authorizer for preparation of a termination letter.

f. The Senior Authorizer will prepare a letter to advise the insured of termination of TPD payments. The letter will include the number of installments paid and the value of remaining installments (rerated amount of insurance).

(l) Also included in the letter status of the account and amount required to pay premiums through the current month.

(2)Status of the loan or lien account, when applicable.

(3)Upon completion, the Senior Authorizer will route all material to the General Clerk.

NOTE: If cash surrender, no termination letter is involved. Route all material to the Adjustment Clerk.

g. The General Clerk will release the letter (certified mail) and route all other material, with the insurance folder, to the Adjustment Claims Clerk.

h. The Adjustment Claims Clerk will prepare a second VA Form 21-8046. item 4A, "STOP," will be checked and reason code 06 will be inserted. Item 12, REMARKS, will show, NO LONGER TOTALLY DISABLED OR RERATED TPD FOR CASH SURRENDER. The original will be sent to Finance; the duplicate filed in the DIB folder. A control number will be assigned to the form which will be released through the Control Clerk. If a fiduciary is involved, an extra copy is prepared for release to the Veterans Services Officer. The case will be held on the Adjustment Claims Clerk's desk until the VA Form 21-8046 and VA Form 4-456 are returned from the Finance activity.

i. When the VA Form 21-8046 with reason code 06 is returned with the VA Form 4A56, slowing month of discontinuance of payments, prepare an original and 3 copies of VA Form 29-328, Underwriting Worksheet. The insurance folder will be recharged and hand carried, with all material attached, to Miscellaneous Accounts and Service Unit for preparation of input documents to insert the rerated policy on the insurance master tape.

j. Policy Service Unit will then process the cash surrender or any other action necessary on the rerated policy.

6.21 PROCEDURE-TERMINATION OF TOTAL PERMANENT DISABILITY BENEFITS AT INSURED'S REQUEST

a. Income and waiver benefits will cease at the request of the insured.

b. Send a dictated conservation letter explaining that resumption of premium payments on the rerated amount of insurance is necessary.

c. If the requested discontinuance date is previous to the date of last benefit payment, the insured will be asked to return the amount of payment made after the requested discontinuance date, and to pay premiums from that due date.

d. Refer to paragraph 6.20c through j for procedure.

e. If the insured is also receiving benefits under the total disability rider, a reminder should be included that it is possible to collect total disability income payments which do not reduce the face amount of flee contract and also maintain a waiver of premiums on the basic coverage.

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CHAPTER 7. WAIVER DIARIES

CONTENTS-Continued

CHAPTER 7. WAIVER DIARIES

7.01 TYPES OF DIARIES

a. The two primary types of waiver diaries are pending diaries and review diaries. A pending diary is a non- freeze diary inserted on the pending transaction tape at the time a claim for disability insurance benefits is received. These diaries are used to control the processing of new waiver applications. Review diaries are also non- freeze diaries and are used to provide information for controlling the release of questionnaires used to obtain information necessary to perform periodic reviews of active waiver cases. Review diaries contain codes representing disabilities, the effective date of disability, and the next review date. Both pending and review diaries will be discussed in detail below.

b. A third type of waiver diary, the off tape diary, may be used when there is no master record on tape. Off-tape diaries will be discussed in paragraph 7.12.

c. The final type of waiver diary used by the Insurance Claims Section is a frozen 974 pending diary. This 974 diary is used to insert a life freeze to prevent the automatic release of dividend payments on USGLI (United States Government life Insurance) contracts.

7.02 PENDING DIARIES

a. The basic document used to establish a pending waiver diary is VA Form 29-8524, Waiver Diary. The Transaction Type used to insert a pending diary is TT008. (See fig. 701.) A VA Form 29-8524 is prepared in the Receipt and Dispatch Unit whenever a VA Form 29-357, Claim for Disability Insurance Benefits, is received. The ADP system will establish a pending diary, generate a skeleton VA Form 29-1565-3, Decision Disability Insurance Benefits, and an IRPO (Insurance Record Printout) reason code APPPND, for each policy in the master record.

(See fig. 7.02.) The ADP system will also release VA Form 29-5885, Information About Your Insurance, to the insured to acknowledge receipt of the application for waiver.

b. The VA Form 29-5885, released upon receipt of a claim for disability insurance benefits, will contain the following message:

> YOUR CLAIM FOR DISABILITY INSURANCE BENEFITS HAS BEEN RECEIVED AND IS BEING PROCESSED. YOU SHOULD CONTINUE TO PAY PREMIUMS WHILE YOUR CLAIM IS PENDING. THIS WILL INSURE CONTINUOUS PROTECTION SHOULD YOUR CLAIM BE DENIED.

c. If an application for benefits involves a paid-up contract, the second and third sentences will be omitted. If TDIP is involved and both the parent policy and TDIP rider are paid to the end of the premium payment period, the second and third sentences will also be omitted.

7.03 PENDING DIARIES ENTRIES-DESCRIPTION

a. The pending waiver diary will appear in the pending transaction area of the VA Form 29-5886b, Insurance Record Printout. The pending diary will appear as follows:

b. An explanation of the pending diary shown above follows:

(1) Trans. Type-Always "978."

(2) Call-up Date-Month, day, and year that the system will initiate action.

(3) Call-up Type-Always "MSC 4" indicating a miscellaneous pending transaction.

(4) Diary Control Character-Always "5" indicating a pending waiver application.

(5) Call-up Code Type-Always "944" indicating Insurance Claims Section followup action.

(6) Application Receipt Date-In the pending waiver diary, the month, day, and year shown in this field is the date the claim for waiver was received by the VA.

7.04 PENDING CLAIM FOR DIB OR T&P

a. When a claim for DIB is filed prematurely, within 6 months of the beginning date of total disability, the pending diary should be changed to indicate the status of the claim.

b. The Claims Examiner, Authorizer or Senior Authorizer will prepare VA Form 29-5859c, Waiver Diary Action, to change the pending diary to indicate a premature claim. (See fig. 7.03.) In addition to the basic entries, the following will be shown:

(1) PRMCL will be shown in the ICS Message Area field.
(2) Call-up Date field will reflect a date 6 months from the alleged date of total disability. However, if the evidence indicates a beginning date of total disability other than the one claimed, enter a call-up date 6 months from the date supported by the evidence of record.

c. At the end of the 6-month period, the PRMCL message should be changed to EVID6MOS and the application receipt date should be changed to a date 6 months from the alleged date of total disability. VA Form 29- 5895c should be used to make these changes (see fig. 7.04).

d. When a claim for total and permanent disability benefits is received for a USGLI contract, a frozen 974 diary will be prepared to insert a life freeze into the master record. This 974 diary will prevent the automatic

release of dividend payments when a claim for T&P benefits is pending. VA Form 29-5895a, Pending Transaction Input Card, will be used to insert the diary (see fig. 7.05).

7.05 WAIVER APPROVAL-SYSTEM PROCESSING OF VA FORM 29-1565-3, DECISION DISABILITY INSURANCE BENEFITS.

a. When a claim for DIB is approved, the Claims Examiner, Authorizer, or Senior Authorizer will complete VA Form 29-1565-3 and route it to the General Clerk/Adjustment Claims Clerk.

b. The General Clerk/Adjustment Claims Clerk will file the original of VA Form 29-1565-3 on the right side of the insurance folder. Copy 2 will be attached to the insurance folder and recharged to the Voucher Audit Unit for review and subsequent release to the Keypunch Unit. The Keypunch Unit will use this form as a source document for preparing a TT078 to change the pending waiver diary to a review diary and cause automatic processing by the system. (See fig. 7.02.) Copy 3 of VA Form 29-1565-3 will be routed to the Control Clerk in the Insurance Claims Section for insertion into the control file.

c. When TDIP benefits are involved, the General Clerk will route copy 2 with the insurance folder to the Adjustment Claims Clerk. The Adjustment Claims Clerk will prepare VA Form 29-462, Authorization for Insurance Payments, affix it and Copy 2 of VA Form 29-1565-3 to the insurance folder and forward insurance folder to the appropriate Authorizer or Senior Authorizer. The Authorizer/Senior Authorizer will sign VA Form 29462 and route the insurance folder and attached material to the Voucher Audit Unit. The folders recharged to the Voucher Audit Unit will be listed on VA Form 29-710, Transmittal List of Award Actions.

7.06 WAIVER APPROVAL-CLERICAL PROCESSING OF VA FORM 29-1565-3

a. If any of the following conditions exist, VA Form 29-1565-3 cannot be used as a source document for preparing a TT078 to automatically process waiver cases. A waiver case requires clerical processing when:

(l) The insurance is inforce under a Section 724 waiver.

(2) The decision is an amended or supplemental award.

(3) A waiver is granted on a two policy case and the effective months of waiver differ.

NOTE: When the effective date of waiver/refund involves different months on *a two-policy* case, the system *will process the* case provided *the disability effective date* is not more than 1 year prior to *the application* receipt *date.*

(4) The due dates after termination of waiver differ on a two-policy case.

(5) The effective date of waiver is prior to the effective date of the current contract, except for one renewal period.

(6) An RH contract was issued under M29-l, part IV, chapter I.

(7) A two policy case involves TDIP.

(8) There are three or more policies on the master record.

(9) A waiver is approved and TDIP or competency is deferred or a fiduciary has not been approved and entered on the master record, or the refund exceeds $350 on incompetent cases.

(10) The award involves T&P (Total and Permanent) disability (USGLI).

(11) An allotment or DFB is running in an incorrect amount, or more than 1 month in advance.

(12) The policy number in the pending transaction is not identified.

(13) The basic policy is paid-up and the TDIP How Paid is 0, 1,3,6,8, or 9.

(14) The award is for a closed period and the How Paid Code is 3 or 6.

(15) The account is lapsed or the How Paid Code is 0, 1, or 4 and the contract is not in the master record.

(16) There is a lien on the account.

(17) There is no 944 pending diary or the 944 diary for another contract was previously approved.

(18) There is TDIP on a V, RS, or W term contract and the waiver is effective prior to October 1970.

(19) The account is frozen.

(20) The waiver on a J or JR account is effective prior to October 1976.

(21) When waiver involves a Modified Life, Reduced Modified Life and/or Replacement Special OL contracts.

(22) Two or more policies with different funds.

(23) Term policy with skipped months in the previous term period.

(24) Two-policy cases where one has TDIP and the other does not.

(25) Premiums paid into future term period, except for one renewal period.

b. When any of the above conditions exist, clerical preparation of input documents and/or VA Form 29-5886b will be required to process VA Form 29-1565-3 and change the pending diary to a review diary.

c. The General Clerk/Adjustment Claims Clerk will request a frozen RPO. When the RPO is received, it will be routed with copy l and copy 2 of VA Form 29-1565-3 and the insurance folder to the Adjustment Claims Clerk. Copy 3 of VA Form 29-1565-3 will be inserted into the control file.

d. The Adjustment Claims Clerk will prepare the following input documents as applicable and file the original (copy l) VA Form 29-1565-3 in the insurance folder. Copy 2 will be attached to the insurance folder with the input documents and will be recharged to the Voucher Audit Unit.

e. Input documents:

(l) RPO or VA Form 29-8523, Premium/TDIP, transaction type 083, to downdate or update the premium and/or TDIP segment to the commencing date of premiums waiver, change the How Paid to 5 and adjust the accounting controls.

(2) VA Form 29-8523, transaction type 083, second-day release, to update the premium and/or TDIP segment to the current premium month due and adjust the accounting controls.

(3) VA Form 29-5895c, second-day release, transaction type 078, to change the pending waiver-diary to a review diary (see fig. 7.06).

(4) RPO or VA Form 29-8526, Pending Transaction, transaction type 008, to insert a 609 refund pending transaction diary, callup type 609 with an immediate callup date.

NOTE: When the refund is not going to be immediate, make this callup type 974 with a 45-day callup date.

(5) VA Form 29-5926, Request for DFB Action, or VA Form 29-1588, Request for Allotment Deduction Change, to reduce or discontinue the service allotment.

(6) VA Form 29-8526, transaction type 008, to insert a nonfreeze 978 miscellaneous pending transaction diary, callup type 974, with a 75-day callup date for the VA Form 29-5926, and 120-day callup date for VA Form 29-1588.

(7) When the account is not on the insurance master record, prepare the appropriate input documents to insert the account as it appeared on the date of lapse.

(a) If an N account, insert as V with current renewal date.

(b) If a death case, do not insert File account.

7.07 DISALLOWANCE OR DENIAL

a. If a claim for waiver is disallowed or denied, the Claims Examiner, Authorizer or Senior Authorizer will complete VA Form 29-1565-3 (see ch. 4, par. 4.04). Copy I and the insurance folder will be routed to the General Clerk/Adjustment Claims Clerk. Copy 2 and copy 3 of the form will be disposed of in accordance with Records Control Schedule VB-I, part I.

b. The General Clerk will prepare VA Form 29-8524, transaction type 098, to delete the pending waiver diary (see fig. 7.07).

7.08 REVIEW DIARY ENTRIES-DESCRIPTION

a. The pending waiver diary is changed to a review diary at the time a claim for waiver is approved. The review diary will appear as follows:

b. An explanation of the review diary as it appears in the Pending Transactions area is given below:

(1) Trans. Type-Always "978" (denotes diary).

(2) Callup Date-Month, day, and year the system will initiate action.

(3) Callup Type-Always "MSC 4" indicating a miscellaneous pending transaction.

(4) Diary Control Character-A one-digit numeric or alpha code indicating the type of action involved. An explanation of these codes and their functions will be found in paragraph 7.13.

(5) Effective Date of Disability-Month, day and year total disability began.

(6) Callup Type-Always "944" indicating Insurance Claims Section followup action.

(7) Severity Code A one-digit numeric code which, in conjunction with the diary control character, controls system generation of VA Form 29-8313, Disability Benefits Questionnaire. An explanation of these codes and their functions can be found in paragraph 7.13.

(8) Review Date Month, day, and year of the next regular review.

(9) Primary Classification Codes A four-digit number is used to represent the primary disability classification code. A complete listing of disability codes may be found in paragraph 7. 13.

NOTE: Only the primary disability code will be completed unless EVID6MOS or PRMCL appears in the diary message area. Then enter "0000" in the secondary disability code field.

7.09 TYPES OF REVIEWS

a. The two primary types of review actions are Regular reviews and Interim reviews. Regular review actions are taken by Claims Examiners, Authorizers and Senior Authorizers. Interim reviews are processed by General Clerks.

b. When a regular review action is completed, the decision is entered on VA Form 29-808b, Review Decision of Disability Insurance Claims. The top portion of VA Form 29-8313 will be detached and coded to update the waiver diary; the lower portion will be filed on the right side of the insurance or DIB folder. (See fig. 7.08.)

c. Interim review actions are completed by the General Clerks. (See ch. 5, par. 5.01). When making an interim review, the General Clerk will detach the top portion of the overprinted VA Form 29-8313 and forward it to the DPC for processing. The lower portion of the form will be disposed of in accordance with Records Control Schedule VB-1, part I. (See fig. 7.09).

d. A third type of review action is the 19th-year review. On the anniversary of the 19th year of total disability, an RPO with reason code STAREV will be generated. The Claims Examiner will review the DIB and/or insurance folder to insure that all is in order and verify the beginning of total disability on VA Forms 29-1565-3, 29-808b and 29-5886b. After verifying the beginning date of total disability, the Claims Examiner will prepare VA Form 29-8524, TT078, to change the callup date to agree with the next review date, which should be a date 20 years from the effective date of total disability. (See fig. 7. l0.)

e. The final type of review action is the 20th-year review. On the anniversary of the 20th year of total disability, an RPO will be generated with reason code STAREV and the message STATUTORY in the callup date field of the waiver diary. The Claims Examiner will review the DIB and insurance folder to insure that the beginning date of total disability is correct. After verifying the date, the Claims Examiner will initial, date and file the RPO in the insurance or DIB folder. (See M29- I, pt. l, .31, para. 31.32.)

7.10 SCHEDULING AND CONTROL OF REVIEWS

a. VA Form 29-8313 will be released by the system for interim or regular reviews when a callup date is reached and the diary control is "0."

b. The VA Form 29-8313 generated for an interim review will have the next regular review date printed on the front of the form. If TDIP benefits are involved, the date will be prefixed by the letter "T." On the VA Forms 29-8313 released for regular reviews, the words "Regular Review" will appear.

c. When the system releases VA Form 29-8313, a callup date of 45 days will be established. If, at the end of the 45 days, the VA Form 29-8313 has not been returned by the insured, a followup RPO will be generated. Following RPO's generated for interim reviews will bear the legend NORESP; those generated for regular reviews will have the legend REGREV.

d. When a followup RPO is generated, it will be associated with the insurance folder and delivered to the Insurance Claims Section. A second VA form 29-8313 will be prepared clerically in duplicate and noted "Second Request." The original will be dated and released to the insured. The carbon copy will be dated and filed in the insurance folder.

e. When followup action is taken on an interim review within 60 days of the next regular review, the second request should be treated as a regular review; i.e., the second request VA Form 29-8313 will be noted "Regular Review."

7.11 WAIVER TERMINATION

a. When medical or employment evidence indicates that the insured is no longer totally disabled for insurance purposes, VA Form 29-1568, Review Decision Termination, will be prepared by the designated personnel to terminated Disability Insurance Benefits. (See ch. 5, par. 13). The Adjustment Claims Clerk will review the VA Form 29-1568 to determine if the termination can be processed automatically by the system.

b. The VA Form 29-1568 must be processed clerically if any of the following conditions exist:

(l) The account is frozen.

(2) The first premium due after termination of waiver is in the next renewal period.

(3) There are three or more policies in the master record.

(4) There are two policies with different due dates.

(5) A two-policy case and the How Paid Code is "0" on one policy.

c. If none of the above conditions exist, the Adjustment Claims Clerk will prepare VA Form 29-8524 with TT078, code 2, to initiate automatic processing by the system. (See fig. 7. 11.) The system will automatically:

(l) Change the How Paid Code to "9."

(2) Update the policy, premium and optional segment.

(3) Delete the waiver diary.

NOTE: If the premiums were previously paid by DFB, prepare VA Form 29-5926, Request for DFB Action, to resume deductions, and VA Form 29-8530, Life/Miscellaneous, TT082, callup type 951 with a 75-day callup date.

d. When a termination must be clerically processed, refer to chapter 5, paragraph 5.13.

7.12 OFF-TAPE DIARIES

a. When a waiver diary is necessary and no insurance master record exists, VA Form 29-57l6b, DIC Diary Card-NSLI/USGLI, will be used. The control file of VA Forms 29-57l6b is maintained by the General Clerk on a current basis in chronological and terminal-digit order.

b. The Claims Examiner, Authorizer, or Senior Authorizer will prepare VA Form 29-57l6b in triplicate. Essential information, such as file number, veterans name, date diary expires, and purpose of diary, will be entered. If there is more than one reason for preparing a diary requiring different callup dates, only one diary will be prepared and the earliest callup date will be used.

c. The original and second copy will be given to the General Clerk for filing in the control file. The third copy will be filed in the insurance or DIB folder.

d. When the diary period expires, the General Clerk will release the original VA Form 29-57l6b to the Insurance Files [Section] where it will be associated with the insurance folder. When the insurance folder is returned, the duplicate copy retained in the control file will be attached to the folder and routed to the designated personnel.

NOTE: A current VA Form 4-456, Insurance Award Record Printout, will be requested when status is required.

e. The Claims Examiner, Authorizer, or Senior Authorizer will remove the third copy from the insurance or DIB folder. After completing a review decision, a new diary will be prepared if required.

f. When the reason for the diary no longer exists prior to the expiration of the diary, the file copy will be removed from the folder, marked "C," and given to the General Clerk. The General Clerk will then remove the original and duplicate from the control file and dispose of them in accordance with Records Control Schedule VB-l, part I.

7.13 WAIVER-DIARY CODES

a. There are several categories of codes that are used in waiver diaries to direct the action required by the system.

b. These codes are used singly or in combination with other codes or dates to enable the computer to arrive at a particular action to be taken on a callup date that is either supplied clerically or computed automatically by the system. These codes and their functions are outlined below:

(1) Diary Control Characters

CODE	PURPOSE
	Triggers release of VA form 29-8313 unless another call- up action intervenes.
l	Indicates a VA Form 29-8313 has been released or NO MAIL or review RPO has been generated. New callup date will be calculated.
2	Indicates 19th year of disability. Statutory review is next callup. Will release repetitive RPO's until a new callup date is clerically furnished.
3	Indicates 19th year of statutory review has been made, or that claim is statutory because of "loss of or loss of use of." This code will terminate repetitive followup RPO's.
4	Indicates second RPO followup (45 days) since release of a VA Form 29-8313.
5	Indicates a waiver application pending. Repetitive RPO's will be generated every 45 days unless callup is changed with a Transaction Type 078.
6 through 9	Upon receipt of an RPO with a CD (Diary Control Character) 4, if clerical action is not taken to change the DCC, repetitive RPO's will be generated every 45 days. A DDC 4 will be incremented by 2 and additional RPO's will reflect a DCC incremented by l until a maxi mum of 9 is attained.

NOTE: When the DCC appears as a letter instead of a number, it is an indication that the RPO was generated after the review date appearing in the waiver diary. The presence of a letter in the record will provide a different RPO reason code on the next printout (a regular review as opposed to a no response RPO).

(2) Severity Codes. The severity code is used by the system to compute a callup date for the release of a VA Form 29-8313 or to indicate that a waiver is statutory. The system will compute the VA Form 29-8313 callup date from the current processing date, only if the diary control character is a "0." When an award comes up for a regular review, the severity code should be reviewed by the Claims Examiner or Senior Authorizer and changed whenever necessary. Severity codes and their meanings are shown below:

CODE	DESIGNATION	RELEASE SCHEDULE OF VA FORM 29-8313
0	Statutory	None
1	Monthly	Monthly
2	Quarterly	Quarterly
3	Semiannually	Semiannually
4	Three-quarterly	Every 9 months

RELEASE SCHEDULE OF VA

CODE	**DESIGNATION**	**FORM 29-313**
5	Annually	Every 12 months
6	Sesquiannually	Every 18 months
7	Biennially	Every 24 months

9 No Mail None (RPO will be generated on each anniversary of the total disability effective date).

(3) Action Codes. Used for initial awards or terminations. The code is used by the system to take the action indicated. Listed below are the codes and meanings:

CODES	MEANING
1	Award approved
2	Award terminated
3	Award approved and terminated (How Paid code will note be changed).
4	To change information in a diary without adding to the approved or disapproved counts.
5	Partial denial (this will suspend release of the FL 29-9a).
6	Award terminated (XC case)

(4) Disability Classification Codes. The disability classification code indicates the impairment involved. Only the primary disability classification code will be completed, except when the diary message is EVID6MOS or PRMCL, then enter 0000 in the secondary disability code block. The code that represents a cancer or a disability which is statutory pursuant to the provisions of 38 U.S.C. 714 and 758 will be reflected in the primary block. Statutory codes take precedence over all others. When statutory impairments are involved, the code representing the effect rather than the cause will prevail. For example, when blindness in both eyes (Code 6099) was obviously caused by a history of glaucoma (code 6012), the primary code will be 6099. When a disability becomes statutory or when an award comes up for a regular

review, the disability classification code should be reviewed by the Claims Examiner or Senior Authorizer and changed or corrected whenever necessary. Disability classification codes are shown below:

(a) Statutory (Anatomical Loss or Loss of Use of)

One foot-one hand	5116
One foot-one eye	5117
One hand-one eye	5118
Both hands	5159
Both feet	5199

Both eyes	6099
Total loss of hearing in both ears	6277
Organic loss of speech (aphoniz or laryngectomy)	6590
Combination of two or more of above- For example, a quadruple amputee (multiple impairments)	6599

(b) Cardiovascular System

1.The Heart

Rheumatic heart disease	7000
Arteriosclerotic heart disease	7005
Myocardium, infraction of, due to thrombosis or embolism	7006
Hypertensive heart disease	7007
All others including an undefined coronary	7019

2. The Arteries and Veins

Arteriosclerosis, general	7100
Hypertensive vascular disease (essential arterial hypertension)	7101
Aorta or branches, aneurysm of	7110
Arteriosclerosis obliterans	7114
Thrombo.angiitis obliterans (Buerger's disease)	7115
Raynaud's disease	7117
Phlebitis (includes thrombophlebitis)	7121
All others affecting arteries and veins	7129

(c) Cancel

Bones	5012
Brain (neurological-spinal cord excepted)	8002
Digestive system (mouth, esophagus, stomach, colon, intestines, etc.)	7343
Ear	6208
Endocrine system (thyroid, adrenal and pituitary glands)	7914

Eye	6014
Genitourinary system (kidneys, bladder, prostate and reproductive organs)	7528
Gynecological (female organs)	7627
Hodgkins's disease	7709
Leukemia	7703
Respiratory (lungs and pleura)	6819
Skin	7818
Spinal cord (neurological-brain excepted)	8021
Other or unknown (cannot be identified with one of the above)	9990

(d) Mental Disorders

Schizophrenic, all types	9200
All other psychotic disorders	9219
All organic brain disorders (syndromes)	9300
All pyschoneurotic disorders	9400
All psychophysical disorders	9500

(e) Respiratory System

All diseases or impairments of the trachea and bronchi including bronchitis, bronchiectasis and asthma	6600
Tuberculosis, all categories	6701
All other diseases of the lungs and pleura including pleurisy, emphysema, silicosis, etc.	6729
All other respiratory ailments including any that are undefined	6739

(f.) Digestive System

All ulcers	7304
Liver ailments or impairments including cirrhosis	7311
All other impairments of the digestive tract	7349

(g) Genitourinary Systems

All nephritis, pyelitis and pyelonephritis	7502
All injuries to or impairments of the bladder	7514
All injuries to or impairments of the prostate	7526
All others	7539

(h) Gynecological Conditions (All) 7629

(i) Endocrine System

All thyroid and pituitary ailments	7900
All impairments to the adrenal glands (Addison's disease)	7911

Diabetics-all	7913
All others	7919

(j) Neurological Conditions and Convulsive Disorders

Encephalitis, epidemic, chronic	8000
Paralysis agitans (Parkinson's disease)	8004
Bulbar palsy	8005
Brain vessels (embolism, thrombosis or hemorrhage)	8007
Poliomyelitis, anterior	8011
Syphilis (cerebrospinal or meningovascular)	8013
Amyotrophic lateral sclerosis	8017
Multiple sclerosis	8018
Meningitis, cerebrospinal, epidemic	8019
Progressive muscular dystrophy	8023
Cerebral arteriosclerosis	8046
Narcolepsy	8108
All other neurological conditions	8109

(k) Paralysis Affecting Cranial and Peripheral Nerves

If applicable, code under statutory (loss of use of. If not statutory, code under the condition causing the paralysis. If the cause is unknown, code as	8899
Epilepsy (all degrees)	8910

(l) Arthritis and Related Diseases or Ailments

Rheumatoid arthritis	5002
Marie.Strumpell arthritis	5029
Osteomyelitis	5000
All other arthntides	5003
All other related ailments	5039

(m) Eye (Diseases of the Eye-Not Statutory)

1	Retinitis	6006
2	Glaucoma-all	6012
3	Cataracts-all	6027
4	All others (including partial blindness-not statutory)	6039

(n) Ear (Diseases Not Statutory)

Meniere's syndrome	6205
All others (including partial deafness-not statutory)	6269

(o) Fractures (Not Statutory)

Upper body (collarbone, shoulder blade, arms, hands, fingers, ribs and chest)	5248	
Lower body (pelvis, thighs, knees hip, ankles, feet and toes)	5266	
Spine or trunk (coccyx, sacrum and cervical, dorsal and lumbar vertebrae)	5267	
Head-cranium or skull (includes face, cheek, jaw and nose)		5268
Fractures-area unknown	5269	

(p) Whiplash 9991

(q) **Intervertebral Ruptured Discs** (disc syndromes) including sciatica; lumbago; lumbosacral, sacroiliac and low back disorders; and similar ailments

(r) **Personality Traits** other than shown under mental disorders (includes habits, morals, alcoholism, drug addiction and others)

(s) **Miscellaneous**

Benign brain tumors	9980
Benign tumors other than brain	9981
Gunshot wounds	9982
Wounds other than gunshot	9983
Muscle injuries	9993
Systemic diseases (cholera, leprosy, malaria, plague, pellagra, typhus etc.)	9994
Skin ailments or injuries (includes burns, severe scars, psoriasis, etc.)	9995
Dental and oral conditions	9996
Amputations, or loss of use of (not statutory). The condition causing the "loss of use of" should be coded if known; otherwise, code as	9997
Diseases of hemic and lymphatic systems (leukemia and Hodgkin's disease are excluded)	9998
(t) All other ailments or impairments not listed above (or disease unknown)	9999

NOTE: One of the edits performed by the system provides that when a waiver diary input contains a severity code zero (statutory), the system will check to see if the total disability has endured for 20 years or longer (39 U.S. C. 110). If not statutory because of duration, then the edit must check for one of the codes representing anatomical loss or loss of use of

(5) The foregoing disability classifications are listed again in alphabetical order:

Addison's disease	7911
Adrenal glands, all impairments to-(except cancer)	7911
Alcoholism	9992
AMPUTATIONS	
- Feet (both)-statutory	5199
- Hands (both)-statutory	5159

More than two limbs-statutory	6599
Or loss of use of (one limb)-not statutory "loss of use of" impairments, the condition causing the "loss of use of" should be coded if known; otherwise code as	9997
Amyotrophic lateral schlerosis	8017
Aneurism of the aorta or branches	7110
Ankle, fracture of	5266
Aorta, or branches (aneurysm of)	7110
Aphonia-organic loss of speech (also laryngectomy)	6590
Arm, fracture of	5248

ARTERIES AND VEINS

-	Arteriosclerosis, general	7100
-	Hypertensive vascular disease (essential arterial hypertension)	7101
-	Aorta or branches (aneurysm of)	7110
-	Arteriosclerosis obliterans	7114
-	Thromboangiitis obliterans (Buerger's disease)	7115
-	Raynaud's disease	7117
-	Phlebitis (includes thrombophlebitis)	7121
-	All others affecting arteries and veins	7129

ARTERIOSCLEROSIS

- Cerebral	8046
- General	7100
- Obliterans	7114
Arteriosclerotic heart disease	7005

ARTHRITIS AND RELATED DISEASES OR AILMENTS

- Rheumatoid arthritis 5002
- Marie-Strumpell arthritis 5029
- Osteomyelitis

- All other arthritides

- All other related ailments

ARTHRITIS

- Marie.Strumpell 5029

- Rheumatoid 5002

- Undefined 5003

Asthma 6600

Astragalus (ankle), fracture of 5266

Benign brain tumors 9980

Benign tumors other than brain 9981

Bladder, all injuries or impairments to 7514

Blindness-both eyes (loss or loss of use of-statutory) 6099

Blindness-partial but not statutory 6039

Bones-cancers of 5012

Brain-cancers of 8002

Brain-Organic brain disorders (syndromes) 9300

Brain tumors, benign 9980

Brain-Vessels (embolism, thrombosis or hemorrhage) 8007

Bronchi and trachea-diseases of	6600
Bronchiectasis	6600
Bronchitis	6600
Buerger's disease (thromboangiitis obliterans)	7115
Bulbar Palsy	8005
Burns	
Calcaneum (heel), fracture of	5266
Calcareous (heel), fracture of	5266

CANCERS

-Bones	5012
-Brain (neurological spinal cord excepted)	8002
-Digestive system (mouth, esophagus, stomach, colon, intestines, etc.)	7343
-Ear	6208
-Endocrine system (thyroid, adrenal and pituitary glands)	7914
-Eye	6014
-Genitourinary system (kidney, bladder, prostate and -reproductive organs)	7528
-Gynecological (female organs)	7627
-Hodgkin's disease	7709
-Leukemia	7703
-Respiratory (lungs and pleura)	6819
-Skin	7818
-Spinal cord (neurological brain excepted)	8021
-Other or unknown (cannot be identified with one of the above)	9990
Cardiovascular system (see heart; or arteries and veins)	
Carpus (wrist), fracture of	5248
Cataracts	6027
Cerebral arteriosclerosis	8046
Cervical vertebra, fracture of	5267
Cheek bone (malar), fracture of	5268
Chest bone(s), fracture of	
Cholera (systemic diseases)	9994
Cirrhosis of the liver	7311
Clavicle (collarbone), fracture of	
Coccyx, fracture of	5248

Convulsive disorders	
(see neurological conditions and convulsive disorders)	
Coronary-.not further defined	7019
Cranial nerves-paralysis affecting (not statutory). Code under the condition causing the paralysis. If the cause is unknown, code as	8899
Cranium (head or skull), fracture of	5268
Deafness-partial but not statutory	6269
Deafness-total loss of hearing in both ears-statutory	6277
Dental and oral conditions	9996
Diabetes (all categories)	7913
DIGESTIVE SYSTEM	
All ulcers	7304
- Liver ailments or impairments including cirrhosis	7311
- All-other impairments of the digestive tract	7349
Digestive system, cancers of (mouth, esophagus, stomach, colon, intestines, etc.)	7343
Disc syndromes (intervertebral ruptured discs)	8889
DISEASES	

- Addison's disease 7911
- Arteriosclerotic heart disease 7005
- Buerger's disease 7115
- (of the) hemic and lymphatic systems (excluding leukemia and Hodgkin's disease) 9998
- Hodgkin's disease 7709
- Hypertensive heart disease 7007
- Hypertensive vascular disease 7101
- Parkinson's disease 8004
- Raynaud's disease 7117
- Rheumatic heart disease 7000

- Systemic diseases (cholera, leprosy, malaria, plague, pallegra, typhus, etc.) 9994
- (of the) trachea and bronchi 6600

DISORDERS

- Brain (organic brain disorders- syndromes) 9300
- Mental (see under mental disorders)
- Low back (disc syndrome) 8889
- Lumbosacral (disc syndrome) 8889
- Psychoneurotic 9400
- Psychophysiological 9500
- Psychotic 9219
- Sacroiliac 8889

Dorsal vertebra, fracture of 5267

Drug addiction 9992

Dystrophy, progressive muscular 8023

EAR DISEASES-(NOT STATUTORY)

- Moniere's syndrome	6205
- All others (including partial deafness-not statutory)	6269
Ears, cancers of	6208
Ears, total loss of hearing in both ears-statutory	6277
Encephalitis, epidemic, chronic	8000

ENDOCRINE SYSTEM

-	All thyroid and pituitary ailments	7900
-	All impairments to the adronal glands (Addison's disease)	7911
-	Diabetes-all	7913
-	All others-except cancer	7919

Endocrine system, cancers of (thyroid, adrenal and pituitary glands)	7914
Emphysema	6729
Epilepsy (all degrees)	8910
Eye-cancers of	6014

EYE-(DISEASES OF THE EYE-NOT STATUTORY)

- Retinitis	6006
- Glaucoma--all	6012
- Cataracts--all	6027
- All others (including partial blindness-not statutory)	6039
Eye-one foot (anatomical loss or loss of use of)-statutory	5117
Eye-one hand (anatomical loss or loss of use of)-statutory)	5118
Eyes-both (anatomical loss or loss of use of)-statutory)	6099
-Face bones, fracture of	5268
Feet-both (anatomical loss or loss of use of)-statutory	5199
Female organs-cancer of	7627
Female organs-diseases or impairments other than cancer	7629
Femur (thigh), fracture of	5266
Fibula, fracture of	5266
Fingers (phalanges), fracture of	5248
Foot, fracture of	5266
Foot-one eye (anatomical loss or loss of use of)-statutory	5117
Foot-one hand (anatomical loss or loss of use of)-statutory	5116

FRACTURES-(NOT STATUTORY)-CONDENSED LISTING

- Upper body (collarbone, shoulder blade, arms, hands, fingers, ribs and chest)	5248
- Lower body (pelvis, thighs, knees, hip, ankles, feet and toes)	5266
- Spine or trunk (coccyx, sacrum and cervical, dorsal and lumbar vertebrae)	5267

- Head-cranium or skull (includes face, cheek, jaw and nose)	5268
- Fractures-area unknown	5269

FRACTURES-(NOT STATUTORY)-EXPANDED LISTING

-	Ankle	5266
-	Arm (humerus-radius-ulna)	5248
-	Astragalus (ankle)	5266
-	Calcaneum (heel)	5266
-	Calcaneus (heel)	5266
-	Carpus (wrist)	5248
	Cervical vertebra	5267
-	Cheek (malar)	5268
-	Chest (sternum)	5248
-	Clavicle (collarbone)	5248
-	-&ccyx	5267
-	Collarbone (clavicle)	5248
-	Cranium (head or skull)	5268
-	Dorsal vertebra	5267
-	Face bones	5268
-	Femur (thigh)	5266
-	Fibula	5266
-	Fingers (phalanges)	5248
-	Foot	5266
-	Frontal bone (bone of the forehead)	5268
-	Hand	5248
-	Head (cranium or skull)	5268
-	Heel (calcaneum or calcaneus)	5266

- Hip	5266
- Humerus	5248
- Ilium	5266
- Innominate (pelvic)	5266
- Ischium	5266
- Jaw-lower (mandible)	5268
- Jaw-upper (maxilla)	5268
- Knee (patella)	5266
- Leg (femur-fibula-patella-tibia)	5266
- Lower jaw (mandible)	5268
Lumbar vertebra	5267
- Malar (cheek)	5268
- Mandible (lower jaw)	5268
- Maxilla (upper jaw)	5268
- Metacarpus (palm)	5248
- Metatarsus (part of foot)	5266
- Nasal (nose)	5268

- Palm (metacarpus) 5248
- Parietal 5268
- Patella (knee) 5266

- Pelvic (innominate) 5266
- Phalanges (thumb & fingers) 5248
- Phalanges (toes)5266
- Pubic 5266

- Radius (arm) 5248
- Ribs (chest) 5248

- Sacral/sacrum 5267
- Scapula (shoulder blade) 5248
- Shin (tibia) 5266
- Shoulder blade (scapula) 5248
- Skull (cranium or head) 5268
- Spine (trunk) 5267
- Sternum (chest) 5248

- Talus (ankle) 5266
- Tarsus 5266
- Temporal 5268
- Thigh (femur) 5266
- Thumb (phalanges) 5248
- Tibia (shin) 5266
- Toes (phalanges) 5266
- Trunk (spine) 5267

Hand, fracture of	5248
Hand-one eye (anatomical loss or loss of use of)-statutory	5118
Hand-one foot (anatomical loss or loss of use of)-statutory	5116
Hands-both (anatomical loss or loss of use of)-statutory	5159
Head (cranium or skull), fracture of	5268
Hearing-total loss in both ears-statutory	6277

HEART

- Rheumatic heart disease	7000
- Arteriosclerotic heart disease	7005
- Myocardium, infection of, due to thrombosis or embolism	7006

- Hypertensive heart disease	7007
- All others including an undefined coronary	7019
Heel (calcaneum or calcaneus), fracture of	5266
Hemic and lymphatic systems, diseases of (excluding Hodgkin's disease and leukemia)	9998
Hip, fracture of	5266
Hodgkin's disease	7709
Humerus, fracture of	5248
Hypertensive heart disease	7007
Hypertensive vascular disease (essential arterial hypertension)	7101

Ilium, fracture of	5266
Innominate bones (pelvic), fracture of	5266
Intervertebral ruptured discs (disc syndrome)	8889
Ischium, fracture of	5266
Jaw-lower (mandible), fracture of	5268
Jaw-upper (maxilla), fracture of	5268
Knee (patella), fracture of	5266
Laryngectomy, loss of speech (also aphonia)	6590
Leg, fracture of	5266
Leprosy (systemic diseases)	9994
Leukemia	7703
Liver ailments or impairments	7311
Loss of hearing-both ears-statutory	6277
Loss of hearing-partial but not statutory	6269

Loss of sight-both eyes-statutory	6099
Loss of speech (aphonia or laryngectormy)-statutory	6590
Loss or loss of use of (one limb or a part of one limb)-not statutory. For non statutory "loss of use of," impairments, the condition causing "the loss of use of" should be coded if known, otherwise, code as.	9997

LOSS OR LOSS OF USE OF (ANATOMICAL OR OTHERWISE)-STATUTORY

- One foot-one hand	5116
- One foot-one eye	5117
- One hand-one eye	5118
- Both hands	5159
- Both feet	5199
- Both eyes	6099
- Total loss of hearing in both ears	6277
- Organic loss of speech (aphonia or laryngectomy)	6590
- Combination of two or more of above- for example, a quadruple amputee (multiple impairments)	6599
Low back disorder	8889
Lower jaw (mandible), fracture of	5268
Lumbago	8889
Lumbar vertebra, fracture of	5267
Lumbosacral disorders	8889
Lungs, cancers of	6819
Lymphatic and hemic systems, diseases of (exclude Hodgkin's disease and leukemia)	9998
Malar (cheek), fracture of	5268
Malaria (systemic diseases)	9994
Mandible (lower jaw), fracture of	5268
Marie-Strumpell arthritis	5029

Maxilla (upper jaw), fracture of	5268
Meniere's syndrome	6205
Meningitis, cerebrospinal, epidemic	8019
MENTAL DISORDERS	
- Schizophrenic, all types	9200
- All other psychotic disorders	9219
- All organic brain disorders (syndromes)	9300
- All psychoneurotic disorders	9400
- All Psychophysiological disorders	9500
Metacarpus (palm), fracture of	5248
Metatarsus (part of foot), fracture of	5266
Morals (see personality traits)	
Multiple sclerosis	8018
Muscle Injuries	9993
Muscular dystrophy (progressive)	8023
Myocardium, infarction of (due of thrombosis or embolism)	7006
Narcolepsy	8108
Nasal bones (nose), fracture of	5268
Nephritis	7502
NEUROLOGICAL CONDITIONS AND CONVULSIVE DISORDERS	

- Encephalitis, epidemic, chronic 8000
- Paralysis agitans (Parkinson's disease) 8004
- Bulbar palsy 8005
- Brain vessels (embolism, thrombosis or hemorrhage) 8007
- Poliomyelitis, anterior 8011

- Syphilis (cerebrospinal or meningovascular) 8013
- Amyotrophic lateral sclerosis 8017
- Multiple sclerosis 8018
- Meningitis, cerebrospinal, epidemic 8019
- Progressive muscular dystrophy 8023
- Cerebral arteriosclerosis 8046
- Narcolepsy 8108
- All other neurological conditions 8109

- Nose (nasal bones), fracture of 5268

Oral and dental conditions 9996

Osteomyelitis 5000

Palm (metacarpus), fracture of 5248

Palsy (bulbar) 8005

Paralysis affecting cranial and peripheral nerves-if applicable, code under statutory (loss of use of); if not statutory, code under the condition causing the paralysis.
If the cause is unknown, code as 8899

- Epilepsy (all degrees)	8910
Paralysis agitans (Parkinson's disease)	8004
Parietal bones, fraction of	5268
Parkinson's disease (paralysis agitans)	8004
Patella (knee), fracture of	5266
Pellagra (systematic disease)	9994
Pelvic bones (innominate bones), fracture of	5266
Peripheral nerves-paralysis affecting--not statutory	8899
Personality traits--other than shown under mental disorders (includes habits, morals, alcoholism, drug addiction and others)	9992
Phalanges (thumb and fingers), fracture of	5248

Phalanges (toes), fracture of	5266
Phlebitis (includes thrombophlebitis)	7121
Pituitary ailments	7900
Plague (systemic diseases)	9994
Pleura, cancers of	6819
Pleurisy	6729
Poliomyelitis, anterior	8011
Progressive muscular dystrophy	8023
Prostate, all injuries or impairments to	7526
Psoriasis	9995
Psychoneurotic disorders (all)	9400
Psychophysiological disorders (all)	9500
Psychotic disorders (other than schizophrenics)	9219
Pubic bones, fracture of	5266
Pyelitis	7502
Pyelonephritis	7502
Quadruple amputee (statutory)	6599
Radius (forearm bone), fracture of	5248
Raynaud's disease	7117

RESPIRATORY SYSTEM

- All diseases or impairments of the trachea and bronchi including
  - bronchitis, bronchiectasis and asthma 6600
  - Tuberculosis, all categories 6701
- All other diseases of the lungs and pleura including pleurisy, emphysema, siliocosis, etc. 6729

Respiratory system-lungs and pleura-cancers of	6819
Retinitis	6006
Rheumatic heart disease	7000
Rheumatoid arthritis	5002
Ribs (chest), fracture of	5248
Ruptured disc- intervertebral- (disc syndromes)	8889
Sacral/sacrum, fracture of	5267
Sacroiliac disorder	8889
Scapula (shoulder blade), fracture of	5248
Scars	9995
Schizophrenic, all types and degrees	9200
Sciatica	8889
Sclerosis, amyotrrophic lateral	8017
Sclerosis, multiple	8018
Shin (tibia), fracture of	5266
Shoulder blade (scapula), fracture of	5248
Silicosis	6729
Skin, cancers of	7818
Skin, ailments or injuries other than cancer (including burns, severe scars, psoriasis, etc.)	9995

Skull (cranium or head), fracture of	5268
Speech, organic loss of (aphonia or Laryngectomy)-statutory	6590
Spine (trunk), fracture of	5267
Spinal cord, cancers of	8021
STATUTORY (ANATOMICAL LOSS OR LOSS OF USE OF)	
- One foot-one hand	5116
- One foot-one eye	5117

- One hand-one eye	5118
- Both hands	5159
- Both feet	5199
- Both eyes	6099
- Total loss of hearing in both ears	6277
- Organic loss of speech (aphonia or laryngectomy)	6590
- Combination of two or more of above-for example, a quadruple amputee (multiple impairments)	6599

Sternum (chest), fracture of	5248
Syphilis (cerebrospinal or meningovascular)	8013
Systemic diseases (cholera, leprosy, malaria, plague, pellagra, typhus, etc.	9994

Talus (ankle), fracture of	5266
Tarsus, fracture of	5266
Temporal (skull bone), fracture of	5268
Thigh (femur), fracture of	5266
Thrombophlebitis	7121
Thumb (phalanges), fracture of	5248
Thyroid ailments	7900
Tibia (shin), fracture of	5266
Toes (phalanges), fracture of	5266
Trachea and bronchi, diseases of	6600
Trunk (spine), fracture of	5267
Tuberculosis---all degrees (respiratory system only)	6701
Tumors, benign (brain only)	9980
Tumors, benign (other than brain)	9981
Typhus (systematic diseases)	9994

Ulcers-all categories (digestive system)	7304
Ulna (large bone of the forearm), fracture of	5248
Unknown ailment or impairment (also unclassified)	9999
Upper jaw (maxilla), fracture of	5268

Vascular disease (see arteries and veins)

Vertebra (cervical, dorsal and lumbar), fracture of	5267
Voice-organic loss of speech (aphonia or laryngectorny)	6590
Whiplash	9991
Wounds, gunshot	9982
Wounds, other than gunshot	9983
Wrist (carpus), fracture of	5248

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CHAPTER 8. DEATH CASE DECISIONS-NSLI AND USGLI

CHAPTER 8. DEATH CASE DECISIONS-NSLI AND USGLI

SUBCHAPTER 1. NSLI

8.01 ADJUDICATION PROCEDURE

a. When the claim is filed during the lifetime of the insured, and before a determination is made on the claim for waiver of premiums, the insurance matures because of death, the payment of the insurance proceeds take precedence. The Death Claims Section after processing the case, will refer the folder to the ICS (Insurance Claims Section) for preparation of a paper diary, VA Form 29-5716b, DIC Diary Card-NSLI-USGLI, for final determination on the pending claim for waiver of premiums.

b. If a disability waiver determination is necessary to place the insurance in force at death, the Death Claims Section will refer the case to ICS.

8.02 PRELIMINARY PROCESSING

a. When the claim is filed during the lifetime of the insured, the machine produced VA Form 29-1565-3, Decision Disability Insurance Benefits, will be used.

b. If the claim is filed after the death of the insured and the account was active on the date of death, the General Clerk/Claims Examiner will prepare VA Form 29-1565-3, completing the "Claim No."' contract information and "Premiums Paid To" items obtaining the information from the VA Form 29-368d, Report of Status for Settlement of Death Claims. When the VA Fond 29-1565-3 is prepared by the General Clerk, it will be referred with the insurance folder to the Claims Examiner.

c. When the claim is filed after the death of the insured and the account is lapsed, flee Adjustment Claims Clerk/Claims Examiner will prepare VA Form 29-1565-3, completing the items mentioned above including monthly premium rate.

d. The Claims Examiner will check and compare the name, file number, date of birth, claim/social security number, etc., on the VA Form 29-357, Claim for Disability Insurance Benefits, with records in the insurance folder. Status of the insurance lapses and reinstatements, etc., will also be checked. It should be verified that the claim is by the beneficiary; or the estate of the beneficiary; or if the estate is the beneficiary then by administrator, or the next of kin.

e. The Claims Examiner will review the claim to determine the need for initial development of evidence or if the evidence is sufficient to make a decision. The case is either processed to completion or referred to an Authorizer depending on the complexity of the case. (See ch. 2.)

8.03 DEVELOPMENT

a. Instructions for developing a claim are outlined in chapters 2 and 3.

b. The evidence required to establish TD (Total Disability) in death cases, is the same as in live cases. The manner and sources from which evidence is obtained is the same in either case.

c. A paper diary, VA Form 29-5716b, will be prepared for a 45 day diary for control of a pending claim since there is no insurance master record on tape. The notation "XC Case" will be made in the right lower portion of the form.

8.04 PROOF OF TOTAL DISABILITY

a. When a claim for waiver of premiums is filed after the death of the insured, evidence establishing TD for 6 consecutive months must be of record in the VA within 1 year of the insured's death.

b. If evidence is not received within l year from the date of death of the insured, the claim will be disallowed.

c. When the claimant is requested to furnish additional evidence, he/she will be advised of flee time remaining in the 1-year limitation period for the submission of such evidence.

d. When there is timely evidence, but it is lacking only confirmation, additional evidence for the purpose of such confirmation may be sought and obtained even though the1-year period has expired. The question of what is confirming evidence must be determined in each individual case. when there is any doubt, the question should be resolved in favor of the claimant.

8.05 MATURITY OF INSURANCE UNDER 38 U.S.C. 713

a. When premiums cannot be waived under section 712, solely because the insured died before total disability continued for 6 months, and satisfactory proof of such fact is received within l year of the insureds death, the insurance shall be deemed to be in force on the date of death, and the unpaid premiums shall become a charge against the proceeds of his/her insurance. (See 38 U.S.C. 714.)

b. When a decision is rendered by ICS based on such facts, the VA Form 29-1565-3 will be prepared. In the award block enter the notation, "Payable under Section 713."

c. After the decision is made, the case will be referred to the Death Claims Section for payment of the proceeds.

8.06 PREPARATION OF VA FORM 29-1565-3, DECISION DISABILITY INSURANCE BENEFITS

In preparing VA Form 29-1565-3 in a death case, the instructions listed in chapter 4, paragraph 4.04a, will be followed with the exceptions listed below:

Item	Entry Required
Claim No.	Enter a X before the c and number or XSS (Social Security) and number.
Diary Control	Leave blank.
Method of Premium Payment	Leave blank.

Item	Entry Required
Total or Total Permanent Disability Found	
From	Insert the commencing date of disability.
To	Insert the date of death.
Follow-Up Date	Leave blank.
Severity Code	Leave blank.
Review Date	Leave blank.
Disability Classification Code	Leave blank.
Action Code	Leave blank.
Principal Occupation(s)	Leave blank.
Educational Background	Leave blank.

8.07 NOTIFICATION OF ACTION TAKEN

a. When the insured dies before completion of action on his or her claim or when the claim is submitted by an eligible claimant, and such claim is denied or partially denied, a certified letter will be sent to the beneficiary, the administrator of the estate, or next of kin. An appropriate letter will also be sent if the decision is favorable.

b. If a claim for waiver under section 7I2 has not been filed, but entitlement under section 713 is found no letter will be released by the ICS.

c. If the claim is disallowed, no certified letter will be sent; however, an appropriate letter AT (automatic typewriter) will be released to tile beneficiary, administrator of the estate, next of kin or the claimant.

SUBCHAPTER 2. USGLI

8.08 BASIC REQUIREMENTS

a. When no claim for TPD (Total Permanent Disability) insurance benefits was filed during the lifetime of the veteran, and the insurance was in force on the date of claim, or if the insurance had not been canceled or reduced subsequent to July 2, 1926, a decision will not be rendered. The claim will be disallowed.

b. A claim for total disability income benefits will not be considered under any circumstances unless the claim was filed prior to the death of the insured or the beneficiary shows failure to file was due to circumstances beyond the insured's control. Refer to M29-1, Part l ,chapter 32, paragraph 32.12a(10).

8.09 DEVELOPMENT OF EVIDENCE

Preliminary action on claims for disability insurance benefits in death cases will be taken by the Authorizer. The evidence will be developed and a decision rendered in the same manner as in cases in which the veteran is alive.

8.10 ADJUDICATION PROCEDURE

a. When the claim was filed alleging TPD for insurance purposes, and a favorable or partially favorable decision is rendered after the death of the insured under which the insurance matured by reason of TPD, ICS will prepare VA Form 29-1 565-3, showing entitlement; however, award action will not be taken.

b. After the decision is approved and processed, persons entitled to the benefit will riot be advised of the action taken on the claim.

c. The case will be forwarded to the Death Claims Section for all further necessary action.

d. If the decision results in a complete denial of the claim, a disagreement letter (certified) will be sent to the beneficiary or other person who would be entitled to the benefits if granted.

e. Under the total disability provision, when the claim was filed prior to the death of the veteran for TD insurance benefits (sec. 748) and the decision is rendered after death, the claim will be adjudicated substantially in accordance with the procedure for the adjudication of such claim in cases in which the veteran is alive.

f. Upon approval of the decision, the case will be processed as provided in subparagraphs b and c above.

g. If the claim is partially allowed or completely denied, the Authorizer will release a letter (certified) to advise the beneficiary of the action taken.

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CHAPTER 9. FRAUD

CHAPTER 9. FRAUD

9.01 JURISDICTION

a. The Insurance Claims Section is responsible for and has jurisdiction in questions of fraud in the procurement or reinstatement of insurance or the total disability income provision, conversion to an endowment policy and a change of plan to one with a lower reserve. Such cases are subject to appellate reviews by the Board of Veterans Appeals and to suits brought in appropriate Federal District Courts under 38 U.S.C. 784. If the possibility of fraud is detected by another element of the Insurance Operations Division, the case will be referred to the Insurance Claims Section.

b. The Office of the Assistant Director for Insurance, VA Center, Philadelphia, will, upon request from an adjudicating activity, review and render a final decision concerning fraud in unusual or complex cases subject only to review through appellate or judicial procedures. This office may upon its own initiative, review any decisions rendered by the Insurance Claims activities at St. Paul or Philadelphia and, if appropriate, render an independent decision on the merits of the case which will be binding upon such offices.

9.02 INITIAL CONSIDERATION

a. The question of possible fraud must be considered in all cases involving pending claims for disability insurance benefits. Statements add information received in support of, or in connection with, a claim should be compared with statements made in the applications for insurance. Applications are defined as:

(1) Original application for insurance or total disability income provision;

(2) Applications for reinstatement of insurance or total disability income provision on the basis of good health or comparative health;

(3) Applications for change to lower reserve plans;

(4) Applications for conversion to endowment plans.

b. When a claim for disability benefits is received, personnel should note the date the disability is alleged to have commenced and the dates on which the insured claims to have been treated for the disability. The insurance folder should be reviewed to see if any of the applications mentioned above were approved during the period of the alleged disability or treatment.

c. If it appears that an application was approved and failed to disclose any information about a health impairment whether it is the basis for the claim or not, the possibility of fraud must be explored.

d. Information received with disability compensation and pension claims should also be considered.

(I) The insured's claims folder generally should be obtained in all cases where it is indicated that it may contain information bearing on the question of fraud.

(2) When a claims file cannot be obtained because of a pending claim for adjudication benefits, no final action will be taken until the claims folder is received.

e. When the question of fraud is being considered on **a** case involving reinstatement of extended insurance prior to any other development, a request will be made for the amount of extended insurance as of the date

of application for reinstatement. If the requirements of VA Regulation 3422 are met, a fraud decision will not be made.

f. A statement to the effect that fraud was, or was not found, or is awaiting development, will be included for each contract in all decisions made by the Insurance Claims Section.

g. If the evidence essential to determine the question of fraud is not complete, and the particular application which appears to be fraudulent does not directly affect the entire claim for disability insurance benefits, the award block on VA Form 29-1565-3, Decision Disability Insurance Benefits, covering the contract under consideration for fraud wild be `noted, "Deferred-possible fraud." This will permit adjudication of the claim for disability insurance benefits under the other contracts involved.

h. If false or misleading statements were made in connection with procurement or reinstatement of insurance or the total disability income provision, and the applicant's mental condition makes it questionable as to whether he/she comprehended the nature of his/her action in making false statements, the case should be forwarded to the Assistant Director for Insurance, VA Center, Philadelphia (290B), for review as to the possible existence of fraud. Such a case will be fully developed before it is submitted. The fact that the insured may have previously suffered from a mental illness of a varying degree will not of itself warrant submission. Evidence must be present to establish that at the time the application in question was filed, the applicant was suffering from a mental illness of such severity as to cause a radical departure from his/her normal conduct. It must be determined, with reasonable certainty, that the applicant could not be held responsible for his or her act. The evidence must be strongly suggestive that the applicant did not comprehend the nature of his/her act. A finding of incompetency is not, in itself, sufficient to warrant referral of the case to Philadelphia.

9.03 NOTICE

M29-1, part I, chapter 32, paragraph 31.44a, explains briefly the doctrine of notice. Adjudicative personnel must understand that once final action is taken on an application, VA is on notice of all information either expressly given or implied, in the record. VA is prevented from raising the defense of fraud at a later date. Some specific examples of notice are listed below:

a. If the application shows treatment by a physician and that treatment would have been pertinent to accept. ability, VA is on notice of all treatment given by the physician even though the physician did not describe dealing with the insured's condition at the time of the application.

b. If an insured states that he/she has applied for compensation or pension benefits, he/she undoubtedly has suffered from some disability at one time or another. The fact that the nature and degree of the disability were not developed before acceptance will not bar the doctrine of notice if such disability is pertinent,

c. Likewise, if an applicant has applied for compensation or pension and states that he/she has not received benefits, VA is on notice that he/she once suffered from a disability and development should precede acceptance. However, VA cannot be held responsible for disability information contained in the claims file if he/she furnishes a claim number but denies that he/she ever applied for disability benefits, compensation or pension, or that he/she ever received any disability benefits, since this would lead VA to believe that the assignment of the claim number was for other than disability purposes.

d. If a claim number is furnished without supporting statements of disability, VA is on, notice and must examine the "C" file.

9.04 WAIVER OF RIGHTS

a. The general administrative policy regarding fraud determinations is based largely upon well-settled principles of insurance law that an unequivocal act by an insurer, with knowledge of facts which would constitute a cause for forfeiture, which treats the policy as still in force and leads the insured to regard himself/ herself as still protected, will amount to a waiver of forfeiture. Such a waiver may be evidenced by the insurer's words or acts, or the failure to act after acquiring knowledge of the facts, and thus may be inferred from his/her recognition of the continued effectiveness of the policy.

b. When a case has been adjudicated and benefits have been awarded, it will thereafter be improper to hold fraud if the evidence upon which fraud would be predicated had been considered, or was present for consideration at the time the case was previously adjudicated. In such a case, it will be deemed that the VA has waived its right to contest the validity of the application in question.

c. If, upon review of a case for continued entitlement to benefits, evidence suggestive of fraud is received and such evidence is overlooked or improperly evaluated, VA cannot at a later date use this evidence as a basis for finding fraud.

d. Therefore, as a matter of law, an "election" must be deemed to have been made by the VA to continue the policy because of failure to take action to forfeit within a reasonable time after receipt of notice of the material misrepresentation. This constitutes an implicit waiver of the right to forfeit for fraud. Such a waiver need not be expressed. It may be presumed from the facts.

e. The application of the principles of waiver concerning actions on the part of the insurer after knowledge of facts must be consistent with reasonable application from an administrative point of view. The positive action by insurance personnel, other than Insurance Claims, which can cause a waiver of the right to find fraud, are limited to those actions taken when the issue involved embraces a required determination concerning the condition of the insured's health as it affects his/her insurability. Such actions would be in connection with applications for insurance or total disability income provisions, applications for reinstatement of insurance or the income provision on the basis of good health or comparative health, and applications for changes to lower reserve plans.

(l) For example: Assume that an insured, 5 or more years before submission of a claim for benefits, had obtained a rider and at the time of application had not furnished information about treatment for a duodenal ulcer. The material information withheld was such that had it [been available at the time the application was considered, it would have] caused a medical rejection. The insured, after the approval of the rider, has had no further treatment or symptoms referable to GI complaints. After 5 years, the insured files claim for total disability on the basis of a totally different condition from the one withheld and current medical evidence reflects that he/she is still symptom-free of GI complaint.

(2) Under these facts, VA has suffered no detriment as a result of his/ her misconceptions. VA should not enforce the strict legal technicalities in a case such as the above and forfeit the contract because of fraud. VA's responsibilities require that decisions should be just and fair and consistent with all the facts in a given case.

f. When the principles of equity are applied, a formal no fraud decision will be prepared setting forth all the facts as in any formal decision concerning fraud, together with those facts upon which the application of equity is based. The concluding paragraph will be substantially as follows: "Careful consideration has been given to the question concerning fraud. In view of the circumstances, it is the decision of the Insurance Claims Section that it would be against equity and good conscience to cancel the application in question because of fraud."

g. It is obviously impossible to set forth criteria will govern all categories of cases. Each case in which an issue concerning contest of a policy for fraud is raised presents mixed questions of fact and law requiring careful analysis in the light of settled principles of insurance law. It should be borne in mind that, with the passage of time, it generally becomes increasingly difficult not only for the Government to prove all the elements of fraud, but also for the insured to adduce evidence in rebuttal due to loss of witnesses, the loss or destruction of records, etc. Consequently, in fairness to all concerned, it is essential that the VA act promptly upon discovery of fraud and make a final decision whether to forfeit the contract.

9.05 PRINCIPLES OF EQUITY

Extreme care should be exercised in the application of equitable principles. They should not be used to grant relief except in the most deserving cases when there are extenuating circumstances to the degree that it can be reasonably said that the cancellation of the contract would be highly inequitable.

9.06 REQUEST FOR MEDICAL OPINION

When the withheld information appears to be material to the question of acceptability, then examination of the pertinent provisions of the current Medical Underwriting Procedures Manual, M29-1, Part V, should be made by the Authorizer or Senior Authorizer.

a. If the information withheld in the opinion of the Authorizer or Senior Authorizer is obviously immaterial when applied against the manual, an informal written concurrence will be obtained from either the Chief, Medical Determination Section or the Medical Consultant.

b. In some cases in which the rating of M29-l, part V, depends on the condition at the time of application, but the evidence of record relates to the condition of the insured as of a time in the past, it will not be possible to determine materiality. In such cases, it will be necessary to develop for evidence of the condition for any necessary periods of time called for by the manual. This will permit better judgment by the Medical Consultant and may also be of assistance to the Insurance Claims Section with the elements of knowledge and intent.

(l) Example: An insured fails to disclose prior treatment for psychosis occurring 4 years before application for TDIP. In developing a claim for disability benefits, it was determined that additional evidence would be needed regarding the severity of the attack, when such attack occurred, whether the insured has pursued normal activities or whether he/she required treatment and medication since the attack and within the period of time specified by M29-l, part V.

(2) After development has been completed and the evidence withheld appears to be material to the acceptability of the application, the case will be sent by the Authorizer or Senior Authorizer by memorandum to the Medical Consultant, for an opinion. The memorandum will contain the facts in the case, specify the false or incomplete answers or statements made by the insured and cite the pertinent information not available at the time the application was approved. A request will be made for a written opinion as to whether the application would have been acceptable under applicable instructions at that time and also under current instructions. In addition, the Medical Consultant should be requested to clearly state the pertinent provision of the manual, both old and new, under which the application would have been accepted or rejected.

(3) If the concealed health condition is not related to the basis for claim, the Medical Consultant should also be asked whether the condition would have been considered as acceptable at the time the claim was submitted or any earlier date. Careful consideration should be given to materiality if, subsequent to application and prior to claim, the applicant would have been considered an acceptable good health risk.

9.07 NOTICE TO INSURED

a. When it has been concluded on the basis of the Medical Consultant's report and all the evidence of record that VA could reasonably prove all necessary elements of fraud, a letter will be sent to the insured. He or she will be furnished with a photocopy of the pertinent page of the application in question calling his/her attention to the statements made when completing the application, and to the conflicting information VA now has. Insured's attention should be called to that part of the application form which requests truthful answers and emphasizes the consequences of misrepresentation. He/she should also be asked to explain the statements in light of the conflicting evidence.

b. Related Internal Actions

(1) If monthly disability benefits payments are currently being made, they will be terminated effective as of date of last payment, pending the determination of fraud, and the inured will be told of this action.

(2) Waiver of premiums will not be stopped while fraud is being considered.

(3) Immediately upon the discovery of fraud or possible fraud, a warning notice will be filed and so folded as to overlap all materials on the left side of the insurance folder.

The notice should be in large type as follows:

CAUTION

FRAUD IN (appropriate application) UNDER CONSIDERATION.

(signature and title)_____

(date)_____ _____

(4) A 45-day diary message, FRAUD DEC PEND, will be entered in the master record as a flash to all operating personnel.

(5) A policy freeze will be inserted in the master record, except when the fraud involves TDIP also.

(6) All subsequent incoming correspondence related to the fraud action will be referred to the Insurance Claims Section.

(7) Extreme care should be exercised in the release of correspondence to the insured while fraud is pending. These letters must not be in conflict with the possible fraud action. The insurance folder should be reviewed in connection with any action taken while a fraud decision is pending.

9.08 INSURED'S REPLY

a. Careful consideration should be given to the insured's reply and explanation with particular attention focused on the information relating to his/her knowledge and intent.

b. If the reply is unclear or ambiguous, clarification should be requested.

c. A diagnosis in itself is of no value unless VA knows that it was explained to the insured or that he/she was given treatment, medication or recommendations which should have led him/her to know he/she had some health impairment. Again, if clarification is needed, it should be requested.

d. The insured is to receive every courtesy and consideration to which he/she is entitled.

9.09 DEATH OF INSURED WHILE FRAUD DECISION PENDING

a. If the insured dies while a case is under consideration for fraud, development will continue until a decision can be made. The beneficiary will be given the opportunity to rebut the allegation of fraud. A letter will be released informing the beneficiary(ies) that the case is being developed for fraud and giving the current status of the fraud development.

b. If the insured has multiple policies, and only one policy is under development for fraud, proceeds of any policy that can be paid will be released to the beneficiary as soon as the appropriate evidence is received. The beneficiary will be informed that settlement of the other contract(s) will be delayed pending the resolution of the fraud question.

c. If only the TDIP application is under consideration for fraud, the fact that, in most cases, only a small amount of benefits will be payable must be taken into consideration in determining whether to continue to develop the question of fraud.

9.10 PREPARATION OF VA FORM 29-808, DECISION OF INSURANCE CLAIMS SECTION-GOVERNMENT LIFE INSURANCE

a. General

(l) Formal decisions will be prepared on VA Form 29-808, in duplicate, and will be prepared by the Authorizer or Senior Authorizer, as appropriate, requiring the signatures of such Authorizer and the Chief Insurance Claims Section, or designee. No copies of fraud decisions will be released to service organizations.

(2) The decision will follow insofar as practical the format required in the preparation of a "Statement of the Case" so that in the event of an appeal the preparation of such statement can be facilitated.

b. Specific Entries

(1) Item 1, Type of Decision Fraud

(2) Items 2, 3,4 and 5 will be completed with appropriate entries.

(3) Item 6, ilk Remarks area and continuation pages, as needed, will contain the following elements:

(a) Issue

(b) The basis for consideration of the question of fraud

(c) Contention of insured

(d) The law and regulations (38 U.S.C. 710)

(e) Summary of evidence

(f) Reasons for decision

(g) Decision. The decision paragraph should contain a statement substantially as follows: "Based upon the evidence of record, it is the decision of the Insurance Claims Section that the applicant purposely omitted information about his/her health for the purposes of misleading the VA with respect to a health condition which was material to determining his/her acceptability. As a result, the VA was misled into approving the application which would have been rejected had the facts been known." In addition, the following paragraph, completed as appropriate, will be added to the above. "Under the circumstances, the veteran's application for

insurance
_____reinstatement_____dated_____under
total dis inc.prov.

policy number _____ _____ is contestable for fraud and should be canceled."

(4) When two reinstatements are involved and the first one is contestable for fraud, but a later comparative health application by itself is not considered fraudulent, the following will be used as a concluding paragraph under decision. "Since the application dated for reinstatement in the amount of $____was accepted on the basis of the insurance validity in force by the reinstatement dated_____the reinstatement dated _____ should also be canceled."

c. The Authorizer will also refer the folder to the Insurance Adjustment Clerk who will prepare VA Form 29-328, Underwriting Worksheet, by completing items 1 through 12, if appropriate. A voucher number will be assigned to the case and inserted in the top right comer of the form. The refund will consist of all monies paid as premiums without interest on any fraudulent contract for any period subsequent to 2 years after date of issue, less any loan, lien or any other indebtedness.

d. The Insurance Adjustment Claims Clerk will also prepare VA Form 29-8523, Premium/TDIP (Document 03), with transaction type codes 083 and 087 in order to effect the proper accounting. This form will be completed in accordance with existing instructions in MP-6, part II, supplement No. 2.2, paragraphs 205.10 and 205.12. For appropriate accounting information, refer to M29-l, Part II, Chapter 24, Control Accounts.

e. VA Form 4-706, Notice of Refund, must accompany VA Form 29-8523 as this input does not automatically released the refund in cases in which control number 52 is credited. VA Fond 4-706 will be completed as the items indicate. In Item 8, Type of Refund Authorized as Shown Below, the last **check** box will be checked and "Fraud Case" will be inserted next to it. Item II, Calculations-Remarks, will show the calculations made on VA Form 29-328. Reference to VA Form 29-328 will be made citing the fact that ICS made the decision on fraud and the date of the decision.

f. The clerk will also prepare VA Form 29-8527, Accounting Control (Document 07), with transaction type code 099 and reason code 07 in order to remove an insurance contract or both the insurance contract and TDIP (Total Disability Income Provision) rider segments from the insurance in force master tape. Refer to MP-6, part II, supplement No. 2.2, chapter 2, paragraph 209.05.

g. If only the TDIP rider is to be deleted, the clerk will prepare VA Form 29-8531, TDIP (Document 11), with transaction type code 097. Refer to MP-6, part II, supplement No. 2.2, chapter 2, paragraph 213.11.

h. After completing the forms discussed above, they, along with the insurance folder, will be forwarded to the Voucher Audit activity and then to the Miscellaneous Accounts and Service Unit for their respective actions.

9.11 CLAIM FOR DISABILITY INSURANCE BENEFITS INVOLVED

If fraud is found when a new claim for disability insurance benefits is involved or a continuing award is in effect at the time of the preparation of the fraud decision, the Authorizer or Senior Authorizer will prepare a denial of the claim or termination of the award, as appropriate, based on the finding of fraud. if there is more than one contract, and fraud is found in one or more but not all contracts, the entry "Fraud Found in This Contract," will be entered in the appropriate block on VA Form 29-1565-3.

a. When there is a continuing award on a contract and the original application is determined to be fraudulent, the award will be discontinued as of the beginning date.

b. If a reinstatement of a contract is determined to be fraudulent, the contract will be canceled as of the date of the reinstatement, and any continuing award under the reinstatement will be terminated as of the effective date of such award.

c. A memorandum will be prepared to the Policy Service Section calling attention to the fraud decision and requesting action to cancel the contract. The memorandum will also request all the following information to be included in the certified letter to the claimant: The date of cancellation of the contract, the total amount of the premiums and/or suspense items to be refunded, the amount of outstanding loan to be repaid, etc.

d. After the forms are typed, the Authorizer or Senior Authorizer will check, sign the decision, initial the file copy of the memorandum, sign the disallowance or termination forms, and take any other adjudicative action necessary, after which the case will be forwarded for consideration and signature of the Chief, Insurance Claims Section or designee.

e. The Chief of the Insurance Claims Section or designee has final local authority concerning a fraud decision.

f. In view of the legal implications and far-reaching effects of a fraud decision, authority is given to the Chief, Insurance Claims Section, to select individuals with the necessary training and experience to handle cases of possible fraud.

g. Upon return of the folder from the Policy Service Section, the Authorizer or Senior Authorizer will prepare a letter to be sent by certified mail notifying the claimant of the disallowance of the claim or the termination of insurance benefits, the date of cancellation of the contract, the amount to be refunded and all the other pertinent accounting information. The insured will be fully informed of his/her right to appeal and advised of the time limit thereon as in other cases.

9.12 CLAIM FOR DISABILITY INSURANCE BENEFITS NOT INVOLVED

When a determination of fraud is made by the Insurance Claims Section which does not involve a claim for disability insurance benefits, action will be taken as outlined in paragraph 9.11, except that disallowance of claim, stop waiver and stop notice forms will not be necessary. The Insurance Claims Section will prepare and release the certified notification of fraud to the insured after receiving the necessary information from the Policy Service Station.

9.13 DISPOSITION OF FRAUD DECISIONS

The folder with the forms will be forwarded for dating and distribution as follows:

a. The original of the fraud, letter together with the file copy and an envelope, will be hand carried to the Administrative activity for release via certified mail.

b. The folder will be retained in the Insurance Claims Section pending the return of the file copy of the letter. Upon return, the copy will be filed with the original of the fraud decision in the insurance folder.

9.14 FINDING OF NO FRAUD

If a formal decision is prepared in which it is held that there is no fraud, the same procedure for preparation and routing will prevail as when determination is made that there is fraud, except that in such an instance, notice to the insured will not be required. Upon dating of the decision as to fraud, the appropriate folder with the fraud decision will be returned to the Authorizer or Senior Authorizer for action on the claim or will be referred to the originating element, as appropriate.

9.15 REVERSALS OF FRAUD DECISIONS

In any case in which a decision finding fraud or no fraud is rendered by Insurance Claims Section on evidence then of record, no reversal of such decision will be in order by any activity on the same level of authority in the absence of new and material evidence. A mere difference of opinion or judgment is not sufficient; however, new and material evidence will support reconsideration of the question of fraud whenever received.

9.16 REINSTATEMENTS AND UNASSOCIATED REMITTANCES

a. When a question of fraud arises in connection with reinstatement of insurance and the application of previously unassociated remittance(s) would have prevented the lapse of the insurance if applied to the months for which originally paid, the reinstatement of the insurance will be disregarded and fraud will not be considered.

b. If the previously unassociated remittance(s) was insufficient to cover the entire period up to the date of reinstatement, then the date of lapse, for the purpose of consideration of the question of fraud, will be determined on the basis of the insurance having been in force for the period covered by the previously unassociated remittance(s).

9.17 CRIMINAL FRAUD

Generally, when fraud has been found and the insurance or total disability income provision has been canceled, the case should be referred to the General Counsel for possible transmittal to the United States Attorney under VA Regulation 5560 for such action as the Department of Justice, acting through the United States Attorney, may deem necessary when the evidence is sufficient to show a prima facie violation of a criminal status, such as under 38 U.S.C. 787, or 18 U.S.C. 1001. However, there are exceptions in which the Department of Justice has indicated that it will decline prosecution. These are where:

a. The statute of limitations has run, or cases in which the time that would be consumed after referral to the appropriate United States Attorney, and conducting any addition necessary inquiry, would foreclose the possibility of initiating proceedings, prior to the running of the statute. The statute of limitations with respect to criminal fraud is 5 years (18 U.S.C. 3282). This time commences to run from the date of the filing of the fraudulent document. If less than 6 months' time remains within which to bring action, the case will not generally be referred to the Department of Justice.

b. The potential subject of a criminal action is not only a veteran but one who may be laboring under a severe physical handicap, eliciting the strong sympathy of a jury, unless they disclose an aggravated course of misconduct.

c. A doctor who is implicated as an alleged aider or abettor will be prosecuted only in the event the physician has counseled a number of veterans to prepare and submit false claims evidencing ~ pattern of conduct on his/her part.

d. The contract has been properly canceled but it Is shown that although the veteran might have been competent at the time of the commission of the offense he/she has since been rated incompetent or has been adjudicated insane under State court proceedings,

e. Although the contract has been canceled, either before or after such action the veteran was diagnosed as having a terminal illness with a brief life expectancy.

f. Even though all the elements of fraud were present in connection with an application, the veteran later disclosed his/her actual state of health as of the time of the application or prior thereto when he/she ultimately filed a claim for disability income benefits, so as, in effect, to purge the fraud before any payments are made as a consequence thereof.

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10.01 NOTIFICATION OF RIGHT TO APPEAL

a. When a decision is made which is adverse to the allegation made by the claimant, or benefits are terminated, a notice of such adverse action will be sent by certified mail, with a VA Form 1-4107, Notice of Procedural and Appellate Rights, or equivalent information to the claimant and his/her representative, if any. The term "representative" includes agent, attorney or authorized representative. Only one attorney, agent or service organization will be recognized at any one time.

b. The letter will show the date of the decision, reason(s) therefor and advise the claimant and authorized representative of the right to initiate an appeal by filing a notice of disagreement and that such notice must be filed within 1 year from the date of notification. In the event of death, the beneficiary(ies) may exercise the right of appeal.

10.02 NOTICE OF DISAGREEMENT

a. It is the responsibility of the Adjudicator to determine whether a communication is a notice of disagreement. Any written expression of dissatisfaction or disagreement with a decision made on a claim is considered a notice of disagreement. One important factor to be considered when making a determination as to whether an objection raised by the claimant is a notice of disagreement is the intent of such claimant. A mere complaint letter or a mere inquiry for additional or more clarifying information should not automatically be accepted as a notice of disagreement. In most instances, such complaint letters can be handled by a letter of explanation which should also contain a statement reminding the claimant of the time limit for filing a notice of disagreement.

b. A notice of disagreement may be filed by the claimant or his/her appointed representative. This representative may be a service organization (VA Form 23-22, Appointment of Veterans Service Organization as Claimant's Representative, needed); a third party granted power of attorney (VA Form 2-22a, Appointment of Attorney, or Agent as Claimant's Representative); or an attorney who states under his/her letterhead that he/she represents the claimant. If the claimant is incompetent the notice may be filed by the legal guardian or other fiduciary, or in the absence of one of these, by the next of kin or friend.

c. The notice of disagreement must be filed within 1 year from the date of mailing of the notification of adverse decision. Failure to file a notice of disagreement within 1 year shall make the original decision final and the claim will not thereafter be reopened or allowed.

d. A notice of disagreement postmarked prior to the expiration of the 1-year period will be accepted as timely. In computing the time limit for filing, the 1st day of the period will be excluded, but the last day of the period will be included. If the last day falls on a Saturday, Sunday or holiday, the period will be extended to the next workday. The filing of new evidence after receipt of notification of adverse decision does not extend the time limitation for filing a notice of disagreement.

e. While it is contemplated that proper notice of the right to appeal and the time limit involved will be given, failure to notify the insured of his/her right to appellate review or the time limit applicable to a notice of disagreement or substantive appeal will not extend the time limit allowed for taking this action.

f. The BVA (Board of Veterans Appeals) will make a final determination of any appellate jurisdiction when the timely filing of a notice of disagreement or substantive appeal is in question; e.g., a few days late or claimed extenuating circumstances. This final determination will be made after a statement of the case or the equivalent in correspondence has been furnished the claimant-appellant and the issue has been certified to the BVA.

10.03 CONTROL OF APPEAL CASES

a. All insurance appeal cases are controlled by the Appeal Record Control Clerk in the Insurance Division under VARMS (Veterans Appeals Records Management System) as outlined in M23-l, part I, chapter 7.

b. VARMS is an automatic record keeping system designed to maintain controls on appeals, which utilizes ADP (automatic data processing) equipment to maintain appeal records on magnetic tape.

c. A master record is created for each appealed case and is updated with each action as the case moves through the various stages of the appeal until disposition. VARMS will generate edit-update message listings, suspense listings, master listings, and quarterly reports to the BVA as outlined in M23-l, part I, chapter 7.

d. Upon receipt of a notice of disagreement, and at each subsequent stage of the appeal process (release of a statement of the case, receipt of a substantive appeal, hearing requested, certification to BVA, and receipt of a BVA decision), the insurance file should be forwarded to the Appeal Record Control Clerk to establish and update the master record in VARMS.

10.04 PROCESSING OF NOTICE OF DISAGREEMENT

a. When correspondence is initially received in the ICS (Insurance Claims Section) and it is identified as a notice of disagreement, the Adjudicator will review all the evidence of record to determine if the benefits sought can be granted.

b. If no change in the decision is warranted, the following actions will be taken:

(l) Release FL 29-660a, Acknowledgment of Dissatisfaction or other appropriate letter to the applicant and authorized representative, if any, to acknowledge receipt of the notice of disagreement.

(2) Prepare VA Form 29-5895a, Pending Transaction Input Card, to insert a standard nonfreeze diary (callup code type 974) with a callup date of 45 days.

(3) Prepare VA Form 29-5716b, DIC Diary Card-NSLI-USGLI, (paper diary) with a 45-day callup, if no insurance master record exists.

(4) Notify the General Clerk who will prepare and maintain a 5 x 8 control card for ICS on all appeals pending.

(5) Prepare VA Form 3230, Reference Slip, routing the case to the Appeal Record Control Clerk in the Insurance Division for preparation of a VA Form 1-670a, Appeal Record Card (VARMS), and VA Form 20-8772, Veterans Appeal Record Code Sheet, with instructions to return the case to ICS after recording the appeal as outlined in M23-l, part I, chapter 7.

(6) Request any records which are necessary to prepare the statement of the case.

(7) If the claims folder is needed, prepare VA Form 60-7216a, Request For and/or Notice of Transfer of Veterans Records. The claims folder will be held until the substantive appeal is subsequently received, or the time limit for filing expires.

10.05 REVIEW OF THE ORIGINAL DECISION

a. The original decision will be reviewed to determine its correctness. Any additional development necessary will be undertaken at this time. Such development may include a request for the claims folder and/or discussions with the medical consultant, etc.

(1) If the review results in granting of all benefits claimed, the notice of disagreement will be considered withdrawn and the appellant so advised. The case will be forwarded to the Appeal Record Control Clerk for the recording of the proper disposition code (70) in the VARMS master record as outlined in M23-l, part I, chapter 7.

(2) If substantially all benefits are allowed while the notice of disagreement is pending, the appellant will be so advised and told that unless he/she informs the VA within 30 days of the desire to continue the appeal process. VA will withdraw the notice of disagreement. The claimant still has the right to reinstate the notice of disagreement and file and appeal within the 1-year appeal period or 30 days from the date of the letter of notification, whichever is later.

(3) After a notice of disagreement is filed, the allowance of less than substantially all benefits sought will not justify closing he case.

b. When more than one issue was involved in VA's decision and it is not clear with which issue the claimant disagrees, clarification will be requested.

10.06 STATEMENT OF THE CASE

a. When a timely notice of disagreement is received and the issue in question is not resolved by granting the benefits sought or through the withdrawal by the claimant or his/her representative of the notice of disagreement, FL 1-25A, Statement of the Case, will be prepared (see fig. 10.01) and sent to the claimant and his/her representative, if any.

b. The purpose of the statement of the case is to provide the claimant and representative with all the facts pertinent to the issue or issues involved, VA's decision and the basis or reason for the decision. All possible assistance will be given the claimant and representative in obtaining evidence and in the development of the appeal.

c. The statement of the case should not quote from material such as decisions or memorandums or contain insignificant information as to dates a claims folder was requested or received, etc. It should specifically state the issue(s) to be decided. Laws should be quoted but long quotations should be avoided, and the statement of the case should be in language the claimant can understand.

d. It is essential that the statement of the case be complete. It should consist of the following:

(1) Issue The issue which is to be decided should be entered in the space provided on the FL 1-25A. If there is more than one issue, each should be separately stated and numbered. Issues are generally set forth as questions.

(2) Contentions Claimant's contentions should be given under separate heading and should follow the issue(s) to be decided. All contentions, even if they appear frivolous or groundless, should be shown and each must be disposed of in the Reasons section. Contentions may be paraphrased.

(3) Evidence and Adjudicative Action Taken

(a) Basically, the summary of evidence should deal with the facts in the case which are pertinent to the issue(s) with which disagreement has been expressed. Begin by citing the date the claim was filed and total disability was alleged. Following this should be a recitation of the pertinent evidence, generally presented in chronological order. It is not necessary to enter material concerning the insured's service dates, age, occupation, type of insurance plan, the date term

insurance was converted to a permanent plan, etc., unless this material has a direct bearing on the issue that is being appealed. Following this should be a statement of the adjudicative action taken.

(b)When the sole issue is failure to file timely, it is not necessary to recite the medical evidence, unless the evidence would have bearing on the insured's failure to file timely.

(4) Laws The Adjudicator should cite the pertinent sections of title 38, United States Code, Code of Federal Regulations, and paraphrase any other instructions or General Counsel opinions approved by the Administrator. Since departmental manuals and other procedural instructions do not have the force and effect of law or Agency policy, they should not be set forth here, but rather in Reasons for Decision, as appropriate.

(5) Decision The decision on the issue or issues.

(6) Reason(s)

(a) The reasons should be specific and based on the facts presented in the evidence section and the laws and regulations cited in the Laws section. Each argument in the Contentions section should be disposed of here. The language should be as simple and non technical as necessary, depending upon the educational level and apparent understanding of the claimant.

(b) A statement of the case may not disclose matters that would be contrary to 38 U.S.C. 3301 or otherwise contrary to the public interest. Matters considered injurious to the physical or mental health of the applicant include those so considered by responsible medical authority, especially the more severe psychiatric disorders, diseases where prognosis is poor and those of misconduct origin. Sources of information which might provoke feelings of hostility, resentment or rejection on the part of the applicant to his/her family should not be revealed. If the Medical Consultant's opinion is requested and used as evidence, the physician should be referred to by title rather than by name. Such matters may be disclosed to the applicant's designated representative unless the relationship between the applicant and the representative would make disclosure as harmful as if made to the applicant. Thus, sometimes it is necessary to prepare two different versions of the statement of the case; one for the claimant and another for the representative.

NOTE: Any information on disease or impairment supplied by the applicant will be made apart of the statement of the case, regardless of its severity.

e. FL 1-25, Transmittal of Statement of the Case 19 Claimant, will be used to forward the statement of the case to the claimant and his/her representative, if any, with a VA Form 1-9, Appeal to Board of Veterans Appeals. This is the form on which the claimant makes his/her formal appeal.

f. If it is necessary to obtain the claims folder in order to prepare the statement of the case, it will be retained for 60 days. The ICS appeal control card will be annotated charging the folder to the requester. The claims folder will be maintained in the office of the supervisor. At the end of the 60-day period, if no appeal has been received, the claims folder will be returned to the regional office. Should the regional office request return of the folder before expiration of the 60-day appeal period, the Adjudicator will contact the regional office by telephone to see if the information needed can be furnished over the telephone.

g. After the Adjudicator prepares and signs the statement of the case, it will be forwarded to the unit supervisor for review. The unit supervisor will sign the statement of the. case and forward it to the Medical Consultant and the Chief, Insurance Claims Section, for concurrence and signature.

h. Only the original (file copy) of the statement of the case will be signed. The number of copies necessary are:

(1) Original (file copy);

(2) Claimant's copy; and

(3) Representative's copy or copies. (If a service organization, the number of copies will depend on the service organization, see ch. 12, par. 12.03). A copy of the claimant's copy, if not identical, will also be included.

i. The Authorizer will also prepare:

(1) VA Form 29-5895a, to update the nonfreeze diary, with a callup date of 75 days.

(2) VA Form 29-5716b, if no insurance master record exists.

(3) VA Form 3230, routing the case to the General Clerk to update the ICS control card and to the Appeal Record Control Clerk to update the VARMS master record.

10.07 NO RESPONSE

a. If no reply (substantive appeal) is received by the end of the 60 days after release of the statement of the case to the claimant, and upon receipt of the followup 974 diary RPO (record printout) (75 days), the Adjudicator will assume the claimant does not intend to complete the appeal and close the records.

b. This is procedural only and the claimant's substantive rights are not affected as long as the substantive appeal is filed within the remainder of the 1-year period from the notice of the original decision.

c. The Authorizer will take the following actions:

(1) Prepare VA Form 29-5895a to delete the diary, if there is one on tape, or destroy VA Form 29-5716b on an off-tape case in accordance with Records Control Schedule VB-1, part I.

(2) Prepare VA Form 3230 routing the case to the General Clerk with instructions to close out the ICS control card and then to the Appeal Record Control Clerk with instructions to close the case on the VARMS master record as outlined in M23-l, part I, chapter 7.

10.08 SUBSTANTIVE APPEAL

a. A VA Form 1-9, adequately executed, or its equivalent in correspondence from a claimant or his/her representative following the furnishing of a statement of the case, will constitute a substantive appeal.

b. The appeal should clearly identify the benefits sought and set out specific allegations of error in fact or law. These allegations should be related insofar as possible to the specific items in the statement of the case.

c. The substantive appeal should be filed within 60 days from the date of mailing of the statement of the case or within the remainder of the 1-year period from the date of mailing of the notification of the adverse decision being appealed, whichever is greater.

d. When a substantive appeal is postmarked after the expiration of the time limit set above, the claimant and representative, if any, will be notified that the failure to submit the substantive appeal on time prevents further action on the case. The envelope in which the appeal was mailed will be filed in the insurance folder, thus retaining the postmark date.

e. If the claimant appeals our finding that appeal was not timely filed, the decision as to whether an appeal has been timely filed will be made by the BVA after development and certification on such issue. Development should include the statement of the case or an equivalent in correspondence.

f. When the substantive appeal (VA Form 1-9 or its equivalent) is received from the claimant, the Receipt and Dispatch Unit will forward the appeal to the Appeal Record Control Clerk.

NOTE: lf the VA Form 1-9 is inadvertently received directly in ICS, it will be hand carried to the Appeal Record Control Clerk for the necessary action.

g. The Appeal Record Control Clerk, upon receipt of the appeal, will take the following actions.

(1) Obtain the claimant's insurance folder;

(2) Enter the date recorded on the reverse side of the VA Form 1-9 in the space provided;

(3) Update VA Forms 1-670a and 20-8772 filed in the insurance folder;

(4) Make all necessary inputs to update the VARMS master record to reflect receipt of the substantive appeal as outlined in M23-l, part I, chapter 7; and

(5) Forward the insurance folder and substantive appeal to ICS for action.

h. Upon receipt in ICS of the substantive appeal, the Adjudicator will take the following actions:

(1) Check to see that the VA Form 20-8772 has been noted by the Appeal Record Control Clerk to show receipt of the substantive appeal;

(2) Check to see if appeal is timely filed;

(3) Analyze appeal to determine if benefits sought may be granted, or new issues raised, possibly requiring development and! or a supplemental statement of the case;

(4) Check to see if a hearing is requested (see ch. 12);

(5) Obtain claims folder from the regional office of jurisdiction; and

(6) After completion of the above, prepare the case for certification to the BVA.

10.09 CERTIFICATION OF APPEALS

a. Before certifying and preparing VA Form 1-8, Certification of Appeal (which is necessary when forwarding a substantive appeal to the BVA), all effort must be taken to assure that a complete case is being submitted.

b. The following is a checklist of factors to consider in the preparation of VA Form 1-8:

(1) All pertinent evidence required under existing instructions is a matter of record;

(2) The claimant was given an opportunity to make a personal appearance when there was a request for a hearing and a complete transcript of the record is in file if a hearing was held; and

(3) A completed VA Form 1-646, Statement of Accredited Representative in Appealed Case, is of record or there is evidence that the accredited service organization representative was given an opportunity to make a presentation in support of the appeal. If the representative is not stationed at the VA center, check "No" in item 9A and annotate item 9B of the VA Form 1-8, "Service Representative Not on Station."

(4) The insured's claims folder must accompany the insurance folder when certified to the BVA.

c. The Adjudicator, after reviewing the case, will take the following actions:

(l) Prepare top portion of VA Form 1-646 (original only) (see fig. 10.02), attach it to the outside of the insurance and claims folders, and place the case in the designated area for certification by the accredited service organization representative, if any.

(2) Upon return of the case from the representative, the Adjudicator will prepare VA Form 1-8 (original only) and initial in item 17A (see fig. 10.03). Omissions of any material from the case could result in a remand of the case.

(3) Prepare FL 1-26 to notify the claimant and his/her representative that the appeal and the records in the case are being forwarded to the BVA for disposition.

(4) Prepare VA Form 60-7216a to transfer the records (insurance and claims folders) to the BVA.

(5) Prepare VA Form 29-5895a, transaction type 098, to delete the 974 appeal pending diary.

(6) The VA Form 1-8 with the case will be forwarded to the medical consultant for concurrence and signature, and the Chief, ICS, who must sign as the certifying official.

(7) The entire case will be routed to the Appeal Record Control Clerk via the General Clerk who will remove the 5 8 control card from the ICS appeals pending file and place it in the certification file. The General Clerk will also remove the VA Form 29-57l6b, from file, if any, and destroy it in accordance with Records Control Schedule VB-1, Part l.

10.10 SUPPLEMENTAL STATEMENT OF THE CASE

a. A supplemental statement of the case, as the name implies, supplements the original statement of the case so that due process requirements of the law are properly met.

b. A supplemental statement of the case may be required when:

(1) Additional evidence is received;

(2) A material defect in the original statement of the case is discovered or when for any reason the original statement of the case is not adequate to effect the letter and intent of the law; or

(3)The BVA in reviewing the original record finds that omissions or error of substance affecting due process have been made and remands the case for a supplemental statement before proceeding with the final decision.

c. It is generally necessary to furnish a supplemental statement of the case when additional evidence is received after the basic statement of the case was released. There is one exception, however, and that is when additional evidence was submitted by the claimant or his/her representative, and the contents and facts of the evidence so furnished were obviously known by them. Thus, if the claimant has been adequately informed in the original statement of the case as to the pertinent facts, the applicable laws and regulations, and the decision made, including the reasons for the decision, a supplemental statement of the case need not be furnished. Instead, FL 1-26 to the claimant will be properly noted to explain why the additional evidence did not warrant a change in the prior denial of the benefits for which appealed. A brief statement to that effect will also be noted on the VA Form 1-8 in Remarks (item 14).

d. Additional evidence received after the records have been transferred to the BVA will be forwarded to the Board if it has a direct bearing on the issues being appealed. The Board will then determine what procedural steps are required with respect to the new evidence.

e. If the evidence has no direct bearing on the issue before the Board, it will be forwarded to the Insurance Files Section for filing in a temporary folder pending return of the insurance folder from the BVA.

f. The Adjudicator, when preparing the supplemental statement of the case, should not repeat the prior statement of the case in its entirety.

g. Generally, the supplemental should be limited to essential changes or additions to the section of the original statement adequate to give complete information to the claimant.

h. Attaching a copy of the original statement is not necessary, except when good judgment so dictates.

i. "Attachment to FL 1-25" will not be used as the first page. All pages of a supplemental statement of the case will be on plain white bond paper in the format of an original statement.

j. Prepare FL 1-28, Transmittal of Supplemental Statement of the Case to Claimant. This letter gives the claimant a period of 30 days to respond.

k. Prepare VA Form 29-5895a to update the 974 appeal pending diary with a callup date of 45 days or update VA Form 29-5716b if an off-tape case.

l. It will be necessary to have the supplemental statement of the case reviewed for concurrence and signatures. (see par. 1 0.06g).

m. Forward the case to the Appeal Record Control Clerk via the ICS General Clerk, for updating the VARMS master record (code 42, suspense date 1st day, 1 month after release) and update the VA Form 20-8772 in the insurance folder.

n. At the end of the period if there has been no response to the supplemental statement of the case, certify the appeal to the BVA on the evidence of record.

10.11 REMANDS

a. When the BVA determines that additional evidence or clarification of evidence is necessary, they will remand the case to the office of original jurisdiction directing what further development is to be undertaken.

b. Upon receipt of the case, the Appeal Record Control Clerk will update VA Form 20-8772 in the insurance folder, the VARMS master record and forward the remanded case to ICS. The Adjudicator should always check the VA Form 20-8772 to see that VARMS has been updated. (See M23-l, p. I, ch. 7.)

c. The Adjudicator will prepare VA Form 29-5895a to insert a standard nonfreeze diary (callup code type 974) with a callup date of 45 days.

d. When the case is remanded only for assembly of records which were previously considered, a review need not be made. Records will be assembled and the case will be resubmitted to the BVA. It will not be necessary to obtain a VA Form 1-646 from the service organization.

e. If development of the case results in a supplemental statement of the case and, after receiving a response to the supplemental statement, benefits sought still cannot be granted, it will be necessary to prepare a new VA Form 1-646 for review by the service organization representative or to place a notation on the original VA Form 1-646 indicating they have reviewed the case.

f. If the claimant does not respond to the supplemental statement of the case within 30 days, the remanded case will be recertified to the BVA.

g. The original VA Form 1-8 which is in the folder will be used for recertification of the above cases to the BVA. Item 14, Remarks, will be noted: "Determination of *(insert date shown in date block)* Confirmed. *(Date) (Signature and title)."*

h. Prepare VA Form 60-7216a for transfer of the case. Item 14, Reason for Transfer, will be noted: "Remanded-Appellate Review Being Returned."

i. The case will be routed to the Chief, ICS, who is the certifying official. It is not necessary to forward the case to the Medical Consultant for concurrence unless a supplemental statement of the case is prepared.

j. Forward the case to the Appeal Record Control Clerk via the General Clerk.

10.12. WITHDRAWAL

a. The claimant or his/her representative may withdraw a notice of disagreement at any time before a timely substantive appeal is filed or expiration of the time allowed.

b. A substantive appeal may be withdrawn at any time before the BVA enters a decision, except when withdrawal would be detrimental to the appellant or the Government.

c. Once a notice of disagreement or substantive appeal has been filed, the appeal may not be closed because of the claimant's failure to cooperate by furnishing evidence or submitting to an examination. In such cases, entitlement is based on the evidence of record.

d. A withdrawal may be made by the claimant or his/her representative except that a representative may not withdraw either a notice of disagreement or a substantive appeal filed by the claimant personally.

e. An appeal will be withdrawn when all benefits sought are granted without appellate review. This includes a remanded case when a supplemental statement of the case may be involved.

f. The Authorizer will take the following actions when a case is withdrawn:

(l) Prepare an amended decision when all benefits sought are granted and notify the claimant, representative, if any, and the BVA if the case was remanded with a dictated letter.

(2) Prepare VA Form 29-5895a, to delete the nonfreeze diary. If no insurance master record exists destroy VA Form 29-5716b in accordance with Records Control Schedule VB-1, part I.

(3) Forward the case to the Appeal Record Control Clerk.

Veterans
Administration
P O. Box 8079
Philadelphia, PA 19101

April l, 1979
JONES, JOHN C.
V 000 00 00
c 12 345 678

STATEMENT OF THE CASE

IN THE APPEAL
OF

JOHN C. JONES

FROM THE DECISION OF THE
VETERANS ADMINISTRATION

NOTICE TO APPELLANT:

This is not a decision on the appeal you have initiated. It is a "Statement of the Case" which the law requires us to furnish to help you in completing your appeal.

Please read the forwarding letter carefully, as well as the instructions on the enclosed appeal form. These explain your appeal rights and tell you what you must do to complete your appeal.

A copy of this "Statement of the Case" has been furnished your representative:

ISSUE:

Whether the insured is entitled to waiver of premium on his Veterans Service-Rated Insurance policy.

FL 1-25A, Feb. 1980(R)

Figure 10.01 FLI-25A, Statement of the Case

m Approved

For

OM

B **No. 76-022I**

VETERANS ADMINISTRATION

STATEMENT OF ACCREDITED REPRESENTATIVE IN APPEALED CASE

SERVICE ORGANIZATION (Name and Routing Symbol) DATE

TO

Am . 4-14-79

LAST NAME - FIRST NAME MID OF VETERAN	FILE NO.
Jones, John C.	V 000 00 00

All evidence in connection with this appeal has been considered. Please complete and return the statement below on or before the date indicated. If we do not receive either the statement or a request for extension by that date, it will he necessary for us to certify the appeal to the Board of Veterans Appeals on the present record.

REPLY REQUESTED BY (Oslo) ORGANIZATIONAL ELEMENT MAKING REQUEST (NAME AND ROUTING SYMBOL)l

4-21-79 Insurance Claims (297C)

TO BE COMPLETED BY ACCREDITED REPRESENTATIVE

NOTE: *Section 40O5(a) and (b)(2) Title 38. United States Code, gives the claimant the right to be represented and gives the accredited representative the right to file claims far the claimant. The presentation of on agreement by the accredited representative is voluntary and not necessary for completion of the appeal. The opportunity for argument is given the accredited representative in order to accord the claimant the right of full representation at this stage of the appellate process. Failure to file this form may delay the appellate process.*

I HEREBY CERTIFY that a Statement of the case was furnished; that appellate review is desired on the evidence now of record; and that the issues for consideration of the Board of Veterans Appeals are clearly defined.

[ ] I REST THE APPEAL ON THE ANSWER TO THE STATEMENT OF THE CASE AND THE HEARING ON APPEAL *(If Conducted*).

[ ] I WISH TO MAKE THE FOLLOWING ARGUMENT TO SUPPLEMENT THE ANSWER TO THE STATEMENT OF THE CASE AND OTHER ARGUMENT OF RECORD.

VA FORM 1-646 OCKS OF VA FORM 1545. JUL 1955.

Figure 10.02 VA Form 1-646, Statement of Accredited Representative in Appealed Case

CERTIFICATION OF APPEAL

IA. NAME OF APPELLANT	1b. RELATIONSHIP TO VETERAN	2. FILE NO.
		C 12 345 678
3. LAST NAME FIRST NAME MID NAME OF VETERAN		4. INSURANCE FILE NO OR LOAN NO.
Jones John C.		V 000 00 00

THE APPEAL IS FOR *(State the question(s) at issue clearly and concisely.*

5A. SERVICE CONNECTION FOR	5B. DATE OF NOTIFICATION OF SERVICE CONNECTION

6A.INCREASED RATING FOR OF

6B.. DATE OF NOTIFICATION

ACTION APPEALED

7A. OTHER

Entitlement to **NSLI waiver of premium**

7B. DATE OF NOTIFICATION OF ACTION APPEALED

July 14, 10976

8A. APPELLANT REPRE SENTED IN THIS APPEAL BY *(Name of organization, attorney or agent)*

American Legion

8B. ONE OF THE FOLLOWING IS ON FILE AS AUTHORITY FOR REPRESENTATIVE IN THIS APPEAL

[ ] POWER OF ATTORNEY SERVICE ORGANIZATION

[ ] CERTIFICATION THAT VALID POWER OF ATTORNEY OR DECLARATION OF REPRESEN-TATION IS IN ANOTHER VA FOLDER

[ ] DECLARATION OF REPRESENTATIVE (WHEN ATTORNEY IS REPRESENTATIVE)

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CHAPTER 12. POWER OF ATTORNEY AND HEARINGS

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CHAPTER 12. POWER OF ATTORNEY AND HEARINGS

SUBCHAPTER 1. POWER OF ATTORNEY

12.01 RECORD OF POWER OF ATTORNEY

a. VA Form 23-22, Appointment of Veterans Service Organization as Claimant's Representative, is the form designed to provide authority for representation by recognized service organization. For a listing of accredited organizations, see M29-1, part 1, chapter 12, paragraph 12.02.

b. Letters from the insured and various forms in use by veterans service organizations which are clear as to intent and are signed by the insured may be accepted as a valid authorization as stated in VAR's 5626 through 5637.

c. Any attorney or competent person may be recognized as a representative and the designation must be by power of attorney and should be made by the claimant on VA Form 2-22a, Appointment of Attorney, or Agent as Claimant's Representative or its equivalent. (See VAR's 5626 through 5637.)

d. A written declaration of representation on the letterhead stationery of an attorney stating that he/she is authorized to represent a claimant, in the absence of evidence to the contrary, entitles the attorney to represent the claimant. An attorney recognized on the basis of a declaration of representation will be given access only to that information in the folder which could be made available to the claimant under VAR's 503 and 504. However, in order for an attorney to have complete access to all information in an individual's records, the attorney must provide a signed consent from the claimant or the claimant's guardian (see VAR 5629(C)).

e. Only one service organization, attorney or person shall be recognized at any one time to represent a claimant, and the claimant shall be permitted to revoke a power of attorney whenever he/she so desires.

12.02 CLERICAL PROCESSING

a. The preliminary clerical processing of VA Form 23-22, 2-22a or declaration of representation is done by the Administrative Division as outlined in M23-l, part I, chapter 5.

b. If the VA Form 23-22, 2-22a or declaration of representation is received in ICS, prior to preliminary processing by the Administrative Division, it will be attached to the folder after all the necessary action has been taken and routed to the Administrative Division for preliminary processing.

12.03 POWER OF ATTORNEY IN FORCE

a. When there is a valid power of attorney in effect, extra copies of all correspondence to the insured will be prepared and routed or mailed to such service organization, attorney or person as follows:

(1) AL (American Legion) and VFW (Veterans of Foreign Wars)-three copies.

(2) All other service organizations-two copies.

(3) Attorney or other representative-two copies.

b. When the claimant's representative is a service organization which has office space in ICS, the decision with copies of the award, denial, disallowance or termination letter and folder will be routed to the service organization.

c. If the service organization is one which does not have office space in the ICS, however, it is housed in the insurance center, forward copies of the letter only, and notify them that they may inspect the insurance folder in order to properly prepare their appellate argument.

d. When the service organization is not located in the insurance center, copies of the letter will be mailed, including notification that they may come into the VA center to inspect the insurance folder in order to properly prepare their appellate argument.

SUBCHAPTER 2. HEARINGS

12.04 GENERAL

a. A hearing appeal will be granted when a claimant or the representative requests to appear in person or have someone appear as a witness for them. Hearings are held primarily for the purpose of receiving the contention and argument of the claimant or representative to the issue being appealed.

b. A hearing will normally be scheduled for a date after the statement of the case is furnished the claimant and/or representative.

c. At the option of the claimant or representative a hearing may be held:

(l) By the BVA (Board of Veterans Appeals) in Central Office or, if practicable, before a traveling section of BVA;

(2) By the ICS, acting as a hearing agency before the BVA, at the center which has original jurisdiction; or

(3) In the regional office having jurisdiction over the place of residence of the claimant or other office nearest the claimant's residence, acting as a hearing agency for the BVA.

d. When the hearing is to be held at the insurance center which has original jurisdiction, the chairperson of the hearing panel will request the Adjudication Division to schedule a date for the hearing.

e. A letter will be sent to notify the person who requested the hearing as to the date, time and place and that no expenses incurred by a claimant, representative or witness incident to attendance at a hearing may be paid by the Government.

f. The folder will be reviewed prior to the hearing by the group designated to serve as the hearing panel.

g. When the hearing is to be conducted in Central Office, a regional office or other office, the insurance folder and claims folder will be transferred to the office where the hearing is to be conducted. The claimant or representative will be notified by that office as to the date, time and place of the hearing, etc.

h. Argument and testimony introduced at the hearing should be recorded and a complete transcript thereof included in the record for consideration.

12.05 COMPOSITION OF HEARING PANEL

a. The hearing panel at the center which has original jurisdiction will be appointed by the Chief, ICS and will be composed of three members; a Senior Authorizer will act as chairperson, conduct the hearing and administer oaths, a Medical Consultant and an Authorizer. When practicable, one or more members of the hearing panel will be persons who made or participated in the original decision.

b. If the hearing is to be conducted in a regional office, the panel will be designated by the Director of that office.

12.06 CONDUCT OF HEARING

a. Hearings are to be conducted in a manner which complies with the due process requirements and properly reflects the non adversary position between the VA and the claimant.

b. The claimant will be permitted to introduce into the record, in person or by a representative, any evidence available to the claimant which that individual may consider material. This includes arguments and contentions with respect to the facts and applicable law which the claimant may consider pertinent.

c. It is imperative that the members of the hearing panel remember that proceedings before the VA are ex parte in nature. It is the obligation of the VA to assist a claimant in developing facts pertinent to the claim. A hearing is not an adversary proceeding and questions by VA employees in the nature of cross-examination are not permissible. All questions are to be framed to explore fully the basis for claimed entitlement rather than with an intent to refute evidence and discredit testimony. Suggestions to the claimant as to submission of evidence which the claimant may have overlooked and which would be advantageous to the claimant's position should be made.

d. Prior to the hearing, all personnel involved should familiarize themselves with the evidence of record in the particular case. This will include a review of the issues and evidence. Consideration should be given to the nature of evidence necessary for the claimant to establish

entitlement to the benefits. Tentative questions to be asked should be formed at this time. Persons assigned to the hearing should not wait until just prior to or during the hearing to review the claims file.

e. Hearings must be conducted in a proper atmosphere. A hearing room with furniture in good repair, adequate lighting, heating or air conditioning should be available. The furniture should be arranged so everyone in the room can see and hear the witnesses. The United States flag should be appropriately displayed. The appearance and atmosphere of a formal trial or such like proceedings are to be avoided. Hearings are not to be conducted in the Adjudication Division work area.

f. For many claimants, the hearing may be the only personal contact they will have with the VA. Their opinion of the VA will to a great extent be influenced not only by proper hearing facilities but by the conduct and appearance of VA personnel. Appropriate dress and conduct are required. Courteous treatment of the claimant and witnesses, attention to the proceedings and an overt interest in assisting the claimant are expected of VA personnel.

g. Upon arrival, the claimant and any witnesses and representatives will be taken to the hearing room or other appropriate area. The chairperson and other members of the hearing panel will be immediately notified and they will proceed to the hearing room without undue delay.

12.07 PROCEEDINGS OF THE PANEL

a. Members of the hearing panel will introduce themselves to the claimant and any witnesses. Care will be exercised to get correct pronunciation of names.

b. If the claimant does not have a veterans service organization representative present and is not represented by an attorney, the chair will explain the availability of a veterans service organization representative or assistance by a member of the Veterans Services Division. The claimant will be informed there is no obligation to join a veterans service organization and that there will be no charge for representation if the claimant desires the assistance of a member of a veterans service organization. The claimant will also be informed that representation is not mandatory. If the claimant indicates a desire for a representative, the claimant and witnesses will be taken to the appropriate veterans service organization. The situation will be explained and a time for resumption of the hearing, allowing adequate time for review of the evidence, will be set.

c. If a representative is present or the claimant desires to proceed without representation, the purpose and nature of the hearing will be explained. Emphasis on the information gathering aspects of the hearing is to be stressed. The necessity for and use of recording equipment will be explained and the claimant informed that a copy of the transcript will be placed in the file and, if requested, a copy will be furnished to the claimant. The claimant and witnesses will be informed that if they desire to "go off the record" to collect their thoughts or for clarification of any matter, they may so indicate and the recording will be temporarily stopped. The necessity of an oath or affirmation will be explained.

d. If the claimant is represented by an attorney, the chair will explain the proceedings as indicated above. Emphasis should be placed on the informality of the hearing. The attorney will be told that rules of evidence do not apply that considerable latitude in presentation is permitted, and questions should reflect a spirit of helpfulness to the claimant in developing an evidentiary basis for his/her claim.

NOTE: If a third party is present, VA Form 60-5571, Authorization to Disclose a Record in the Presence of a Third Party, will be completed by the claimant in accordance with the Privacy Act of 1974 (PL 93-579).

e. The chair will request the claimant and witnesses to stand and raise their right hands. An appropriate oath will be administered which in substance states: "Do you swear (or affirm) the testimony you are about to give will be the truth, the whole truth, and nothing but the truth?" The oath will be administered prior to commencement of recording of the hearing. If the claimant or any witness refuses to take the prescribed oath or affirmation, he or she should be allowed to take an affirmation in which the person makes a solemn declaration using such words as he or she considers binding on his or her conscience.

f. Prior to commencing testimony, a statement of the issues as shown by the evidence should be made. The claimant and the representative will be asked if this is their understanding of the issues. If there is a misunderstanding of the issues, clarification should be made at that time. This will not be used to limit the scope of relevant issues or to indicate to the claimant that testimony is to be curtailed. If additional issues are raised by the claimant or representative at this point or during the hearing, they are to be properly considered and not ignored.

g. Recording of the hearing will start with the chair's opening statement. This statement will include the fact that a hearing is being held, date and time of commencement of the hearing, authority before which the hearing is being held, name of veteran, name of claimant if not the veteran, file number, and that the claimant and witnesses have been duly sworn in. A brief statement of the issue will be made. If present, the representative or attorney will be asked if he/she desires to make an opening statement; otherwise, the claimant will be given this opportunity. The representative or attorney will be allowed to introduce the claimant's testimony and ask questions concerning the same.

h. Whether the claimant or witnesses should be interrupted by questions or to suggest areas which should be further developed during the course of their testimony will depend upon the individual hearing. While it may appear the testimony is irrelevant and rambling, it must be remembered the purpose of the hearing is to permit the claimants to present their case subject to maintenance of reasonable bounds of relevancy and materiality. While pertinent questions may be asked during testimony, care and tact should be exercised in limiting the witness in order to guard against any indication that his or her testimony is not of importance.

i. Subsequent to the claimant's testimony, VA personnel should ask pertinent questions consistent with the ex parte nature of the hearing. If a medical question is at issue, there should be no hesitancy on the part of the medical member of the hearing panel to observe and comment on the claimant's condition, especially if requested to do so by the claimant or representative. Based on the observation by the medical member, any indicated development, including the scheduling of a VA examination, should be taken as soon as practicable. Questioning should be initiated by the chair with each member given an opportunity, in rotation, to ask questions. While cross-examination is to be avoided, it is important that the claimant be questioned sufficiently to develop fully all contentions to present the claim in its best light.

j. After the claimant's testimony and questioning by members of the panel, the witnesses will be given an opportunity to testify. It is recognized that some representatives and attorneys may desire that the witnesses testify immediately after the claimant and prior to any questions by the panel. In such cases the panel will question the claimant and witnesses after the completion of testimony by the witnesses. Prior to the questioning of the claimant by the panel, the claimant should be asked if there are any objections to any of the witnesses being present. If an objection is raised, the witness or witnesses should be excused.

k. After completion of the testimony, including discussion of any area raised by questions from the panel, the claimant will be given an opportunity to make a final statement. The representative, if there is one, will also be requested to make any closing statement he or she desires. Prior to termination of the hearing, the chair will ask if there is anyone present who has additional comments or testimony before the hearing is completed.

1. Upon completion of the hearing, the chairperson will note the time and inform the claimant and/or representative that the case will receive careful consideration and that all interested parties will be notified of the decision made. The claimant and witness(es) will be escorted from the hearing room and not left to find their own way out of the area.

m. The original typed copy of the transcript and carbon copy, if any, will be attached to the insurance folder and referred to the chairperson of the board, the Medical Consultant, and the Authorizer, respectively, to have the transcript checked and approved, after which the copy, if any, will be released to the claimant's representative. The original transcript will be filed in the insurance folder and will be considered for further development or decision.

n. When the hearing is held in an office other than the insurance center, the case will be processed in a similar manner as above. It will be necessary for all of the appointed board members to check and approve the transcript. The folders will then be transferred back to the insurance center for further development of decision.

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CHAPTER 13. EXTRA HAZARD DETERMINATIONS

CHAPTER 13. EXTRA HAZARD DETERMINATIONS

SUBCHAPTER 1. RULES

13.01 INTRODUCTION

When disability insurance benefits are granted on V and K policies it is necessary to determine if the injury or illness causing total or total permanent disability is due/traceable to the extra hazard of military service. (See M29-1, pt. I, ch. 31, par. 31.47 and ch. 32, par. 32.15.)

13.02 JURISDICTION TO MAKE DETERMINATION OF EXTRA HAZARD

The Adjudicator is responsible for making the extra hazard determination. A finding that the decision is due to the extra hazard of service requires the signature of the Authorizer, Senior Authorizer and section chief.

13.03 DETERMINATION OF EXTRA HAZARD OF SERVICE

VAR's 3192 and 3469 provide generally that a disease or injury which was in fact caused by or is traceable to the performance of duty in the military service is due to the extra hazard of service. It is not true, however, that a condition which is suffered in the line of duty or is connected with service is necessarily due to the extra hazard of service. Since it is not possible to lay down definite rules to cover all cases, good judgment must be exerted after consideration of all the facts when extra hazard is questionable. There are several classes of cases in which the circumstances indicate extra hazard which may be found in M29-1, part I, chapter 31, paragraph 31.47e.

SUBCHAPTER 1. PROCEDURE

13.04 DEVELOPMENT OF EVIDENCE

a. The development of evidence necessary for the determination of whether a disability is due to the extra hazards of service will be made simultaneously with any required development of evidence on the claim for disability insurance benefits if it appears that benefits will be granted under the claim.

b. The determination of the question of extra hazard of service will, if possible, be made concurrently with the decision on the claim. However, under no circumstances will the action on the claim be delayed in order to make the extra hazard determination.

13.05 PREPARATION OF VA FORM 29-1565-3, DECISION DISABILITY INSURANCE BENEFITS

a. When the decision and award on the claim are made, and the evidence establishes that the disease or injury was due to the extra hazard of service, the appropriate block on VA Form 29-1565-3 will be checked and the instructions listed in chapter 4, paragraph 4.04a, will be followed for the completion of the form.

b. A brief statement indicating the disease or injury was caused by or is traceable to the performance of duty in the military service and is due to the extra hazard of service will be made in the Remarks block. Example:

"Primary disability is due to wounds received on 16 June 1952 in Korea."

c. If the number of policies involved requires extra sets of VA Form 29-1565-3, the Extra Hazard block on each set will be checked. However, the extra hazard information shown in the Remarks block need only be shown on one set of VA Form 29-1565-3, and on all other sets show, "See decision this date on policy number _____

d. If the extra hazard determination cannot be made simultaneously with the decision but must be delayed pending additional information, check the Pending block on VA Form 29-1565-3. Insert a 45-day nonfreeze diary with the message, "EX HAZ DEC PEND."

e. When the information is received, the Authorizer who made the initial decision will line through the word "pending" in the "EXTRA HAZARD DETERMINATION" block on the original VA Form 29-1565-3, initial, date and check the "DUE" or "NOT DUE" block depending on which is applicable.

f. If the-determination is made that the waiver is due to the extra hazard of service, it will be necessary for the Adjustment Claims Clerk to adjust general ledger accounts 58 (Waiver-Premium) and 59 (Waiver-Premiums Reimbursable) for the number of months involved based on the effective date of waiver and the next month due in the master record. Also, prepare a VA Form 29-8522, Policy, to change the control character from non reimbursable to reimbursable.

13.06 CORRECTION OF PRIOR DETERMINATION

a. When it is found that there is a clear and unmistakable error in a previous decision due to a prior determination that the disease or injury upon which a claim was based is traceable/not traceable to extra hazard of military service, it will be reversed.

b. If the disability is due to the extra hazards of service, the Authorizer will prepare a narrative decision. VA Form 29-902, Determination of Liability and Certification by the Committee on Extra Hazards of Service, will be used, preparing the original and completing part I only.

c. If the extra hazard determination is reversed because the disability is not traceable to the extra hazard of military service, a narrative decision (summary) will be written on plain white bond paper. The new decision will state:

(l) "Decision dated_____ ,held the veteran's disability(ies) of _____ (was/were) due to the extra hazard of service."

(2) The new evidence which is the basis for reversing the prior decision.

(3)-"Decision of _____ holding disability(ies) due to the extra hazard of service is held to be in error and is reversed."

d. The Adjustment Claims Clerk will make the necessary general ledger accounts adjustment and change the control character as shown in paragraph I3.05f.

Key Changes

Rescissions M29-1, Part 3, Chapter 10 is being removed in its entirety. Appeals process information is being integrated into M29-1, Part 4, Chapter 7 – Appellate Procedures.

Authority By Direction of the Under Secretary for Benefits

Signature

Vincent E. Markey, Director
Insurance Service

Distribution LOCAL REPRODUCTION AUTHORIZED

Key Changes

Rescissions M29-1, Part 3, Chapter 12 is being removed as the information is already included in M29-1, Part 1, Chapter 35- Third Party Requests and M29-1, Part 4, Chapter 7- Appeals.

Authority By Direction of the Under Secretary for Benefits

Signature

Vincent E. Markey, Director
Insurance Service

Distribution LOCAL REPRODUCTION AUTHORIZED

Key Changes

Rescissions M29-1, Part 3, Chapter 13 is being removed as VA Insurance is no longer conducting extra hazard determinations for disability claims.

Authority By Direction of the Under Secretary for Benefits

Signature

Vincent E. Markey, Director
Insurance Service

Distribution LOCAL REPRODUCTION AUTHORIZED