
Traumatic Injury Protection Under Servicemembers' Group Life Insurance (TSGLI)

A Procedural Guide

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Part 1 - General Provisions of TSGLI

General Information

The Servicemembers' Group Life Insurance Traumatic Injury Protection (TSGLI) program is an automatic provision under Servicemembers' Group Life Insurance (SGLI). TSGLI provides for payment to Servicemembers who are severely injured (on or off duty) as the result of a traumatic event and suffer a loss that qualifies for payment under TSGLI. TSGLI is designed to help traumatically injured Servicemembers and their families with the financial burdens associated with recovering from a severe injury. TSGLI payments range from \$25,000 to \$100,000 based on the qualifying loss suffered. The benefit is paid to the member, someone acting on the member's behalf if the member is incompetent, or the members' SGLI beneficiary if the member is deceased. TSGLI coverage was added to SGLI policies effective December 1, 2005 with a retroactive provision covering injuries from October 7, 2001 through November 30, 2005. All members covered under SGLI who experience a **traumatic event** that directly results in a **traumatic injury** causing a **scheduled loss** defined under the program are eligible for TSGLI payment.

Basic Definitions

There are several terms that are key to the TSGLI program. These terms are defined below. If TSGLI Branch of Service Certifying Officials have specific questions on TSGLI claims that deal with these issues, they should contact the Chief, Program Administration and Oversight Staff at the Department of Veterans Affairs Insurance Center (see Appendix C for contact information.)

Traumatic Event - A traumatic event is the application of external force, violence, chemical, biological, or radiological weapons, or accidental ingestion of a contaminated substance causing damage to a living being occurring on or after October 7, 2001.

Exposure to the elements includes heat stroke and frostbite. In such cases the severe exposure to the heat and cold are traumatic events in and of themselves. For example, being diagnosed with heat stroke after collapsing during a physical training run in scorching temperatures would be a traumatic event.

External Force - An external force is any sudden or violent motion causing an unexpected impact from a source outside of the body and independent of body mechanics.

Body Mechanics – Body mechanics is the use of one's body in production of motion or posture of the body, including movements during routine daily activities.

The event must involve a physical impact upon an individual. Some examples would include: an airplane crash, a fall in the bathtub, or a brick that falls and causes a sudden blow to the head. For example, a member who sprains an ankle while running in a basketball game would not be eligible for TSGLI payment because the loss was due to routine body mechanics involved in the twisting of the ankle while running.

Physical impacts do not require penetrating injuries to occur. Non-penetrating blast injuries, such as those common with the use of improvised explosive devices that cause concussive injuries, still involve external force and violence from the power of the blast coming into contact with an individual.

Direct Result– Direct result means there must be a clear connection between the traumatic event and resulting loss and no other cause, aside from the traumatic event can play a part in causing the loss. (See "Injuries Excluded from TSGLI Payment" in Part 1 for more information on the direct result standard when a preexisting condition contributed to the loss.)

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

Scheduled Loss - A scheduled loss is a condition listed in the TSGLI Schedule of Losses if that condition is directly caused by a traumatic injury. The Schedule of Losses lists all covered losses and payment amounts (see Appendix A, Schedule of Losses).

Eligibility for TSGLI

All members of the uniformed services who have full-time or part-time Servicemembers' Group Life Insurance (SGLI) are automatically covered by TSGLI while the member is in service. For those who suffered an injury between October 7, 2001 and November 30, 2005 that resulted in a qualifying loss, members are covered by TSGLI regardless of whether they had SGLI coverage at the time of their injury. TSGLI coverage automatically ends upon the member's separation or release from service or the member's declination of SGLI coverage. Spouses and children covered under Family SGLI are not covered by TSGLI.

Coverage Periods for Full-Time and Part-Time TSGLI

In general, members are covered under TSGLI for the same periods they are covered under SGLI. The only exception is that TSGLI coverage ends on the date the member separates from service, while SGLI coverage continues for a minimum of 120 days after the member separates from service. There are two situations that govern the TSGLI coverage period.

- 1) Member is covered under full-time SGLI
- 2) Member is covered under part-time SGLI

1) Member is Covered Under Full-time SGLI

When a member is covered under full-time SGLI, the member's TSGLI coverage is full-time as well. This means the member is covered under TSGLI 24 hours per day, 365 days per year, both on and off duty. A Servicemember is covered under full-time SGLI and therefore full-time TSGLI if the member meets one of the following conditions:

- The member performs active duty or active duty for training under a call or orders that specifies 31 days or more OR
- The member is a Ready Reservist who is assigned to a unit in which the member is scheduled to drill at least 12 times during the year. This includes members who are drilling for pay and members who are drilling for retirement points.

2) Member is Covered Under Part-time SGLI

When a member is covered under part-time SGLI, the member's TSGLI coverage is part-time as well. Part-time TSGLI covers the member only during the actual days of duty and while proceeding directly to and returning directly from their scheduled duty. A member is covered under part-time SGLI and therefore part-time TSGLI if the member meets one of the following conditions

- The member is a Ready Reservist who is under a call or order that specifies less than 31 days OR
- The member is a Ready Reservist who is not scheduled to drill at least 12 times during the year.

Note: Members eligible for part-time coverage become eligible for full-time coverage when they perform active duty or active duty for training, under calls or orders that specify 31 days or more.

When Coverage Begins

SGLI and TSGLI coverage begins automatically for Servicemembers who enter onto active duty or Ready Reserve service or are deployed to a combat theater of operations. Entry onto active duty or Ready Reserve service is defined as follows:

- A civilian who enlists for regular active duty
- A civilian who enlists in the Ready Reserve

- A Ready Reservist who is mobilized to active duty status
- A Ready Reservist who is demobilized and returns to reserve status
- A member who completes active duty and is assigned to the Ready Reserve

Qualifying for TSGLI Payment

Basic Requirements

In order to qualify for TSGLI payment, a member must meet all of the following requirements:

- 1) The member must suffer a scheduled loss (see Part 4, Scheduled Losses) that is a direct result of a traumatic injury due to a traumatic event and no other cause.
- 2) The member must have suffered the traumatic event before midnight of the day that the member separates from the uniformed services*
- 3) The member must suffer the scheduled loss within two years (730 days) of the traumatic event**.
- 4) The member must survive for a period of at least seven full days from the date of the traumatic event. The seven-day period begins on the date and time of the traumatic event, as measured by Zulu (Greenwich Meridian) time, and ends 168 full hours later.
- 5) If injured on or after December 1, 2005, the member must be insured by SGLI at the time of the traumatic event. If injured from October 7, 2001 through November 30, 2005, the member does not need to be insured under SGLI to qualify for a TSGLI payment.

**Note 1: The scheduled loss may occur subsequent to the date of termination of duty status in the uniformed services, provided it is within two years of the traumatic event.*

***Note 2: See notes under each of the Scheduled Losses listed below for an explanation of how the 730- day limitation period is applied to that loss:*

- Coma
- Loss of ADL due to Traumatic Brain Injury(TBI) or Other Traumatic Injury (OTI)
- Hospitalization due to TBI or OTI

Injuries Excluded From TSGLI Payment

The following injuries are excluded from TSGLI payment:

- 1) Injuries caused by one of the following:
 - a) A mental disorder
 - b) A mental or physical illness or disease, (not including illness or disease caused by a pyogenic infection, biological, chemical, or radiological weapons, or accidental ingestion of a contaminated substance.)
 - c) Attempted suicide
 - d) Intentionally self-inflicted injury or an attempt to inflict such injury
 - e) Diagnostic procedures, preventive medical procedures such as inoculations, medical or surgical treatment for an illness or disease, or any complications arising from such procedures or treatment.
 - f) The member's willful use of an illegal or controlled substance, unless administered or consumed on the advice of a medical professional.
- 2) Injuries sustained while committing, or attempting to commit, a felony.

Certain exclusions and terms above warrant additional explanation.

A mental disorder or a mental or physical illness or disease.

Any loss arising solely and directly from a mental disorder or physical illness or disease is not covered.

Example 1: mental disorder/disease: A member has schizophrenia. Due to a psychotic episode, the member is hospitalized for 15 days. The member's loss is not covered by TSGLI.

Example 2: physical illness or disease: A member has a stroke. Due to the stroke, she is permanently paralyzed on her right side. The member's loss is not covered by TSGLI.

Preexisting Conditions

If both a traumatic event and a preexisting mental disorder or physical illness or disease contribute to a loss, the loss may be covered. This determination depends on how much the preexisting condition substantially contributed to the scheduled loss.

The scheduled loss can be covered if a member can prove that a preexisting condition did not substantially contribute to a scheduled loss by showing that the preexisting condition (1) did not aid or lend assistance to the production of the scheduled loss, or (2) the preexisting condition only casually shared in producing the loss and was not a substantial causal factor or the proximate cause of the loss.

How to Apply:

- (1) Does the member have a pre-existing medical condition such as an illness or disease?
 - (a) If yes, then ask did illness or disease contribute to loss?
 - (b) If no, then continue with adjudication.
- (2) If the illness or disease contributed to the loss, then was this the predominant cause of the loss?
 - (a) If yes, then ask "but for" the illness or disease, would the member have suffered the loss?
 - (b) If no, then continue with adjudication.
- (3) Would loss have occurred if member did not suffer from pre-existing condition such as illness or disease?
 - (a) If yes, then continue with adjudication.
 - (b) If no, then deny claim.

Factors to Consider:

- (1) Severity of external force: the more severe the external force, the more likely it is that the traumatic event and not an illness or disease was the substantially contributing factor causing the loss.
- (2) Evidence in medical records of treatment recovery periods that are disproportionate to previously reported injuries: a longer than usual recovery time for a loss, may indicate that it is more likely that an illness or disease, and not a traumatic event, was the substantial contributor to causing the loss.
- (3) Similarity of losses/recovery periods from other claims submitted by members injured by similar traumatic events, including traumatic events suffered in the same incident: the more similar the loss or recovery periods from claims due to similar or the same traumatic event, the more likely that the loss was caused by the traumatic event. If other members suffered traumatic events in the same incident and did not suffer losses, then the more likely it is that illness or disease substantially contributed to the loss.
- (4) Medically accepted evidence that certain pre-existing illnesses and disease cause certain TSGLI losses, such as paralysis, amputation, etc.: Evidence the member has a serious physical illness or disease that medical science has shown causes certain TSGLI losses (e.g. ALS and paralysis) means that it is less likely that the traumatic event caused the loss.

Example 1: preexisting condition does not substantially contribute to loss: A member has a preexisting condition of diabetes. The member is involved in a car accident. After the car accident, the member's leg is amputated. The member's medical records show that prior to the car accident the member's diabetes had not resulted in any diabetic neuropathy, foot ulcers, or foot infections. Additionally, the records show that in the car accident, the blunt force trauma of the head on collision caused such significant damage to the bone, tissue, nerve and vascular systems of the leg that amputation was sole option for the member. The member's loss is covered by TSGLI.

Example 2: preexisting condition does substantially contribute to loss: A member has a preexisting condition of severe depression and has been hospitalized multiple times in the last year. The member is involved in a car accident and suffers a mild traumatic brain injury (TBI). The member is unable to perform the activities of daily living of bathing, dressing, eating, or toileting without verbal assistance. Medical records show that the member, even before the accident, was unable to care for himself due to his depression, including requiring verbal assistance with reminders to eat, dress, and perform hygiene activities. The member's loss is not covered by TSGLI.

Anaphylactic Shock

A traumatic event, such as an insect sting or animal bite, that results in anaphylactic shock causing a loss is covered. This is because the program does not consider anaphylactic shock an illness or disease. However, if the same traumatic event results in an illness or disease and the disease causes a loss, the loss is not covered.

Example 1: traumatic event and anaphylactic shock: A member is stung by a bee. Due to the sting, the member goes into immediate anaphylactic shock. The member goes into a coma for 30 days from the shock. The member's loss is covered by TSGLI.

Example 2: traumatic event and illness/disease: A member is bitten by a tick. The member develops Rocky Mountain Spotted Fever (RMSF) from the tick bite. The member has severe damage to her blood vessels from the RMSF resulting in amputation of her hand. The member's loss is not covered by TSGLI.

Diagnostic procedures, preventive medical procedures such as inoculations, medical or surgical treatment for an illness or disease, or any complications arising from such procedures or treatment.

Any loss arising from diagnostic procedures or medical and surgical treatments and complications from illness or disease, rather than a traumatic injury, are not covered.

Example 1: diagnosis of an illness or disease: A member goes to the hospital for a routine colonoscopy. Due to medical error, the patient is injured and must remain in the hospital for 15 days. The member's loss is not covered by TSGLI.

Example 2: medical or surgical treatment for an illness or disease: A member has diabetes and her condition begins to cause problems to her leg resulting in the amputation of her leg. The member's loss is not covered by TSGLI because it was the result of treatment for an existing condition.

Example 3: complications arising from medical or surgical treatment: A member undergoes heart bypass surgery. During the surgery, the member's aorta is nicked and the member must remain in the hospital for an additional 15 days. The member's loss is not covered by TSGLI because it was the result of complications arising from medical treatment.

Example 4: routine medical treatment: A member is given a routine vaccination, has a severe reaction to the vaccination, and goes into a coma for 15 days. The member's loss is not covered by TSGLI.

Complications from necessitated by traumatic event - A loss arising from complications of necessary surgery to treat a traumatic injury are covered. These situations are not excluded under the medical or surgical treatment

exclusion above because the surgery was required due to a traumatic injury, not simply the result of treatment of an illness or disease.

Example, surgical treatment of a traumatic injury: A member's vertebra is fractured in a mortar blast in Iraq. While undergoing surgery for the fractured vertebrae, a blood clot forms during the surgery on the member's back, causing the member to be paralyzed from the waist down. The member's loss is covered by TSGLI.

Pyogenic infection - a pyogenic infection is a pus forming infection, often caused by a wound.

Example: A member is injured in a car accident. She suffers injuries to her leg. Unfortunately, her wounds develop a pus-forming infection (pyogenic infection) and spread gangrene up her leg resulting in the loss of her leg. The member's loss would be covered by TSGLI.

Chemical Weapon - a chemical substance intended to kill, seriously injure, or incapacitate humans through their physiological effects.

The chemical exposure must be due to chemical weapons to be covered by TSGLI. This chemical exposure can occur in combat or outside of the combat zone in areas, such as, weapons storage facilities. Exposure to chemicals used in manufacturing or other civilian activity is not covered by TSGLI.

Example 1: A member is exposed to mustard gas, a chemical weapon. He loses his vision due to the exposure. The member's loss would be covered by TSGLI.

Example 2: A member works at a chemical manufacturing plant. Due to an explosion at the plant the member is exposed to chemical burns of the eye and loses his vision. The member's loss would not be covered by TSGLI.

Radiological Weapon - radioactive materials or radiation-producing devices intended to kill, seriously injure, or incapacitate humans through their physiological effects.

The radiological exposure must be due to nuclear weapons to be covered by TSGLI. This exposure can occur in combat or outside of the combat zone in areas, such as, weapons storage facilities. Exposure to nuclear radiation used as a civilian power source is not covered by TSGLI.

Example 1: A member is searching for weapons and finds a cache of nuclear weapons and is exposed to radiation. The member suffers nerve damage and is unable to dress and transfer for 120 days. The member's loss would be covered under TSGLI.

Example 2: A member is exposed to radiation while working at an Army weapons depot and is accidentally exposed to radiation. The member subsequently develops cancer and has to have his leg amputated. The member's loss would be covered by TSGLI.

Example 3: A member lives near to nuclear power plant. The plant has a nuclear release and the member is exposed to radiation. The member develops cancer and is hospitalized for 15 days. The member's loss would not be covered by TSGLI.

Biological Weapon – biological agents or microorganisms intended to kill, seriously injure, or incapacitate humans through their physiological effects

The biological agent exposure must be due to biological weapons to be covered by TSGLI. This exposure can occur in combat or outside of the combat zone in areas, such as, weapons storage facilities.

See examples under, “Chemical Weapon”

Contaminated Substance - food or water made unfit for consumption by humans because of the presence of chemicals, radioactive elements, bacteria, or organisms.

The accidental ingestion of a contaminated substance must occur through oral ingestion, rather than through other means, such as skin absorption. Ingestion is defined as “taking into the gastrointestinal tract by means of the mouth”.

Example 1: A member serving in Iraq is involved in a skirmish with enemy forces. He is forced to wait out the enemy for three days in a remote area. He only has a one-day supply of water. In order to survive, he drinks water from a small stream nearby. After escaping from his hiding place, the member returns to his base and becomes ill with vomiting, diarrhea, and a fever. After a number of days with these symptoms, the member falls into a coma for 20 days. It is determined that the illness causing the coma was a result of drinking contaminated water from the stream. The member’s loss would be covered by TSGLI.

Example 2: A member eats out at a restaurant. She becomes ill later that day with severe vomiting and diarrhea. She becomes so dehydrated and ill that she is hospitalized for 15 consecutive days. It is determined that she has botulism from the tainted food she ate at the restaurant. The member’s loss would be covered by TSGLI.

Example 3: A member is assisting with Hurricane Florence. To rescue people stranded in their homes, the member must wade through deep water contaminated by sewage and other industrial toxins. He later becomes ill due to exposure to chemical toxins in the water and must be hospitalized for 15 days. It is determined that the toxins causing the member’s illness were absorbed through his skin. The member’s loss is not covered by TSGLI.

Injuries sustained while committing, or attempting to commit, a felony.

Any loss occurring while the member is committing or attempting to commit a felony is not covered. The member does not have to be convicted of the felony for the exclusion to apply. The exclusion can be applied based on the evidentiary facts in the claim.

Example: A member crashes his motorcycle into a tree while intoxicated by alcohol over the legal limit. The member loses his arm in the crash. Driving under the influence is a felony in the state in which the crash occurred. However, as no one other than the member is injured in the crash, no felony charges are filed in the case. The member’s loss would not be covered by TSGLI as long as evidence exists that the member’s blood alcohol was over the legal limit while driving as required to prove a felony in the state where the crash occurred.

Amount Payable Under TSGLI

The maximum amount payable under TSGLI for all injuries resulting from a single traumatic event is \$100,000. There are three scenarios that govern payments under TSGLI:

- 1) A single injury resulting from a single traumatic event
- 2) Multiple injuries resulting from a single traumatic event
- 3) Multiple injuries resulting from multiple traumatic events

1) A Single Injury Resulting From a Single Traumatic Event

When a member suffers an injury from a single traumatic event, the member's TSGLI benefit will be the amount payable for that injury listed on the schedule of losses up to a maximum of \$100,000. The member will not be paid for the same loss resulting from the same traumatic event more than once.

Example 1: A member is hit by shrapnel in the face and injures his right eye. The member loses vision in the right eye for 180 days. The member is paid \$50,000 for loss of vision in the right eye.

Example 2: A member is hit by shrapnel in the face and injures his right eye. The member loses vision in the right eye for 180 days. The member is paid \$50,000 for loss of vision in the right eye. Three months later the member's vision improves above the standard for payment for TSGLI. A year later, the member's vision in the right eye once again deteriorates and the member loses full vision in the eye. The member **will not be** paid an additional \$50,000 for the loss of vision in the right eye.

2) Multiple Injuries Resulting From a Single Traumatic Event

When a member suffers multiple injuries from a single traumatic event, the member's TSGLI benefit will be the amount for the highest paying scheduled loss up to a maximum of \$100,000. Certain injuries can be combined and treated as a single scheduled loss and others cannot (See Part 4, Schedule of Losses, for information about combining injuries).

Example: A member permanently loses sight in both eyes due to a traumatic event on April 1, 2021. The benefit under the schedule for permanent loss of sight in both eyes is \$100,000. The member loses one foot May 1, 2021, as a direct result of a traumatic injury of the same traumatic event. The benefit under the schedule for the loss of one foot is \$50,000. The member will be paid \$100,000 for permanent loss of sight, which is the higher paying scheduled loss.

3) Multiple Injuries Resulting From Multiple Traumatic Events

When a member suffers multiple injuries from multiple traumatic events, these events can be broken down into two categories, multiple traumatic events that occur within a seven-day period and multiple traumatic events that occur more than seven full days apart.

a) Multiple traumatic events that occur within a seven-day period

Multiple traumatic events that occur within seven days are treated as a single event. This seven-day period begins with the day on which the first traumatic event occurs. The member's TSGLI benefit will be the amount for the highest paying scheduled loss up to a maximum of \$100,000. Certain injuries can be combined and treated as a single schedule loss and others cannot (See Part 4, Schedule of Losses, for information about combining injuries).

Example: A member loses a foot as a result of an IED explosion on Jan 1, 2021. On January 2, 2021, the vehicle transporting the injured member is involved in an accident. As a result of the accident, the member permanently loses sight in both eyes. The loss of sight carries a scheduled benefit of \$100,000 and the loss of 1 foot carries a scheduled benefit of \$50,000. Since the two traumatic events occurred within seven days of one another they are treated as a single event. The member's TSGLI benefit will be \$100,000 for permanent loss of sight, which is the higher paying scheduled loss.

b) Multiple traumatic events that occur more than seven full days apart

Multiple traumatic events that occur more than seven full days apart are treated as separate events, and the injuries from each event are evaluated individually. The member's TSGLI benefit will be the amount for the highest paying scheduled loss **from each event** up to a maximum of \$100,000 **for each event**. Certain

injuries can be combined and treated as a single scheduled loss and others cannot (See Part 4, Schedule of Losses, for information about combining injuries).

Example: A member loses sight in both eyes on May 1, 2021 as the result of a civilian motorcycle accident. The member submits an application for the loss of sight in both eyes on May 30, 2021. The member is paid \$100,000 for the loss of sight.

The same member loses one foot due to an automobile accident that occurred on November 1, 2021. The member submits a second application for the second loss on December 1, 2021. Since the second event occurred more than 7 full days after the first event, the member is paid an additional \$50,000 for the loss of one foot. The member's total TSGLI benefit is \$150,000.

TSGLI Premiums

The premium for TSGLI is a flat rate of \$1 per month for both Active duty and Ready Reserve members with full-time SGLI coverage. Members with part-time coverage and members on funeral honors or one-day muster duty will pay the premium indicated in the table below.

Duty Status	Premium
Reservists w/part-time SGLI coverage	\$1.00 per year
Funeral honors & 1 day muster duty	No charge

Note: These rates are determined by VA and are subject to change based on claims experience.

Part 2 –Ending TSGLI Coverage

General Information

The member cannot choose to decline TSGLI coverage only, nor can the member elect TSGLI coverage without SGLI coverage. TSGLI coverage is automatic for those members insured under SGLI. However, if the member declines SGLI, he or she is also declining TSGLI coverage.

TSGLI coverage will end due to any event that causes the member's SGLI coverage to end.

Ending TSGLI Coverage

TSGLI coverage ends due to the following events:

- 1) Member elects to decline SGLI coverage (SGLI Online Enrollment System (SOES) election/SGLV form 8286)
- 2) Member separates from service
- 3) Member dies

1) Member Elects to Decline SGLI Coverage

When a member declines SGLI coverage by making a SOES election/completing SGLV Form 8286, the member's SGLI coverage and TSGLI coverage stay in effect until midnight of the last day of the month in which the member declines coverage. A premium for TSGLI is due for the month in which the member declines coverage. No further premiums are due until such time as the member restores SGLI coverage.

Example: The member elects in SOES on the 15th of the month to decline SGLI coverage. A premium is deducted from the member's pay for both SGLI and TSGLI for that month. The member loses a leg as a result of a car accident on the 25th of the same month. The member is still covered under TSGLI and will receive payment of \$50,000 for the loss of the leg. If the car accident occurs on the 1st or after of the following month, the member would not be covered under TSGLI at the time of the event and would not receive a TSGLI benefit payment.

2) Member Separates From Service

When a member separates or is released from service, TSGLI coverage stays in effect until midnight of the day of release. TSGLI coverage is not in effect during the 120-day post-separation period nor during the 2-year SGLI Disability Extension. A premium is due for the month in which the member is released. No further premiums are due.

3) Member Dies

When a member dies, a premium for TSGLI and SGLI is due for the month of the death. No further premiums are due.

Part 3 –Restoring TSGLI Coverage

General Information

The member can restore TSGLI coverage by restoring SGLI coverage. To restore SGLI, and therefore TSGLI, the member must elect to do so in SOES/complete SGLV Form 8286. The “good health” of the member is an issue in being eligible to restore SGLI coverage. The health questions in SOES/SGLV Form 8286 must be answered.

Restoring TSGLI Coverage

TSGLI coverage can be restored, after it has been declined or reduced, when one of the following events occurs:

- 1) Member's change in duty status* begins automatic maximum coverage
- 2) Member elects to restore SGLI coverage

*A “change in duty status” is defined as follows:

- A Ready Reservist/National Guard member who is mobilized to active duty status
- A Ready Reservist/National Guard member who is demobilized and returns to reserve status
- A member who completes active duty and is assigned to the Ready Reserve

1) Member's Change in Duty Status Begins Automatic Maximum Coverage

After a member has declined SGLI coverage, and therefore TSGLI, a change in duty status will automatically begin both SGLI at the maximum level and TSGLI coverage. The member is not required to request an increase in coverage through SOES/ SGLV Form 8286 in this situation.

2) Member's Deployment to Combat Zone

After a member has declined SGLI coverage, and therefore TSGLI, deployment to a combat zone will automatically begin both SGLI at the maximum level and TSGLI coverage. The member is not required to request an increase in coverage through SOES/ SGLV Form 8286 in this situation.

However, the member's SGLI coverage and therefore TSGLI will be returned to no coverage upon return from deployment to the combat zone.

3) Member Elects to Restore SGLI Coverage

After a member has declined SGLI coverage, and therefore TSGLI coverage, and wants to restore coverage outside of change of duty status, he/she must request an increase in coverage through SOES/ SGLV Form 8286 in order to restore his/her SGLI. TSGLI coverage is automatically restored if and when the Service Member's restoration of SGLI coverage is approved.

The member must answer all of the health questions in SOES/SGLV 8286. If the member answers “Yes” to any of the health questions, SOES, (or if completing the SGLV 8286, the unit) refers the election to the Office of Servicemembers' Group Life Insurance (OSGLI) for a decision on coverage. No premiums for SGLI and TSGLI are due until OSGLI determines coverage is approved. If coverage is approved, premiums are due back to the month the election was received by the service.

Example: The member previously declined SGLI coverage, and therefore TSGLI coverage as well. The Service Member's election to restore SGLI coverage is received on February 8th. Assuming all health questions are answered as “No”, the premium deduction begins immediately with the February pay. If the member answers “Yes” to any health questions, OSGLI must approve the coverage before premiums begin. If OSGLI approves the coverage in March, premiums are collected at that time for both February and March.

Part 4 –Schedule of Losses

General Information

A scheduled loss is a loss that is suffered as a result of a traumatic event and is listed on the Schedule of Losses. The Schedule of Losses (see Appendix A) outlines the injuries covered under TSGLI and the amount payable for each injury. Certain injuries listed in the schedule may be combined and treated as a single scheduled loss. Payments range from a minimum of \$25,000 to a maximum of \$100,000. This section is a guide for using the schedule to combine injuries as a single loss, evaluating the type of loss suffered and determining the TSGLI benefit payment amount.

Using the Schedule to Combine Injuries as a Single Loss

When a member suffers multiple injuries from a single traumatic event, the member's TSGLI benefit will be the amount for the highest paying loss listed on the Schedule of Losses up to a maximum of \$100,000. Certain injuries can be combined and treated as a single scheduled loss and others cannot.

The Schedule of Losses is divided into two parts:

- 1) Part 1 – Injuries that MAY be combined as a single loss
- 2) Part 2 – Injuries that MAY NOT be combined as a single loss

1) Part I – Injuries that MAY be combined as a single loss

Part 1 lists injuries that may be combined with each other and treated as a single scheduled loss (except where noted otherwise). The total payment amount may not exceed \$100,000.

Example 1: combining injuries as a single loss: A member is injured in a car accident. As a result, her hand is amputated and she suffers uniplegia (paralysis of one leg). Since these injuries are listed on Part 1 of the schedule, they can be combined as a single loss. The member's payment would be \$50,000 for amputation of hand and \$50,000 for uniplegia of one leg for a total payment of \$100,000.

Example 2: paying the maximum scheduled benefit: A member is injured in an IED blast. The member suffers 2nd degree burns to 20% of his body, which has a scheduled loss payment of \$100,000. The member also suffers the loss of hearing in one ear which has a scheduled loss payment of \$25,000. Although both injuries are listed in Part 1 of the schedule, the member cannot receive more than \$100,000 as the result of a single traumatic event. Therefore, the member would receive \$100,000 for burns.

Example 3: Part 1 injuries that cannot be combined: A member is injured in a motorcycle accident. The member suffers amputation of one foot. Although Part 1 lists amputation of foot, amputation of all toes on one foot, and amputation of big toe on one foot as separate injuries, the schedule indicates that these injuries cannot be combined with each other. Therefore the member would receive \$50,000 for loss of foot.

Example 4: Multiple Part 1 Injuries suffered within a 2-year period: A member is injured in an automobile accident. The member suffers injuries to both her feet, and her left foot is amputated in July 2021. The member files a TSGLI claim and is paid \$50,000 for amputation of her left foot. In September 2022, the member develops complications with the injuries to her right foot and has to have her big toe amputated. Since both injuries are listed in Part 1 of the schedule and the member has not received the maximum TSGLI payment of \$100,000, the member files a second TSGLI claim and is paid \$25,000 for loss of big toe.

2) Part II – injuries that MAY NOT be combined as a single loss

Part 2 lists injuries that cannot be combined with injuries in Part 1 or with each other. If the member has multiple injuries that are listed in both parts of the schedule, the member will receive payment for the highest paying loss up to a maximum of \$100,000.

Example 1: A member is injured in a car accident. The member suffers an injury to her abdomen that results in the inability to perform Activities of Daily Living (ADL) for 30 days. The member also has one hand amputated. Since injuries listed in Part 2 cannot be combined with injuries listed in Part 1, the member will receive \$50,000 for the amputation of her hand as this is the highest paying loss.

Example 2: A member is injured in an IED blast. The member suffers loss of hearing in one ear and injuries to both hands that result in the inability to perform Activities of Daily Living (ADL) for 60 days. Since injuries listed in Part 2 cannot be combined with injuries listed in Part 1, the member will receive \$50,000 for the loss of ADL for 60 days as this is the highest paying loss.

Evaluating Loss(es) Suffered

Losses must meet the TSGLI standard in order to be eligible for a benefit payment. This section is a guide to evaluating these losses. There are 9 categories of losses covered.

- 1) Sensory Losses
- 2) Burns
- 3) Paralysis
- 4) Amputation
- 5) Limb Reconstruction
- 6) Facial Reconstruction
- 7) Coma
- 8) Activities of Daily Living (ADL)
- 9) Inpatient Hospitalization
- 10) Genitourinary Losses

1) Sensory Losses

There are three sensory losses covered under TSGLI: loss of sight, loss of hearing and loss of speech.

a) **Total and permanent loss of sight OR loss of sight that has lasted 120 days**

When a member has a loss of sight, the member is eligible for a TSGLI benefit for total and permanent loss of sight if the member meets one of the following three standards:

If the member's visual acuity in at least one eye is...	And their peripheral vision in at least one eye is...	And the loss of vision ...
1. 20/200 or less (worse) with corrective lenses	N/A	has lasted at least 120 days OR will not improve (with reasonable certainty) throughout member's life.
2. Greater (better) than 20/200 with corrective lenses	a visual field of 20 degrees or less	has lasted at least 120 days OR will not improve (with reasonable certainty) throughout member's life.

If the member's visual acuity in at least one eye is...	And their peripheral vision in at least one eye is...	And the loss of vision ...
3. Non-existent due to complete loss of the eye(s)	N/A	N/A

b) Total and permanent loss of hearing

When a member has a loss of hearing, the member is eligible for a TSGLI benefit for total and permanent loss of hearing if the member meets the following standard:

If the member's average hearing threshold sensitivity for air conduction in at least one ear is...	and the loss of hearing will...
80 decibels or more	not improve (with reasonable certainty) throughout the member's life.

Hearing Acuity - Hearing acuity must be measured via puretone audiometry by air conduction at 500 Hz, 1000 Hz and 2000 Hz to calculate the average hearing threshold. Loss of hearing must be clinically stable and unlikely to improve.

c) Total and permanent loss of speech

When a member has a loss of speech, the member is eligible for a TSGLI benefit for total and permanent loss of speech if the member meets the following standard:

If the member suffers...	and the loss of speech will...
An organic loss of speech (lost the ability to express oneself, both by voice and whisper, through normal organs for speech). *	not improve (with reasonable certainty) throughout the member's life.

*If a member uses an artificial appliance, such as a voice box, to simulate speech, he/she is still considered to have suffered an organic loss of speech and is eligible for a TSGLI benefit.

2) Burns

When a member suffers burns, the following standards apply:

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

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

Facial Burns Calculator: Use this calculator to convert head burns as a percentage of Total Body Surface Area (TBSA) into a percentage of the face alone. It allows you to determine if a member meets the standards of full or partial thickness burns to 20% of the face.

Example: TBSA of the head burned is 5% on Burn Chart. Divide in half to get 2.5% TBSA of face burned. Then, take 2.5% TBSA of the face as part of the body and divide by 3.5%, the portion of the TBSA that is the face (without neck included), obtaining 71% of the face is burned.

Note 1: This calculator is based on the face being approximately 1/2 of the head. If the member in question has burns on the head that are mostly on the back of the head, not the face, you will need to estimate how much of the face is burned as compared to TBSA of the head and divide by that number instead of by 2.

Example: While TBSA of head is 4%, the burn chart shows approximately 75% of the burns are located on the back of the head. This would mean that you would need to use 1% TBSA of the head for placement in the burn calculator above - 25% of 4.

Note 2: If the claim involves only burns to the face and not to the remainder of the head, the TBSA percentage in the calculation should not be divided in half.

Example: TBSA of the head burned is 3% on Burn Chart, but burns are ONLY on the face, not elsewhere on the head. Take 3% TBSA of the face as part of the body and divide by 3.5%, the portion of the TBSA that is the face (without neck included), obtaining 85.7% of the face is burned.

Note 3: TBSA of the head based on the Rule of Nines or similar tools cannot be more than 9%.

Note 4: This calculator is not applicable for calculating burns as a percentage of the entire body to determine if the member meets the standard of 2nd degree or worse (partial or full thickness) burns over 20% of the entire body. In this case, simply use the total TBSA provided on the Burn Chart.

Road Rash: The medical field considers road rash a deep skin abrasion due to the scraping of skin on hard surfaces. While road rash may be treated at a Burn Center for wound care, it is not a burn. Members suffering from road rash due to a traumatic event should not claim burns on their TSGLI application, but identify other losses covered under TSGLI for which they qualify.

Example: A member is injured when his motorcycle slides on a wet road. He has deep skin abrasions, termed road rash, on his arms and legs. He undergoes wound care at a local Burn Center. He is unable to perform bathing and dressing for 30 days after his accident. The member does not qualify for payment under burns but does qualify for \$25,000 for the inability to perform two ADL for 30 days.

3) Paralysis

When a member is paralyzed, the member is eligible for a TSGLI benefit for paralysis if his/her loss meets the following standard:

If the member suffers...	AND paralysis fall into one of these four categories
Complete paralysis due to damage to the spinal cord or associated nerves, or to the brain.	<p>Quadriplegia - paralysis of all four limbs*</p> <p>Paraplegia - paralysis of both lower limbs*</p> <p>Hemiplegia - paralysis of the upper and lower limbs* on one side of the body</p> <p>Uniplegia- paralysis of one limb*</p>

*A limb is defined as an arm or a leg with all its parts.

4) Amputation

There are 4 amputation losses listed on the schedule. The TSGLI standard for each of these losses is listed below.

a) Amputation of hand

When a member loses a hand, the member is eligible for a TSGLI benefit for loss of hand if the member's hand is amputated at or above* the wrist.

*The words "at or above" in the standard refers to the loss being closer to the body.

b) Amputation of fingers

When a member loses four fingers on the same hand or the member loses one thumb, the member is eligible for a TSGLI benefit for amputation of fingers if the member meets the following standard:

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

**The words "at or above" in the standard refers to the loss being closer to the body.*

c) Amputation of foot

When a member loses a foot,) the member is eligible for a TSGLI benefit for amputation of foot if the member meets the following standard:

If the member suffers...	
Amputation of foot at or above* the ankle	

**The words "at or above" in the standard refers to the loss being closer to the body.*

d) Amputation of toes

When a member loses all toes on the same foot (including big toe), four toes on the same foot (not including the big toe), or loses one big toe, the member is eligible for a TSGLI benefit for amputation of toes if the member meets the following standard:

If the member suffers...	OR the member suffers...	OR the member suffers...
Amputation of all toes (including the big toe) on the same foot at or above* the metatarsophalangeal joint.	Amputation of four toes (not including the big toe) on one foot at or above* the metatarsophalangeal joint.	Amputation of big toe at or above* the metatarsophalangeal joint.

**The words "at or above" in the standard refers to the loss being closer to the body.*

5) Limb Reconstruction

When a member suffers Limb Reconstruction the following standards apply:

If the member undergoes...	OR undergoes...	AND a surgeon certifies that...
<p>One of the following four surgeries:</p> <ol style="list-style-type: none"> 1. Bone grafting to reestablish stability and enable mobility of the limb; 2. Soft tissue grafting/flap reconstruction to reestablish stability and enable mobility of the limb; 3. Vascular reconstruction to restore blood flow and support bone and tissue regeneration; or 4. Nerve reconstruction to allow for motor and sensory 	<p>Two of the following four surgeries:</p> <ol style="list-style-type: none"> 1. Bone grafting to reestablish stability and enable mobility of the limb; 2. Soft tissue grafting/flap reconstruction to reestablish stability and enable mobility of the limb; 3. Vascular reconstruction to restore blood flow and support bone and tissue regeneration; or 	<p>the patient is undergoing limb reconstruction as defined in the left column.</p>

If the member undergoes...	OR undergoes...	AND a surgeon certifies that...
restoration and muscle re- enervation	4. Nerve reconstruction to allow for motor and sensory restoration and muscle re- enervation	

Limb Reconstruction is defined as a surgical process, usually involving bone or skin grafts, bone resection, reconstruction, and or plastic surgery techniques, designed to treat post-traumatic limb defects that can severely limit long-term function.

Note: Open and closed fractures, compartment syndrome, fasciotomies, and debridements, in and of themselves, do not constitute limb reconstruction.

6) Facial Reconstruction

When a member suffers a severe maxillofacial injury, the member is eligible for a TSGLI benefit for facial reconstruction if the member meets the following standard:

If the member undergoes...	AND a surgeon certifies that...
<p>surgery to correct traumatic avulsions (i.e. separation, detachment or tear) of the face or jaw that cause discontinuity defects.</p> <p>Note: In order to meet the standard for facial reconstruction, the member must experience a penetrating facial injury (avulsion) and lose bone or tissue that without replacement would leave a "gap" in the area of injury (discontinuity defect).</p> <p>The term avulsion means a forcible detachment or tearing of bone and/or tissue due to a penetrating or crush injury.</p> <p>The term discontinuity defect means an absence of bone and/or tissue from its normal bodily location, which interrupts the physical consistency of the face and impacts at least one of the following functions: mastication, swallowing, vision, speech, smell, or taste.</p>	<p>the surgery was to correct discontinuity loss to one or more of the following facial areas:</p> <p>the upper or lower jaw (requires bone loss),</p> <p>50% or more of the cartilaginous nose (requires cartilage/tissue loss),</p> <p>50% or more of the upper or lower lip (requires tissue loss),</p> <p>30% or more of the left or right periorbita (requires tissue loss),</p> <p>50% or more of any of the following facial subunits (requires tissue or bone loss):</p> <ul style="list-style-type: none"> • forehead, • left or right temple, • left or right zygomatic, • left or right mandibular, • left or right infraorbital • chin

Note: Loss of teeth alone does not constitute facial reconstruction under the standard for the loss of the upper and lower jaw.

7) Coma due to Traumatic Brain Injury (TBI)

A member will be considered eligible for a TSGLI benefit for coma if:

The member is in a coma with...	that lasts for...
brain injury measured at a Glasgow Coma Score of 8 or less	at least 15 consecutive days

When a member is in a coma due to a traumatic injury, TSGLI benefits will be paid based on the number of consecutive days the member is in a coma.

The duration of the coma includes the date the coma began and the date the member recovered from the coma.

Benefits Schedule - Payments for coma due to TBI will be made as follows:

- \$25,000 at the 15th consecutive day
- An additional \$25,000 at the 30th consecutive day
- An additional \$25,000 at the 60th consecutive day
- An additional \$25,000 at the 90th consecutive day

Example 1: On May 1, a member goes into a coma as the result of a military motor vehicle accident. The member recovers from the coma 60 days later on June 29. The member's TSGLI benefit will be \$75,000 for the 60 consecutive days in a coma.

Note: The member's first day in a coma must occur within 730 days of the traumatic event in order to receive payment. If subsequent days in a coma occur after the 730-day period ends, the member can still be paid a benefit, up to the maximum number of consecutive days in a coma that began before the end of the 730-day period. As soon as the member comes out of a coma, the consecutive day period ends and no further benefits can be paid.

Example 2: On January 1, 2020, a member is hit by an IED. He is treated for a range of shrapnel wounds and TBI throughout the next two years. A piece of shrapnel that remained lodged in the member's brain from the IED moves causing bleeding and swelling. On December 26, 2021, the member goes into a coma from the bleeding and swelling. The member remains in a coma until January 17, 2022. The member's TSGLI benefit will be \$25,000 for 15 consecutive days in a coma.

8) Activities of Daily Living (ADL)

Activities of Daily Living (ADL) are routine self-care activities that a person normally performs every day without needing assistance. There are six basic ADL: eating, bathing, dressing, toileting, transferring (moving in and out of bed or chair) and continence (managing or controlling bladder and bowel functions). The following aspects of ADL loss are covered in this section:

- a) Determining if a member has loss of ADL
- b) Loss of ADL due to TBI
- c) Coma combined with loss of ADL due to TBI
- d) Coma due to TBI and other loss on Part 1 of the TSGLI Schedule of Losses
- e) Loss of ADL due to TBI and other loss on Part 1 of the TSGLI Schedule of Losses
- f) Loss of ADL due to traumatic injury (other than traumatic brain injury)
- g) Break between consecutive periods of inability to perform ADL
- h) Loss of ADL due to another injury that qualifies for payment on Part 1 of the TSGLI Schedule of Losses
- i) Loss of ADL due to TBI and OTI

a) Determining if a member has a loss of ADL

A member is considered to have a loss of ADL if the member **REQUIRES assistance** to perform at least two of the six activities of daily living. If the patient is able to perform the activity by using accommodating equipment (such as a cane, walker, commode, etc.) or adaptive behavior, the patient is considered able to independently perform the activity.

REQUIRES assistance is defined as:

- **Physical assistance** - when a member requires hands-on assistance from another person to perform the ADL
- **Stand-by assistance** - when a member requires someone to be within arm's reach to allow them to perform the ADL safely because the member's ability fluctuates.
- **Verbal assistance** - when a member requires oral instruction in order to complete the ADL due to cognitive impairment. Without these verbal reminders, the member would not remember to perform the ADL.

Without this physical, stand-by, or verbal assistance, the member would be incapable of performing the task.

Accommodating equipment and adaptive behavior are defined as:

- **Accommodating equipment** - tools or supplies that enable the member to perform ADL without physical, stand-by, or verbal assistance from another person. Examples of accommodating equipment, include, but are not limited to:

- Wheelchair
- Walker or cane
- Reminder apps
- Velcro clothing or slip-on shoes
- Grabber or reach extender
- Toilet seat raiser
- Wash basin
- Shower chair
- Show or tub modifications, such as wheelchair or no-step access, grab bar or handle

Once the member is able to perform the ADL without assistance, using the accommodating equipment, the member no longer meets the ADL standard.

- **Adaptive Behavior** – compensating skills that allow the member to perform ADL without physical, stand-by, or verbal assistance from another person. An example of adaptive behavior is if a nurse teaches the member how to roll out of bed safely into a chair or wheelchair. Once the member is able to perform the roll without assistance, the member no longer meets the ADL of transferring.

The table below should be used to help to determine whether a member has lost the ability to perform a particular ADL. *For additional information on TSGLI ADL standards, definitions and examples, please view the TSGLI Training available at <https://www.benefits.va.gov/INSURANCE/training1.asp>.*

Patient is...	if he/she requires physical, stand-by, or verbal assistance from another person...
UNABLE to bathe independently	<p>to wash, while in a shower or bathtub or using a sponge bath, at least three of the six regions of the of the body listed below.</p> <p>Regions of the body are: head and neck, back, front torso, pelvis (including the buttocks), arms, or legs.</p> <p>Note: If a member is able to self-bathe using a sponge bath, even if he/she cannot use the shower or tub, the member is ABLE to bathe independently.</p>
UNABLE to maintain continence independently	<p>to manage catheter or colostomy bag, if present, OR is ur is unable to maintain complete control of bowel and bladder function, if no catheter or colostomy bag is present</p> <p>Note: If a member uses a catheter or colostomy bag, and is able to manage the equipment independently, the member is ABLE to maintain continence independently.</p>
UNABLE to dress independently	<p>to lobtaint and put on appropriate clothes and shoes (i.e. dress for the correct season). This includes both obtaining the clothes from drawers/closets and removing or placing clothes on the body.</p> <p>Note: The inability to tie shoes or use zippers, buttons or belts without assistance does not, in and of itself, meet the requirement for inability to dress. The member must show that accommodating equipment, such as slip-on shoes, clothing without buttons, or clothing with elastic bands, could not be used to self-dress.</p>
UNABLE to eat independently	<p>to get food from plate to mouth; take liquid nourishment from a straw or cup; or is fed intravenously or by a feeding tube.</p> <p>Note 1: Requiring assistance in food preparation (cooking or cutting food) is not part of the eating ADL standard.</p> <p>Note 2: If a member is able to obtain sufficient nourishment through a liquid diet, via straw or cup, the member is ABLE to eat independently.</p>
UNABLE to toilet independently	<p>to get on and off the toilet, clean self after toileting, get clothing off and on before and after toileting, clean organs of excretion after toileting, or use a bedpan or urinal.</p>
UNABLE to transfer independently	<p>to move into or out of a bed or chair.</p>

Note: If member was approved for Special Compensation for Assistance with Activities of Daily Living (SCAADL), this does not guarantee eligibility for a TSGLI benefit. The eligibility criteria for SCAADL is not the same as the ADL loss standards under the TSGLI program.

b) Loss of ADL due to TBI

When a member is unable to perform at least two of the six activities of daily living (ADL) due to TBI, TSGLI benefits will be paid based on the number of consecutive days the member has loss of ADL due to the brain injury.

The duration of the loss of ADL includes the date the member began to be unable to perform ADL and the date the member was again able to perform ADL.

Benefits Schedule - Payments for loss of ADL due to TBI will be made as follows:

- \$25,000 at the 15th consecutive day
- An additional \$25,000 at the 30th consecutive day
- An additional \$25,000 at the 60th consecutive day
- An additional \$25,000 at the 90th consecutive day

Example 1: On May 1 a member suffers a TBI due to a helicopter accident. As a result, the member is unable to dress and transfer without assistance from May 1 through May 30. The member's TSGLI benefit will be \$50,000. The \$50,000 benefit for inability to perform two ADL includes \$25,000 for 15 consecutive days and an additional \$25,000 for 30 consecutive days.

Note: The member's first day of ADL loss due to TBI must occur within 730 days of the traumatic event in order to receive payment. If subsequent days of ADL loss due to TBI occur after the 730-day period ends, the member can still be paid a benefit, up to the maximum number of consecutive days of ADL loss that began before the end of the 730-day period. As soon as the member regains ADL function, the consecutive day period ends and no further benefits can be paid.

Example 2: On January 1, 2019, a member is hit by an IED and suffers a TBI. After initial improvements in his condition, almost two years later on December 28, 2020, the member's TBI worsens to the point of losing his ability to perform the ADL of bathing and dressing. The member regains his ability to perform the ADL of bathing and dressing on February 15, 2021. The member's TSGLI benefit will be \$50,000 for the loss of two ADL for 30 consecutive days. If the member should again lose the ability to perform two ADL after the break in consecutive days of ADL loss on February 15, 2021, he cannot be paid an additional benefit.

c) Coma combined with loss of ADL due to TBI

When a member is in a coma due to TBI, TSGLI benefits will be paid based on the number of consecutive days the member is in a coma. If the member also has loss of ADL due to TBI, the time in a coma and the loss of ADL due to TBI must be analyzed as one continuous time period, not two separate time periods.

Note: Loss of ADL due to TBI will only be considered after the member comes out of the coma, and will be paid on the same benefit schedule.

Benefits Schedule - Payments for coma and loss of ADL from TBI will be made as follows:

- \$25,000 at the 15th consecutive day
- An additional \$25,000 at the 30th consecutive day
- An additional \$25,000 at the 60th consecutive day
- An additional \$25,000 at the 90th consecutive day

Example: On May 1, a member goes into a coma as the result of a military motor vehicle accident. The member recovers from the coma 30 days later on May 31. However, the member remains unable to independently perform two of six activities of daily living due to TBI for an additional 30 days, until July 1. The member's TSGLI benefit will be \$75,000. The payment consists of \$50,000 for the 30 consecutive days in a coma, and \$25,000 for the additional 30 consecutive days of inability to independently perform two of six ADL due to TBI.

d) Coma due to TBI and another loss on Part 1 of the TSGLI Schedule of Losses

When a member suffers a coma in combination with another loss listed on Part 1 of the TSGLI Schedule of Losses, the member's TSGLI benefit will include the benefit for the number of consecutive days the member is in a coma plus the benefit for the other injury up to a combined maximum payment of \$100,000.

The duration of the coma includes the date the coma began and the date the member recovered from the coma.

Benefits Schedule - Payments for coma will be made as follows:

- \$25,000 at the 15th consecutive day
- An additional \$25,000 at the 30th consecutive day
- An additional \$25,000 at the 60th consecutive day
- An additional \$25,000 at the 90th consecutive day

Example: On May 1, a member goes into a coma as the result of an automobile accident. The member recovers from the coma 77 days later on July 16, and his doctor finds he has suffered total and permanent loss of speech. The member submits a TSGLI claim on August 1. The benefit paid to the member will be \$50,000 for the loss of speech plus \$50,000 for 30 days in a coma*, for a total of \$100,000. The \$50,000 benefit for the coma includes \$25,000 for 15 consecutive days and an additional \$25,000 for 30 consecutive days.

*Note: Even though the member's coma extended through 60 days, an additional payment of \$25,000 will not be made because the combined payment cannot exceed the \$100,000 maximum.

e) Loss of ADL due to TBI and another loss on Part 1 of the TSGLI Schedule of Losses

When a member is unable to perform two of the six activities of daily living (ADL) due to TBI in combination with another loss on Part 1 of the TSGLI Schedule of Losses, the member's TSGLI benefit will include the benefit for the number of consecutive days the member has loss of ADL due to the brain injury plus the benefit for the other injury up to a combined maximum payment of \$100,000.

The duration of the loss of ADL includes the date the member began to be unable to perform ADL and the date the member was again able to perform ADL.

Benefits Schedule - Payments for loss of ADL due to traumatic brain injury will be made as follows:

- \$25,000 at the 15th consecutive day
- An additional \$25,000 at the 30th consecutive day
- An additional \$25,000 at the 60th consecutive day
- An additional \$25,000 at the 90th consecutive day

Example: A member suffers a traumatic brain injury and permanently loses sight in one eye as the result of a helicopter accident on May 1. Beginning that same day, the member is unable to eat, transfer or toilet without assistance. Fifteen days later on May 15, the member regains the ability to eat, transfer and toilet. The member's TSGLI benefit will be

\$50,000 for the loss of sight in one eye plus \$25,000 for 15 consecutive days of lost ADL due to traumatic brain injury, for a total of \$75,000.

f) Loss of ADL Due to Traumatic Injury Other Than TBI (OTI)

When a member is unable to perform two of the six activities of daily living (ADL) due to a traumatic injury other than TBI, the TSGLI benefit will be paid based on the number of consecutive days the member is unable to perform ADL.

The duration of the loss of ADL includes the date the member began to be unable to perform ADL and the date the member was again able to perform ADL.

Benefit Schedule - Payments for loss of ADL due to traumatic injury other than brain injury (OTI) will be made as follows:

- \$25,000 at the 30th consecutive day
- an additional \$25,000 at the 60th consecutive day
- an additional \$25,000 at the 90th consecutive day
- an additional \$25,000 at the 120th consecutive day

Example 1: A member sustains shrapnel wounds to the pelvis and is unable to get out of the bed (transferring) and unable to go to and from the bathroom (toileting) for 31 days from May 1 through May 31. The member's TSGLI benefit will be \$25,000 for the 30 days of loss of ADL.

Note: The member's first day of ADL loss due to OTI must occur within 730 days of the traumatic event in order to receive payment. If subsequent days of ADL loss due to OTI continue after the 730-day period ends, the member can still be paid a benefit, up to the maximum number of consecutive days of ADL loss that began before the end of the 730-day period. As soon as the member regains ADL function, the consecutive day period ends and no further benefits can be paid.

Example 2: On January 1, 2020, a member falls down a cliff while hiking and injures both legs. Almost two years later on December 29, 2021, a pyogenic infection in both legs related to the fall causes the member to lose the ability to perform the ADL of bathing, transferring and dressing. The member regains his ability to perform the ADL of bathing and dressing on January 30, 2022. The member's TSGLI benefit will be \$25,000 for the loss of two ADL for 30 consecutive days. If the member should again lose the ability to perform two ADL after the break in consecutive days of ADL loss on January 30, 2022, he cannot be paid an additional benefit.

g) Break Between Consecutive Periods of Loss of ADL

If a member has a loss of ADL for a scheduled number of consecutive days, then regains the ability to perform ADL, the member must have a loss of ADL for the full length of the next scheduled payment interval in order to be eligible for another TSGLI payment. The member must sustain the loss of at least two of the six ADL for the entire period of days. The tables and example below illustrate this situation.

Loss of ADL Due to TBI

If the member has a loss of ADL for...	then regains the ability to perform ADL...	The member must have a loss of ADL for another...	to receive the next TSGLI benefit payment.
15 consecutive days		30 consecutive days	
30 consecutive days		60 consecutive days	
60 consecutive days		90 consecutive days	

Loss of ADL Due to OTI

If the member has a loss of ADL for...	then regains the ability to perform ADL...	The member must have a loss of ADL for another...	to receive the next TSGLI benefit payment.
30 consecutive days		60 consecutive days	
60 consecutive days		90 consecutive days	
90 consecutive days		120 consecutive days	

Example: A member is hospitalized with shrapnel wounds on January 1 and is unable to dress or bathe for 30 consecutive days. The member receives a benefit of \$25,000 for 30 days of OTIADL loss. The member is released from the hospital on January 31 with no ADL limitations. On March 1, the member has additional surgery and treatment for the shrapnel wounds and is again unable to bathe and dress. In order to receive an additional payment for this second period of OTI ADL loss, the member must be unable to bathe and dress for 60 consecutive days from March 1.

h) Loss of ADL due to another injury (OTI) that also qualifies for payment on Part 1 of the TSGLI Schedule of Losses

When a member has a loss of ADL due to OTI that also qualifies for payment on Part 1 of the TSGLI Schedule of Losses the certifying official must compare the scheduled payment for the loss on Part 1 to the scheduled payment for the loss of ADL due to OTI on Part 2 of the Schedule of Losses. In some cases the member would receive a greater amount for loss of ADL due to OTI on Part 2, than for the loss listed on Part 1. The table below illustrates this situation.

The member...	with a scheduled payment on Part 1 of...	The member also has loss of ADL due to OTI for...	with a scheduled payment on Part 2 of...	The member's benefit will be...
Loses a foot	\$50,000	30 consecutive days	\$25,000*	\$50,000 for the loss of foot
Loses a foot	\$50,000	60 consecutive days	\$50,000*	\$50,000 for either the loss of foot or 60-day ADL loss
Loses a foot	\$50,000	90 consecutive days	\$75,000 *	\$75,000 for the 90-day loss of ADL

*The scheduled payment represents the total of the \$25,000 benefit payments made at 30-day intervals.

i) Loss of ADL due to TBI and OTI

When a member has loss of ADL due to both TBI and OTI because of injuries to the brain and other parts of the body, the certifying official must compare the scheduled payment for the ADL loss due to TBI on Part 1 to the scheduled payment for the loss of ADL due to OTI on Part 2. The table below illustrates this situation.

This situation can occur when the member's initial treatment is due to a head injury, which improves, but the other bodily injuries continue to cause loss of ADL.

The member...	with a scheduled payment on Part 1 of...	The member has loss of ADL due to OTI after initial TBI ADL Loss for an additional...	with a scheduled payment on Part 2 of...	The member's benefit will be...
Loses ADL due to TBI for 15 days	\$25,000	30 consecutive days	\$25,000*	\$25,000 for either 15-day ADL loss due to TBI or 30-day ADL loss due to OTI
Loses ADL due to TBI for 15 days	\$25,000	60 consecutive days	\$50,000*	\$50,000 for 60-day ADL loss due to OTI
Loses ADL due to TBI for 30 days	\$50,000	90 consecutive days	\$75,000 *	\$75,000 for the 90-day loss of ADL due to OTI

*The scheduled payment represents the total of the \$25,000 benefit payments made at 30-day intervals.

9) Inpatient Hospitalization

A member who is hospitalized as an inpatient for 15 consecutive days as the result of a traumatic injury is eligible for a \$25,000 payment under TSGLI. The following general rules apply to the inpatient hospitalization benefit.

- a) Inpatient hospitalization days include transportation time from the site of the injury to the hospital, transfers from one hospital to another, the day of admission and the day of release.
- b) Payment for a 15-day inpatient hospital stay replaces the first ADL milestone payment only and can only be issued once per qualifying traumatic event. Subsequent periods of 15-day inpatient hospitalization due to the same traumatic injury do not qualify for an additional benefit.
- c) Combinations of inpatient hospitalization and ADL loss must be continuous (occur on consecutive days) to qualify for the second ADL milestone payment.
- d) Inpatient hospitalization for fewer than 15 consecutive days and inpatient hospitalization for non-consecutive days that add up to 15 days are not eligible for the TSGLI benefit.
- e) Inpatient hospitalization for TBI may be combined with other losses on Part 1 of the TSGLI Schedule of Losses provided the inpatient hospitalization is primarily due to TBI or coma.
- f) Inpatient hospitalization for traumatic injuries other than TBI may not be combined with other losses on Part 1 of the TSGLI Schedule of Losses.
- g) Inpatient hospitalization for illnesses and diseases is not covered under TSGLI (except for illnesses/diseases caused by a pyogenic infection, biological, chemical, or radiological weapon, or accidental ingestion of a contaminated substance).
- h) Inpatient hospitalization when TBI and PTSD may both be present.
- i) Therapeutic trips during inpatient hospitalization are considered inpatient hospitalization and do not break the 15-day consecutive period. See additional information below under "Inpatient Hospitalization Days" for more information on therapeutic trips.

The Inpatient Hospitalization benefit provides the opportunity for a member to receive a TSGLI benefit even if the loss of ADL are for less than 30 consecutive days.

Definition of an Inpatient Hospitalization Facility: Any one of the four types of facilities listed below that meet all of the following criteria:

1. Accredited by the Joint Commission or its predecessor, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or accredited or approved by a program of the qualified governmental unit in which such institution is located if the Secretary of Health and Human Services has found that the accreditation or comparable approval standards of such qualified governmental unit are essentially equivalent to those of the Joint Commission or JCAHO;
2. Used primarily to provide, by or under the supervision of physicians, to inpatients, diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons;
3. Requires every patient to be under the care and supervision of a physician; and
4. Provides 24-hour nursing services rendered or supervised by a registered professional nurse and has a licensed practical nurse or registered on duty at all times.

Four Types of Facilities

1. An inpatient acute care facility is one that provides care for a short duration, generally 30 days or less, to treat a serious injury, an episode of illness/disease, or the residuals of surgery.
2. An inpatient rehabilitation facility is a healthcare institution that meets federal criteria for Medicaid and Medicare reimbursement for inpatient rehabilitation and provides intensive rehabilitation for inpatients.
3. A skilled nursing facility is a healthcare institution that meets federal criteria for Medicaid or Medicare reimbursement for nursing care and provides skilled rehabilitative services and other related health services.
4. Any Armed Forces medical facility that is authorized to provide inpatient acute care, inpatient rehabilitation, or skilled nursing care to eligible Servicemembers.

See 38 CFR 9.21(a)(8).

Note 1: The following VA Medical Center treatment programs are included in the inpatient hospitalization definition: Polytrauma Transitional Rehabilitation Programs (PTRP) and Post-Deployment Rehabilitation and Evaluation Programs (PREP). The VA Medical Center Service member Transitional Advanced Rehabilitation Programs (STAR) does not meet the definition of inpatient hospitalization. Other programs at medical centers need to be evaluated based on the standards in the definition of inpatient hospitalization.

a) Counting of Consecutive Days for Inpatient Hospitalization

The count of consecutive inpatient hospitalization days begins when the injured member is transported from the site of the injury to the hospital, includes the day of admission, continues through subsequent transfers from one hospital to another, and includes the day of release.

Example 1: A member is injured in Iraq on March 1. The member is stabilized in the field, then medevac'd to Landstuhl on the same day. The member spends 4 days in Landstuhl being further stabilized, and is flown to Walter Reed on March 4. The member is released from Walter Reed to Mologne House on March 15. The member has 15 consecutive hospitalization days (March 1 – 15) and is paid a \$25,000 TSGLI benefit.

Example 2: A member is injured in an automobile accident on March 1. The member is taken to a local trauma center and is admitted to the hospital. On March 6, the member's condition stabilizes and the member is transferred to another

hospital. The member is released from the second hospital on March 17. The member has 15 consecutive hospitalization days (March 1-15) and is paid a \$25,000 TSGLI benefit.

The count of consecutive inpatient hospitalization days continues, unbroken, while the member is on a therapeutic trip outside of the hospital. The term therapeutic trip means a facility-approved pass to leave a hospital facility, accompanied or unaccompanied by hospital staff, as part of a member's treatment plan and with which the member is able to return without having to be readmitted to the facility.

Example 1: A member is injured by a TBI on February 2nd, 2019. During the following year, the member begins having additional cognitive difficulties and is admitted on June 1, 2020 to a VA Polytrauma Center for TBI treatment. As part of that treatment, on June 12, 2020, the member is given a pass home by her treatment team to determine if she can handle the home environment using some of the skills developed while in inpatient treatment. The member is not discharged from the hospital during this period, rather she returns on June 14, 2020 and reports immediately to her treatment team relating her experiences at home. The member is later formally discharged on June 20, 2020. The member has 15 consecutive days of hospitalization (June 1-June 15) and is paid a \$25,000 TSGLI benefit.

Note: The member's first day of inpatient hospitalization must occur within 730 days of the traumatic event in order to receive payment. If subsequent days of hospitalization continue after the 730-day period ends, the member can still be paid a benefit, as long as the 15 days of inpatient hospitalization that began before the end of the 730-day period are consecutive.

Example 3: On January 1, 2019, a member is hit by an IED and suffers a TBI. After initial improvements in his condition, almost two years later on December 30, 2020, the member is hospitalized at a VA Polytrauma Center for TBI treatment. The member remains in the hospital through January 17, 2021. The member's TSGLI benefit will be \$25,000 for 15 consecutive days of inpatient hospitalization.

b) Payment for a 15-day inpatient hospital stay replaces the first ADL milestone payment.

If a member is hospitalized as an inpatient for 15 consecutive days, the member's hospitalization takes the place of the first ADL milestone payment only. Fifteen days of inpatient hospitalization cannot be substituted for any other ADL milestone payment. Payment will be made for the 15-day inpatient hospitalization OR the first ADL milestone, whichever occurs first. Once a payment has been made for 15-day inpatient hospitalization, there are no additional payments for subsequent 15-day inpatient hospital stays due to the same traumatic injury.

There are two situations covered by this replacement.

- Member is hospitalized due to Coma or a Traumatic Brain Injury (TBI) that does not rise to the level of a coma
- Member is hospitalized due to other traumatic injury

Member is hospitalized due to Coma or TBI - When a member is hospitalized as an inpatient for 15 consecutive days and the hospitalization is because the member is in a coma or primarily to a TBI that does not rise to the level of a coma, payment for hospitalization replaces the 15-day Coma or TBI ADL milestone.

Member is hospitalized due to other traumatic injury - When a member is hospitalized as an inpatient for 15 consecutive days and the hospitalization is due to a traumatic injury other than Coma or TBI, payment for inpatient hospitalization replaces the 30-day other traumatic injury ADL milestone.

The chart below illustrates these replacements.

		For Coma/TBI	For Other traumatic injury
15- day inpatient hospitalization replaces first ADL milestone only	ADL milestone 1	15 days	30 days
	ADL milestone 2	30 days	60 days
	ADL milestone 3	60 days	90 days
	ADL milestone 4	90 days	120 days

Example 1: A member is injured in a car accident on March 1. He is hospitalized from March 1 to March 12 but due to his back injuries he is unable to perform the ADL of bathing and dressing for 30 days from March 1 to March 30. He regains his ADL on March 31. However, due to complications, he is hospitalized a month later from May 1 to May 15. The member will receive a \$25,000 benefit for loss of ADL due to OTI for 30 days. He will not be paid for the subsequent 15-day hospitalization. Payment is made for either the 15-day hospitalization OR the first ADL milestone, whichever occurs first, not both.

Example 2: A member is injured in an accident on a construction site on July 1 resulting in major abdominal injuries. The member is taken to a local hospital trauma center and is admitted to the hospital. Due to the severity of her injuries, she is hospitalized for two months. She is released from the hospital on September 4. The member is eligible for a \$25,000 payment for a 15-day inpatient hospitalization. The member will not be paid any additional benefit for the additional 45 days in the hospital, unless there is continuous ADL loss – see (c) below as the 15-day inpatient hospitalization benefit is a one-time benefit paid for the first 15-days of hospitalization only.

c) Combinations of inpatient hospitalization and ADL loss must be continuous (occur on consecutive days) to qualify for the second ADL milestone payment

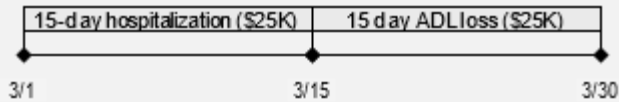
If a member is hospitalized as an inpatient for 15 consecutive days the member’s hospitalization takes the place of the first ADL milestone payment only. If the member is also unable to perform two ADL during and/or after 15 days of inpatient hospitalization, the member’s ADL loss must continue through or immediately follow the first ADL milestone to qualify for the second ADL milestone payment. In other words, the ADL loss must follow on consecutive days after the 15-day inpatient hospitalization period ends.

There are two situations covered by this rule:

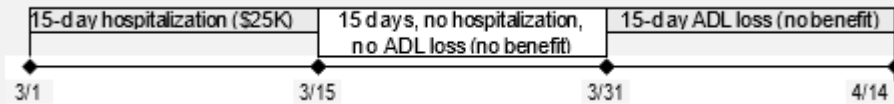
- Member is hospitalized in a coma or has a Traumatic Brain Injury (TBI) that does not rise to the level of a coma and has subsequent ADL loss
- Member is hospitalized due to other traumatic injury and has subsequent ADL loss.

Member is hospitalized as an inpatient in a coma or TBI) and has subsequent ADL loss - When a member is hospitalized as an inpatient for 15 days due to coma or TBI, the member’s hospitalization replaces the first 15-day ADL milestone. If the member suffers 15 days of ADL loss that begins or continues after inpatient hospitalization/coma, the member’s ADL loss must continue through or immediately follow the 15th day of inpatient hospitalization/coma to qualify for the second ADL milestone payment.

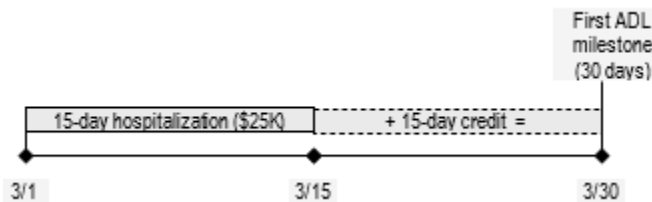
Example 1: A member is injured in a construction accident on March 1, suffers a TBI and is admitted to the hospital. The member is released from the hospital on March 15. From March 1 through March 31, the member is unable to eat, dress and transfer without assistance due to TBI. The member will receive a \$50,000 TSGLI benefit, \$25,000 for 15-day inpatient hospitalization (which counts as the first ADL milestone), and \$25,000 for 15 days of inability to perform ADL (the second ADL milestone)



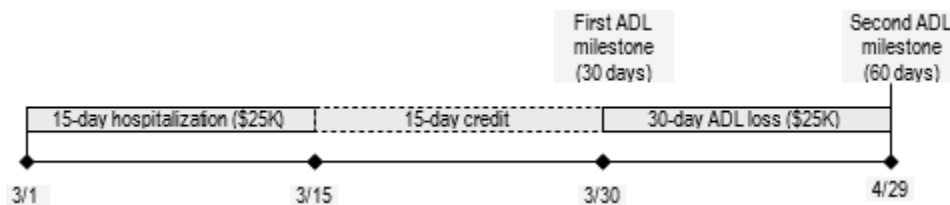
Example 2: A member is in an automobile accident on March 1, suffers a head injury resulting in TBI and is admitted to the hospital. The member is released from the hospital on March 15 and is able to perform ADL. On March 31, the member’s condition worsens and the member needs assistance bathing and toileting. This assistance is needed until April 14. The member will receive a \$25,000 TSGLI benefit for the 15-day inpatient hospital stay (which counts as the first ADL milestone). The member cannot receive payment for the loss of ADL because the member’s loss of ADL did not immediately follow the 15-day inpatient hospitalization period. There was a break in the consecutive days requirement for qualifying for the next ADL milestone.



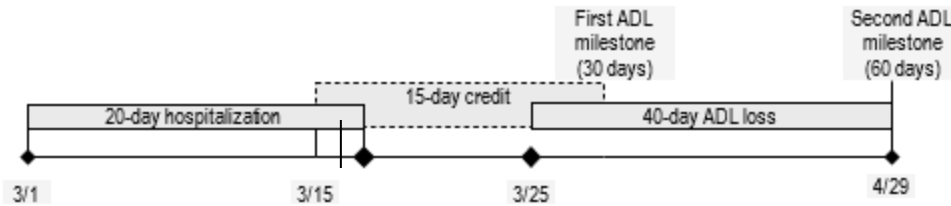
Member is hospitalized as an inpatient due to other traumatic injury and has subsequent ADL loss - When a member is hospitalized as an inpatient for 15 days due to a traumatic injury other than coma or TBI, the member’s 15-day inpatient hospitalization replaces the first 30-day ADL milestone. In other words, if the member is hospitalized as an inpatient for 15 days, they are deemed to have reached the first 30-day ADL milestone. In effect, this means the member receives a 15-day “credit” to complete the first 30-day milestone period.



If the member suffers ADL loss after 15 days of inpatient hospitalization, the member’s ADL loss must continue for 30 days from the end of the first 30-day milestone to qualify for the second ADL milestone payment.

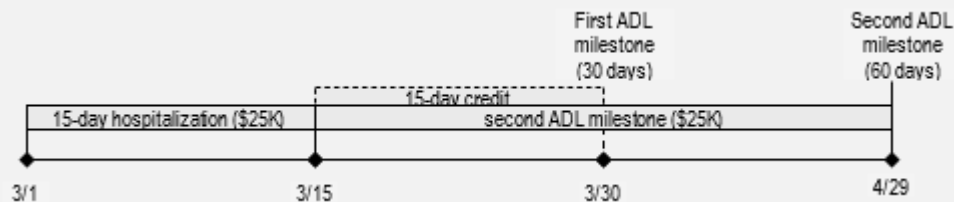


Inpatient hospitalization could extend into the credit period and/or ADL loss could begin at any time during the credit period, but this will not affect the requirement of continuous ADL loss for 30 days from the end of the first ADL milestone to receive the second ADL milestone payment.

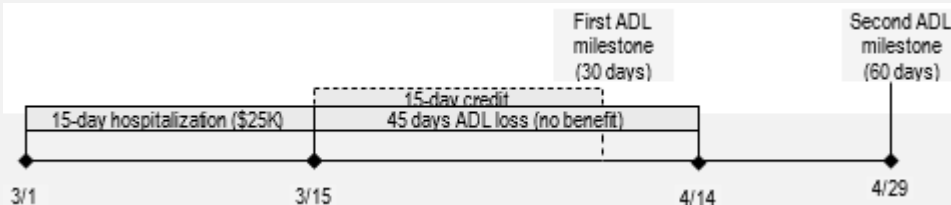


The examples below illustrate how inpatient hospitalization combined with ADL loss is applied.

Example 1: A member is injured in an IED blast on March 1, suffers injuries to arms and torso and is admitted to the hospital. The member is released from the hospital on March 15. From March 1 through April 29, the member is unable to eat, dress and transfer without assistance. The member will receive a \$50,000 TSGLI benefit, \$25,000 for 15-day inpatient hospitalization, (March 1 – March 15) which deems the member to have reached the first ADL milestone period at March 30, and \$25,000 for continuous ADL loss for 30 days from the end of the first ADL milestone (March 30 – April 29), reaching the second ADL milestone period.



Example 2: A member is in an automobile accident on March 1, suffers a leg injury and is admitted to the hospital. The member is released from the hospital on March 15. From March 1 through April 14, 45 days, the member is unable to dress and transfer without assistance. The member will receive a \$25,000 TSGLI benefit for the 15-day inpatient hospital stay, (March 1 – March 15) which deems the member to have reached the first ADL milestone period at March 30th. The member cannot receive an additional payment for the loss of ADL that occurred after the hospitalization because the member's loss of ADL, while 45 days in length, did not continue until April 29th, the 60- day milestone, needed for another \$25,000 payment.



Note: The member's first day of inpatient hospitalization must occur within 730 days of the traumatic event in order to receive payment. If subsequent days of hospitalization, immediately followed by consecutive days of the loss of ability to perform two ADLs, occur after the 730-day period ends, the member can still be paid a benefit, up to the maximum number of consecutive days of inpatient hospitalization and ADL loss that began before the end of the 730-day period.

Example 1: On January 1, 2019, a member is hit by an IED and suffers a TBI. After initial improvements in his condition, almost two years later on December 25, 2020, the member is hospitalized at the Tampa VAMC for TBI treatment. The member remains in the hospital through January 17, 2021. From January 17, 2021 through February 28, 2021 the member is unable to perform the ADLs of bathing, dressing and toileting without verbal assistance. The member's TSGLI

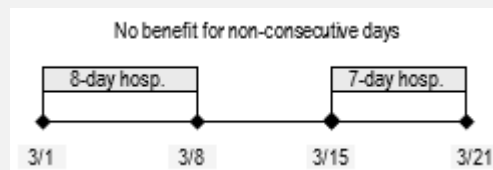
benefit will be \$75,000 for loss of two ADL for 60 days due to TBI, which includes payment for 15 consecutive days of hospitalization as the first ADL milestone.

Example 2: On January 1, 2019, a member is hit by an IED and suffers a TBI. After initial improvements in his condition, almost two years later on December 25, 2020, the member is hospitalized at the Tampa VAMC for TBI treatment. The member remains in the hospital through January 17, 2021. From January 17, 2021 through February 28, 2021 the member is unable to perform the ADL of bathing, dressing and toileting without verbal assistance. On April 15, 2021, the member is again unable to perform the ADLs of bathing, dressing and toileting without verbal assistance and does not regain that ability until August 1, 2021. The member's TSGLI benefit will be \$75,000 for loss of the ability to perform two ADL for 60 days due to TBI beginning on December 25, 2020. This includes payment for 15 consecutive days of hospitalization as the first ADL milestone. The member cannot be paid for the loss of the ability to perform two ADL that began on April 15, 2021 as there was a break, which means the first day of ADL for the new period began after the 730-day limit.

d) Inpatient hospitalization for fewer than 15 days and hospitalization for non-consecutive days is not eligible for the TSGLI benefit.

If a member is hospitalized as an inpatient for less than 15 days, or for non-consecutive periods, the member is not eligible for the TSGLI benefit for hospitalization.

Example: A member is injured in a construction accident on March 1 and is admitted to the hospital. The member is released from the hospital on March 8 (8 days). The member then develops complications from his injury and is readmitted to the hospital on March 15. The member is released from the hospital on March 21 (7 days). Even though the member was hospitalized as an inpatient for a total of 15 days, the member is not eligible for the TSGLI benefit because the days were not consecutive.



e) Inpatient hospitalization for coma or another TBI may be combined with other injuries provided inpatient hospitalization is primarily due to TBI or coma.

If a member is hospitalized as an inpatient for 15 consecutive days due to TBI or coma and the member has another injury that is listed on Part 1 of the Schedule of Losses, the member's TSGLI benefit will include the benefit for the 15-day inpatient hospitalization plus the benefit for the other injury (up to \$100,000). In order to combine the two benefits, the member's hospitalization must be due to coma or TBI.

Example 1: On March 1, a member suffers TBI and permanently loses sight in one eye as the result of a helicopter accident. The member is admitted to the hospital on March 1 and the member remains in the hospital to treat swelling of the brain. The member is released on March 17 (17 days). Since the member's inpatient hospitalization was due to TBI, the member's TSGLI benefit will be \$50,000 for the loss of sight in one eye plus \$25,000 for 15 consecutive days of hospitalization due to TBI, for a total of \$75,000.

Example 2: A member is in an automobile accident on March 1, suffers a head injury and loss of one hand, and is admitted to the hospital in a coma. The member recovers from the coma on March 19, but remains in the hospital until March 30 due to amputation of his hand. Since the member had a 15-day inpatient hospitalization due to coma, the member's TSGLI benefit will be \$50,000 for the loss of one hand plus \$25,000 for 15 consecutive days of hospitalization due to coma, for a total of \$75,000. Note: If the member meets the Glasgow Coma Score criteria to be under the Coma

Loss rather than hospitalization, the member would be paid the same amount of \$75,000. Member's cannot be paid simultaneously for the same time period for 15-day inpatient hospitalization, coma, and TBI ADL.

f) Inpatient hospitalization for traumatic injuries other than coma or TBI may be not combined with other injuries.

If a member is hospitalized as an inpatient for 15 consecutive days due to a traumatic injury other than coma or TBI and the member has another injury, the member's TSGLI benefit will be for the highest paying injury.

Example: A member is in a vehicle that is hit by an IED on March 1. The member suffers injuries to his leg and has mild TBI. The member is admitted to the hospital on March 1 and his leg is amputated. The member remains in the hospital for further treatment of wounds associated with his leg injury and is released from the hospital on March 18. Since inpatient hospitalization due to "other traumatic injuries", in this case injuries to his leg, cannot be combined with other injuries as a single loss, the member's TSGLI benefit will be \$50,000 for the loss of one leg because it is the higher paying of the two injuries.

g) Inpatient hospitalization for illnesses and diseases is not covered under TSGLI (except for illness or disease caused by a pyogenic infection, biological, chemical, or radiological weapon, or accidental ingestion of a contaminated substance).

Illnesses and diseases are not considered traumatic injuries under TSGLI and, therefore inpatient hospitalization resulting from either, does not provide a TSGLI benefit.

Example: A member has had insulin-dependent diabetes since childhood. His sugar spikes high and he is in the hospital for 15 days with complications from a diabetic coma. The member is not entitled to a TSGLI benefit for hospitalization or coma.

h) Inpatient hospitalization when TBI and PTSD may both be present

In some cases, medical professionals are not able to determine whether a member is suffering from TBI or PTSD (or both), as they can present similarly. The member may be hospitalized undergoing diagnostic assessment to determine which condition is present. In such cases, utilize the following chart to determine if the member's hospitalization would result in a payable loss.

If the member is hospitalized for 15 consecutive days to undergo a diagnostic assessment for...	And the assessment determines that...	The loss is...
PTSD	The member has PTSD and not TBI	Not payable as losses due to illnesses/diseases are excluded from payment.
PTSD	The member has TBI	Payable for \$25,000
PTSD	The member has TBI and PTSD	Payable for \$25,000
TBI	The member has PTSD and not TBI	Payable for \$25,000
TBI	The member has TBI	Payable for \$25,000
TBI	The member has TBI and PTSD	Payable for \$25,000

i) Therapeutic trips during inpatient hospitalization are considered inpatient hospitalization and do not break the 15-day consecutive period

A therapeutic trip is a hospital or facility-approved pass signed by the member's attending physician or nurse practitioner to leave the hospital or facility. The trip may be accompanied by facility staff or unaccompanied, as part of the member's treatment plan, and with which the member is able to return to the hospital without having to be readmitted to the hospital or facility. These trips are often part of a member's treatment plan for individuals with TBI.

Example : A member is involved in a car accident on April 1.. The member suffers an apparently minor head injury from the accident. He does not suffer any TSGLI losses at the time of the accident. However, a year later he is admitted to a VA facility with symptoms of TBI caused by the accident. During his 16 days at the facility, he goes home for a weekend three days before discharge on a physician-approved therapeutic trip to determine how he is able to function at home after treatment. The member is entitled to a TSGLI benefit of \$25,000 for inpatient hospitalization.

10) Genitourinary Losses

When a member suffers anatomical loss of the penis, the member is eligible for a TSGLI benefit if the member meets the following standard:

If the member suffers...	OR the member suffers...
Amputation of the glans penis or any portion of the shaft of the penis above the glans penis (i.e. closer to the body),	Damage to the glans penis or shaft of the penis that requires reconstructive surgery

When a member suffers permanent loss of use of the penis, the member is eligible for a TSGLI benefit if the member meets the following standard:

If the member suffers...	OR the member suffers...
Damage to the glans penis that results in complete loss of the ability to perform sexual intercourse that is reasonably certain to continue throughout the lifetime of the member	Damage to the shaft of the penis that results in complete loss of the ability to perform sexual intercourse that is reasonably certain to continue throughout the lifetime of the member

When a member suffers anatomical loss of one or both testicle(s), the member is eligible for a TSGLI benefit if the member meets the following standard:

If the member suffers...	OR the member suffers...	OR the member suffers...
Amputation of, or damage to one or both testicle(s) that requires testicular salvage	Amputation of, or damage to one or both testicle(s) that requires reconstructive surgery	Amputation of, or damage to one or both testicle(s) that requires reconstructive surgery and testicular salvage

When a member suffers permanent loss of use of both testicles, the member is eligible for a TSGLI benefit if the member meets the following standard:

If the member suffers...
Damage to both testicles resulting in the need for hormonal replacement therapy that is medically required and reasonably certain to continue throughout the lifetime of the member
NOTE: Based on medical advice, TSGLI benefits are not payable for loss of use of one testicle, as remaining testicle will compensate for damaged testicle.

When a member suffers anatomical loss of the vulva, uterus or vaginal canal, the member is eligible

for a TSGLI benefit if the member meets the following standard:

If the member suffers...	OR the member suffers...
Complete or partial amputation of the vulva, uterus, or vaginal canal	Damage to the vulva, uterus, or vaginal canal that requires reconstructive surgery

When a member suffers permanent loss of use of the vulva or vaginal canal, the member is eligible for a TSGLI benefit if the member meets the following standard:

If the member suffers...
Damage to the vulva or vaginal canal that results in complete loss of the ability to perform sexual intercourse that is reasonably certain to continue throughout the lifetime of the member.

When a member suffers anatomical loss of one or both ovaries, the member is eligible for a TSGLI benefit if the member meets the following standard:

If the member suffers...	OR the member suffers...	OR the member suffers...
Amputation of, or damage to one or both ovaries that requires ovarian salvage	Amputation of, or damage to one or both ovaries that requires reconstructive surgery	Amputation of, or damage to one or both ovaries that requires reconstructive surgery and ovarian salvage

When a member suffers permanent loss of use of both ovaries, the member is eligible for a TSGLI benefit if the member meets the following standard:

If the member suffers...
Damage to both ovaries resulting in the need for hormonal replacement therapy that is medically required and reasonably certain to continue throughout the lifetime of the member
NOTE: Based on medical advice, TSGLI benefits are not payable for loss of use of one ovary, as remaining ovary will compensate for damaged ovary.

When a member suffers total and permanent loss of urinary system function, the member is eligible for a TSGLI benefit if the member meets the following standard:

If the member suffers...	That requires...
Damage to the urethra, ureter(s), both kidneys, bladder or urethral sphincter muscle(s)	<ul style="list-style-type: none"> • Urinary Diversion • Hemodialysis • Or Both
...which is reasonably certain to continue throughout the lifetime of the member.	

Part 5 – Filing a Claim for TSGLI

General Information

The member must use SGLV 8600, Application for TSGLI Benefits, to apply for TSGLI benefits. The application is available from the branch of service or the Department of Veteran's Affairs Insurance website at www.benefits.va.gov/insurance. The member (or guardian or power of attorney or military trustee) and a medical professional must complete the application.

The TSGLI application has 17 pages and is divided into two parts:

Part A, Member's Claim Information and Medical Authorization

Part B, Medical Professional's Statement.

Social Security Number

A space for the member's Social Security number is provided on pages 4 through 17 of the application. The member, guardian, power of attorney or military trustee must fill in the Social Security Number on each of these pages.

Completing Part A, Member's Claim Information & Medical Authorization

Part A of the application provides information about the Service Member's claim and his legal representative (if applicable). It also provides payment information and authorizes the service branch and OSGLI to request information about the Service Member.

Part A must be completed by: The Service Member, the appointed guardian, the power of attorney or the military trustee. Part A is divided into 7 sections:

1. Service Member Information
2. Guardian or Power of Attorney or Military Trustee Information
3. Traumatic Injury Information
4. Payment Options
5. Financial Counseling Request
6. Signature and Supporting Documentation
7. Authorization for Release of Information

Section 1 – Service Member Information

The Service Member Information Section provides identifying information for the Service Member who is requesting TSGLI benefits. This section must be completed.

As required under TSGLI regulations, the Service Member is the only person who can complete the TSGLI application unless they are medically incapacitated. In cases where the Service Member is medically incapacitated, a guardian, power of attorney, or military trustee can complete the form. See Section 2 below.

Medically incapacitated means the Service Member has been determined by a medical professional to be physically or mentally impaired by physical disability, mental illness, mental deficiency, advanced age, chronic use of drugs or alcohol, or other causes that prevent sufficient understanding or capacity to manage his or her own affairs competently.

Optional Third Party Authorization – the member should fill in this section if he/she wants to authorize a third party to speak with OSGLI or the branch of service on his/her behalf.

Section 2 – Guardian, Power of Attorney or Military Trustee Information

The Guardian, Power of Attorney or Military Trustee Section provides information about the Service Member's legal representative. This section is **only** completed when the Service Member has been determined by a medical professional on Part B of the TSGLI application to be medically incapacitated and cannot complete the application. If this section is completed, the guardian, power of attorney or military trustee must include one of the following 4 items:

- Letters of guardianship,
- Letters of conservatorship,
- Power of attorney, or
- Completed Application for Trusteeship (DoD Form 2827)

What is a Military Trustee? - A military trustee is a fiduciary appointment made by the Defense Finance and Accounting Service at the Department of Defense on behalf of incompetent Servicemembers. The military trustee can choose how to disburse the member's TSGLI benefit payment. The military trustee must provide an annual accounting of any disbursements, including the TSGLI payment, to DFAS. The appointment is verified by the trustee's submission of DoD Form 2827, titled "Application for Trusteeship".

NOTE: A member's guardian, or agent or attorney-in-fact acting under a valid power of attorney (POA) or military trustee can elect any of the available payment options (lump sum check, electronic funds transfer, Alliance) but payment will be issued in the member's name. If payment is elected via EFT, the bank account must list the member as an account owner. POA documents and court orders for guardianship/conservatorship are reviewed to determine if the POA or court order provides sufficient authority to engage in insurance and financial transactions.

If the POA signature date is after the traumatic event date and the physician certified that the member is unable to handle his or her affairs, a signed physician statement attesting to whether the member had the capacity to sign over POA on the date it was executed will be required. If this statement cannot be provided, or the physician attests the member was not capable of handling his or her affairs on the date the POA was executed, court appointed guardianship/conservatorship of the member will be required.

If a POA submits the application but the medical professional checks that the member has the medical capacity to handle his/her affairs, Part A will need to be returned for the member to complete and the member informed that under current TSGLI laws that the member must apply and be paid the proceeds if they have the medical capacity to do so.

Section 3– Traumatic Injury Information

The Traumatic Injury Information Section provides information about the Service Member's traumatic injury. It contains three subsections.

Injuries that Qualify for TSGLI Payment – This section provides information about key definitions and terms that help determine whether a Service Member is/was eligible for TSGLI payment. Please review before submitting a claim.

Information About Your Loss - The Service Member, guardian, power of attorney or military trustee should answer the questions listed here. If any of these questions are answered yes, the member's loss does not qualify for TSGLI payment.

Tell Us About Your Traumatic Injury – The member, guardian, power of attorney or military trustee should indicate if they were covered by Servicemembers' Group Life Insurance and describe the injury and its cause, giving specific date, time and location information if possible.

Note to Certifier: This section should be compared with Part B to ensure that all possible scheduled losses described here are included in the medical professional's statement.

Section 4– Payment Options

The Payment Options Section provides information about how the TSGLI benefit should be paid. There are three methods of payment:

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

If the Servicemember does not indicate a payment type in Section 4, the TSGLI benefit will be paid through an Alliance Account. If a guardian, power of attorney or military trustee does not select a payment option, the TSGLI benefit will be paid by check. Please note: A guardian, power of attorney, or military trustee will only be issued payment directly if the Service Member is medically incapacitated.

*An Alliance Account is an interest bearing draft account established in the beneficiary's(ies') name(s) with a draft book. The beneficiary can write drafts ("checks") for any amount up to the full amount of the proceeds. There are no monthly service fees or per check charges and additional checks can be ordered at no cost, but fees apply for some special services including returned checks, stop payment orders and copies of statements/checks.

The funds in an Alliance Account begin earning interest immediately and will continue to earn interest until all funds are withdrawn. Interest is accrued daily, compounded daily and credited every month. The interest rate may change and will vary over time subject to a minimum rate that will not change more than once every 90 days. You will be advised in advance of any change to the minimum interest rate via your quarterly Alliance Account statement or by calling Customer Support at (877) 255-4262.

The Bank of New York Mellon is the Administrator of the Prudential Alliance Account Settlement Option, a contractual obligation of The Prudential Insurance Company of America, located at 751 Broad Street, Newark, NJ 07102-3777. Draft clearing and processing support is provided by The Bank of New York Mellon. **Alliance Account balances are not insured by the Federal Deposit Insurance Corporation (FDIC).** The Bank of New York Mellon is not a Prudential Financial company.

For more information about these payment options, see Part 7, Payment of TSGLI Benefits.

Section 5 – Financial Counseling

The Financial Counseling Section allows the TSGLI recipient to elect to receive free, VA-sponsored financial counseling. By checking off this box, the financial counseling organization sponsored by VA will reach out directly to you.

Section 6 – Signature and Supporting Documentation

This Section has two parts:

- a) Supporting Documentation – lists out the supporting documentation the Service Member is submitting with their claim. This should include medical documentation of the qualifying losses as well as information verifying the traumatic event. If needed, it may also include information to rule out application of the TSGLI program exclusions in Section 3.
- b) Signature - provides the signature verifying the member's (or if medically incapacitated the guardian, power of attorney, or military trustee) identity. The Service Member, guardian, power of attorney or military trustee must sign section 6 or payment will be delayed.

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

When a Claimant is Physically Unable to Sign the Application for TSGLI Benefits

A claimant may sign the TSGLI application by a mark ("X")--or verbally affirm the validity of the information provided in the form if:

- The claimant is unable to provide his or her signature due to a physical injury or disability;
- The claimant is of sound mind; **AND**
- Two impartial witnesses observe the claimant's mark or verbal affirmation* and add their own signatures to the appropriate signature block on the form.

* If the claimant indicates his or her agreement by verbal affirmation, that information should be noted on the form by one of the two impartial witnesses to the claimant's act (e.g., "Member physically unable to sign or mark **but has verbally attested to the information on this form.**").

Note: A signature by a notary public is not required to attest to the validity of the mark or verbal affirmation made by the claimant, nor to the signatures of the two impartial witnesses.

Impartial Witness - An impartial witness is defined as a person who will receive no direct or indirect financial benefit from the claimant's receipt of a TSGLI payment.

Examples of an impartial witness: a medical professional who has been providing medical care to the TSGLI claimant, administrative personnel at the medical treatment facility, or fellow Service Members

Individuals who would not be considered an impartial witness include the claimant's family members, such as parents, children, or spouse.

Section 7 – Authorization to Release Information

The Authorization to Release Information Section authorizes the release of the Service Member's medical and personal information to the branch of service and the Office of Servicemembers' Group Life Insurance (OSGLI). The Service Member, the guardian, power of attorney or the military trustee must sign this section. The TSGLI claim cannot be paid without this authorization.

Completing Part B, Medical Professional's Statement

Part B of the application provides medical information about the Service Member's losses, medical condition and inability to perform certain activities.

Part B must be completed by a medical professional. The medical professional must be a licensed practitioner of the healing arts acting within the scope of his/her practice. Part B is divided into 6 sections:

1. Patient Information
2. Qualifying Losses Suffered by Patient
3. Other Information
4. Medical Professional's Comments
5. Medical Professional's Information
6. Medical Professional's Signature

Section 1 - Patient Information

The patient information section provides the patient's name, and the date of the patient's injuries. If the patient is deceased, the medical professional must insert the date, time and cause of death.

Section 2 - Qualifying Losses Suffered by Patient

The qualifying losses section lists the TSGLI qualifying losses, along with the definition of each loss. The medical professional must determine if the patient's loss meets the definition given. The medical professional should then:

Check the box next to each loss the patient has experienced that meets the definition given

Fill in any additional information requested.

Note: The patient's loss **MUST** meet the definition of loss given or it should not be checked on the application.

Detailed instructions for each loss are given below.

Inpatient Hospitalization

If the patient has been hospitalized as an inpatient for 15 consecutive days as a result of a traumatic injury, the medical professional should check the box for inpatient hospitalization.

The medical professional should give information about the longest period of consecutive days the patient was hospitalized as an inpatient.

Example: A patient is injured in an automobile accident on March 1, and is hospitalized for 5 days to stabilize his injuries. On April 1, the patient is readmitted to the hospital for surgery associated with those same injuries. The patient develops complications and remains hospitalized until April 20. The medical professional should enter inpatient hospitalization information for the second period of hospitalization, as it was the longest number of consecutive days hospitalized.

The count of consecutive inpatient hospitalization days begins when the injured member is transported to the hospital from the site of injury (if applicable), includes the day of admission, continues through subsequent transfers from one hospital to another, and includes the day of release. It also includes any time the Service Member was on an approved therapeutic trip/pass as described in Chapter 4 of the TSGLI Procedures Guide.

After determining the longest period of inpatient hospitalization, the medical professional should fill in:

- The predominant reason for the patient's inpatient hospitalization, TBI or another traumatic injury
- The date the patient was transported to the hospital (if applicable)
- The date the patient was admitted to the first hospital,
- The date the patient was released from the final hospital,
- The name and address of the hospital (or hospitals).
- If the patient is still hospitalized as an inpatient, the medical professional should check the box indicating the patient is still hospitalized.

Definition of an Inpatient Hospitalization Facility: Any one of the four types of facilities listed below that meet all of the following criteria:

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

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

3. Requires every patient to be under the care and supervision of a physician; and
4. Provides 24-hour nursing services rendered or supervised by a registered professional nurse and has a licensed practical nurse or registered on duty at all times.

Four Types of Facilities

1. An inpatient acute care facility is one that provides care for a short duration, generally 30 days or less, to treat a serious injury, an episode of illness/disease, or the residuals of surgery.
2. An inpatient rehabilitation facility is a healthcare institution that meets federal criteria for Medicaid and Medicare reimbursement for inpatient rehabilitation and provides intensive rehabilitation for inpatients.
3. A skilled nursing facility is a healthcare institution that meets federal criteria for Medicaid or Medicare reimbursement for nursing care and provides skilled rehabilitative services and other related health services.
4. Any Armed Forces medical facility that is authorized to provide inpatient acute care, inpatient rehabilitation, or skilled nursing care to eligible Servicemembers.

See 38 CFR 9.21(a)(8).

Note 1: The following VA Medical Center treatment programs are included in the inpatient hospitalization definition: Polytrauma Transitional Rehabilitation Programs (PTRP) and Post-Deployment Rehabilitation and Evaluation Programs (PREP). The VA Medical Center Service member Transitional Advanced Rehabilitation Programs (STAR) does not meet the definition of inpatient hospitalization. Other programs at medical centers need to be evaluated based on the standards in the definition of inpatient hospitalization.

Counting consecutive inpatient hospitalization days for TSGLI qualifying loss – When counting consecutive inpatient hospitalization days, any breaks in inpatient hospitalization days would cause the count of days to start over. For example, if the patient is released from the hospital to a nursing facility or to his/her home after 10 days in the hospital, the count of consecutive hospitalization days end on the day of release. If the patient is subsequently re-hospitalized, the count of hospitalization days would begin at one, and the patient would have to accrue 15 consecutive days of inpatient hospitalization from the date of admission to qualify for TSGLI payment.

Loss of Sight

If the patient’s loss meets the definition of loss of sight in one or both eyes, the medical professional should check the box(es) for loss of sight in the left and/or right eye and fill in:

- The date loss of sight began in the left and/or right eye
- The best corrected visual acuity and field in the left and/or right eye

A member will be considered eligible for a TSGLI benefit for loss of sight if the loss meets one of the three standards below:

The member’s visual acuity in at least one eye is...	And their peripheral vision in at least one eye is...	And the loss of vision ...
1. 20/200 or less (worse) with corrective lenses	N/A	has lasted at least 120 days OR will not improve (with reasonable certainty) throughout member’s life.

The member's visual acuity in at least one eye is...	And their peripheral vision in at least one eye is...	And the loss of vision ...
2. Greater (better) than 20/200 with corrective lenses	a visual field of 20 degrees or less	has lasted at least 120 days OR will not improve (with reasonable certainty) throughout member's life.
3. Non-existent due to complete loss of the eye (s)	N/A	N/A

Measurement of Visual Acuity and Peripheral Vision - The medical professional should use any medically acceptable standard for measuring visual acuity and peripheral vision.

Loss of Speech

If the patient's loss meets the definition of loss of speech, the medical professional should check the box for loss of speech and fill in the date loss of speech began.

A member will be considered eligible for a TSGLI benefit for loss of speech if:

The member suffers...	and the loss of speech will...
an organic loss of speech (lost the ability to express oneself, both by voice and whisper, through normal organs for speech). *	not improve (with reasonable certainty) throughout member's life.

*If a member uses an artificial appliance, such as a voice box, to simulate speech, he/she is still considered to have suffered an organic loss of speech and is eligible for a TSGLI benefit.

Evaluating Organic Loss of Speech - The medical professional should use the standards below when evaluating organic loss of speech.

Organic Loss of Speech	Will be measured by:
Lost the ability to express oneself, both by voice and whisper, through normal organs for speech.	<p>Evaluating the following aspects of speech:</p> <ol style="list-style-type: none"> Audibility -- the ability to speak at a level sufficient to be heard; Intelligibility -- the ability to articulate and to link the phonetic units of speech with sufficient accuracy to be understood; and Functional efficiency -- the ability to produce and sustain a serviceably fast rate of speech output over a useful period of time. <p>When at least <i>one</i> of these attributes is missing, overall speech function is not considered effective.</p> <p>Assessments of speech proficiency should be made by an otolaryngologist or a speech therapist whose evaluation should be based <i>both</i> on personally listening to the claimant's speech and on a history of the claimant's performance in everyday living. The findings should be sufficient to provide the physician with a clear picture of the individual's speech capacity. Such an analysis would cover the attributes of speech discussed above and would include a detailed description of the following points:</p> <ol style="list-style-type: none"> <i>The intensity of speech (audibility)</i> -- the conditions under which the individual can and cannot be heard (e.g., in quiet surroundings, noisy places, a moving automobile); the maximum distance at which individuals can be heard; whether their voices tend to become inaudible, and if so, after how long; <i>The ability to articulate (intelligibility)</i> -- the frequency of any difficulties with pronunciation, the extent to which the individual is asked to repeat, and

Organic Loss of Speech	Will be measured by:
	3. <i>The rate of speech and the degree of ease with which the individual's speech flows (functional efficiency) -- how long he or she is able to sustain consecutive speech; the number of words spoken without interruption or hesitancy; whether he or she appears fatigued, and if so, after how long.</i>

Loss of Hearing

If the patient's loss meets the definition for loss of hearing in one or both ears, the medical professional should check the box(es) for loss of hearing in left and/or right ear and fill in:

The date loss of hearing began in the left and/or right ear

The average hearing acuity in the left and/or right ear measured without amplification device

A member will be considered eligible for a TSGLI benefit for loss of hearing if:

The member's average hearing threshold sensitivity for air conduction in at least one ear is...	and the loss of hearing will...
80 decibels	not improve (with reasonable certainty) throughout member's life.

Measuring Hearing Threshold Sensitivity - The medical professional should use the standard below when measuring hearing threshold sensitivity.

Hearing Threshold Sensitivity for Air Conduction	Will be measured by:
80 decibels	Utilizing pure-tone audiometry. A hearing threshold sensitivity measurement of 80 decibels should be reached by obtaining a pure-tone average (PTA). The PTA is the average of pure tone hearing thresholds at 500, 1000, and 2000 Hz. Examinations will be conducted without the use of hearing aids or other hearing amplification device.

Burns

If the patient's loss meets the definition for burns to the body or burns to the face, the medical professional should check the box(es) for burns to the body and/or face and fill in as appropriate:

- The percentage of the body (including face and head) affected by burns
- The percentage of the face affected by burns

When filling in the percentage of the face and body affected by burns, the medical professional should calculate the percentage of the entire body, including the face and head, affected by burns. If applicable, the medical professional should then make a separate calculation of the percentage of the face affected by burns. Percentage may be measured using the Rule of Nines or any other acceptable alternative.

A member will be considered eligible for a TSGLI benefit for burns if:

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

Note: Road Rash is not considered a burn, but rather a deep skin abrasion due to the scraping of skin on hard surfaces. Members suffering from road rash due to a traumatic event should not claim burns on their TSGLI application, but identify other losses covered under TSGLI for which they qualify.

Coma

If the patient has been in a coma due to brain injury for at least 15 consecutive days the medical professional should check the box for coma and fill in:

- The date of onset of the coma
- The date of recovery from the coma
- The patient’s Glasgow coma score at the 15th, 30th, 60th and 90th day for each time period applicable

If the patient is still in a coma, the medical professional should check the box indicating that the coma is ongoing.

A member will be considered eligible for a TSGLI benefit for coma if:

The member is in a coma with...	that lasts for...
brain injury measured at a Glasgow Coma Score of 8 or less	at least 15 consecutive days

Facial Reconstruction

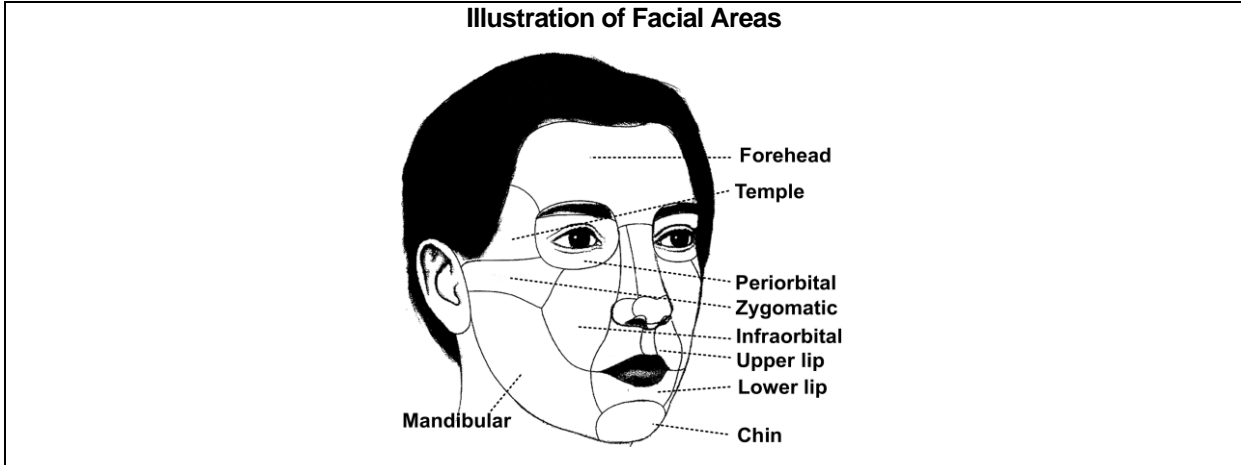
If the patient’s loss meets the definition for facial reconstruction, a surgeon must sign complete this section of the form. The surgeon should:

- Check the box(es) for the area(s) of the patient’s face that required surgery
- Fill in the date the first surgery was performed
- Certify the surgery by filling in his/her name, speciality, phone number, and signing where appropriate.

A member will be considered eligible for a TSGLI benefit for facial reconstruction if:

the member undergoes...	AND...
<p>surgery to correct traumatic avulsions of the face or jaw that cause discontinuity defects.</p> <p>Note: In order to meet the standard for facial reconstruction, the member must experience a penetrating facial injury (avulsion) and lose bone or tissue that without replacement would leave a “gap” in the area of injury (discontinuity defect).</p> <p>An avulsion is defined as: a forcible detachment or tearing of bone and/or tissue due to a penetrating or crush injury.</p> <p>Discontinuity is defined as: an absence of bone and/or tissue from its normal bodily location, which interrupts the physical consistency of the face and impacts at least one of the following functions:</p>	<p>the surgery was to correct discontinuity loss to one of the following facial areas:</p> <p>the upper or lower jaw, (loss of bone required)</p> <p>50% or more of the cartilaginous nose, (loss of cartilage/tissue required)</p> <p>50% or more of the upper or lower lip, (loss of tissue required)</p> <p>30% or more of the left or right periorbital, (loss of tissue required)</p> <p>50% or more of any of the following facial subunits (loss of bone or tissue required):</p> <ul style="list-style-type: none"> • forehead, • left or right temple, • left or right zygomatic, • left or right mandibular,

the member undergoes...	AND...
mastication, swallowing, vision, speech, smell, or taste.	<ul style="list-style-type: none"> • left or right infraorbital • chin



Amputation of Hand

If the patient's loss meets the definition for amputation of hand, the medical professional should check the box(es) for amputation of left and/or right hand and fill in the date(s) of amputation.

A member is considered eligible for a TSGLI benefit for loss of hand if the member's hand is amputated at or above the wrist. The words "at or above" refer to the loss being closer to the body.

Amputation of Fingers

If the patient's loss meets the definition for amputation of fingers, the medical professional should:

- Check the box(es) for the fingers that were amputated
- Fill in the date(s) of amputation

A member will be considered eligible for a TSGLI benefit for amputation of fingers if:

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

Amputation of fingers and or thumb at or above the metacarpophalangeal joint requires ...

The loss of 4 fingers on the same hand or the loss of the entire thumb to the metacarpophalangeal joint as shown below:



Distal interphalangeal joints
 Proximal interphalangeal joints
 Metacarpophalangeal joints

Please be aware the words “at or above” in the standard refers to the loss being “closer to the body” than the metacarpophalangeal joint – in other words, loss of the entire finger.

Amputation of Foot

If the patient’s loss meets the definition for amputation of foot, the medical professional should check the box(es) for amputation of left and/or right foot and fill in the date(s) of amputation.

A member is considered eligible for a TSGLI benefit for loss of foot if:

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

**The words “at or above” in the standard refers to the loss being closer to the body.*

Amputation of Toes

If the patient’s loss meets the definition for amputation of toes, the medical professional should:

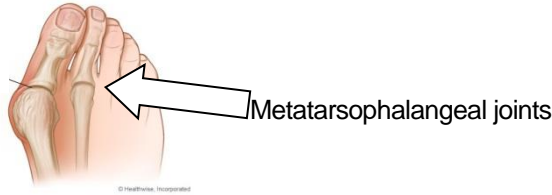
- Check the box(es) for the toes that were amputated
- Fill in the date(s) of amputation

A member will be considered eligible for a TSGLI benefit for loss of toes if:

the member suffers...	OR the member suffers...	OR the member suffers...
Amputation of four toes on one foot at or above* the metatarsophalangeal joint (not including the big toe)	Amputation of big toe at or above* the metatarsophalangeal joint.	Amputation of all toes (including the big toe) on the same foot at or above* the metatarsophalangeal joint.

Amputation of 4 toes or big toe at or above the metatarsophalangeal joint requires ...

The loss of 4 toes on the same foot or the loss of the big toe to the metatarsophalangeal joint as shown below:



Please be aware that the words “at or above” in the standard refers to the loss being “closer to the body” than the metatarsophalangeal joint – in other words, loss of the entire toe.

Limb Reconstruction

If the patient’s loss meets the definition for limb reconstruction, a surgeon must sign this section. The surgeon should:

- Check the boxes for the types(s) of surgery the member underwent
- Check the box(es) for the limb(s) affected
- Fill in the date the first surgery was performed
- Certify the surgery by filling in his/her name, speciality, telephone number and signing where appropriate

A member will be considered eligible for a TSGLI benefit for limb reconstruction if:

the member undergoes...	OR undergoes...	AND a surgeon certifies that...
<p>One of the following four surgeries:</p> <ol style="list-style-type: none"> 1. Bone grafting to reestablish stability and enable mobility of the limb; 2. Soft tissue grafting/flap reconstruction to reestablish stability and enable mobility of the limb; 3. Vascular reconstruction to restore blood flow and support bone and tissue regeneration; or 4. Nerve reconstruction to allow for motor and sensory restoration and muscle re-enervation 	<p>Two of the following four surgeries:</p> <ol style="list-style-type: none"> 1. Bone grafting to reestablish stability and enable mobility of the limb; 2. Soft tissue grafting/flap reconstruction to reestablish stability and enable mobility of the limb; 3. Vascular reconstruction to restore blood flow and support bone and tissue regeneration; or 4. Nerve reconstruction to allow for motor and sensory restoration and muscle re-enervation 	<p>the patient is undergoing limb reconstruction as defined in the left column.</p>

Paralysis

If the patient's loss meets the definition of paralysis, the medical professional should:

- Check the box for the type of paralysis the patient has suffered
- Fill in the date of onset

A member will be considered eligible for a TSGLI benefit for paralysis if:

the member suffers...	AND paralysis fall into one of these four categories
Complete paralysis due to damage to the spinal cord or associated nerves, or to the brain.	Quadriplegia - paralysis of all four limbs* Paraplegia - paralysis of both lower limbs* Hemiplegia - paralysis of the upper and lower limbs* on one side of the body Uniplegia - paralysis of one limb* *A limb is defined as an arm or a leg with all its parts.

Genitourinary Losses

If the patient's loss meets the definition of for one or more genitourinary losses, the medical professional should:

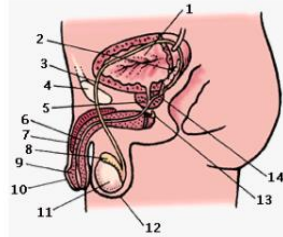
- Check the box for the type of genitourinary losses the patient has suffered
- Fill in the date of loss or amputation.

A member will be considered eligible for a TSGLI benefit for genitourinary losses based on the following criteria:

- **Anatomical Loss of the Penis** if he suffers amputation of the glans penis or any portion of the shaft of the penis above the glans penis (i.e. closer to the body), OR damage to the glans penis or shaft of the penis that requires reconstructive surgery.
- **Permanent Loss of Use of the Penis** if he suffers damage to the glans penis OR damage to the shaft of the penis that results in complete loss of the ability to perform sexual intercourse that is reasonably certain to continue throughout the lifetime of the member.
- **Anatomical Loss of One Testicle** if he suffers the amputation of, or damage to one testicle that requires:
 - Testicular salvage,
 - Reconstructive surgery,
 - Or both.
- **Anatomical loss of both testicles** if he suffers amputation of, or damage to both testicles that requires:
 - Testicular salvage,
 - Reconstructive surgery,
 - Or both.

- **Permanent loss of use of both testicles** if he suffers damage to both testicles resulting in the need for hormonal replacement therapy that is medically required and reasonably certain to continue throughout the lifetime of the member.

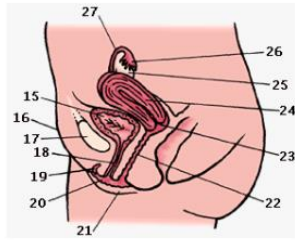
Male Genitourinary System



1 bladder, 2 seminal vesicle, 3 vas deferens, 4 pubic symphysis, 5 prostate, 6 urethra, 7 penis, 8 epididymis, 9 glans penis, 10 foreskin, 11 testicle, 12 scrotum, 13 Cowper's gland, 14 ejaculatory duct,

- **Anatomical loss of the vulva, uterus, or vaginal canal** if she suffers the complete or partial amputation of the vulva, uterus, or vaginal canal **OR**, damage to the vulva, uterus, or vaginal canal that requires reconstructive surgery.
- **Permanent loss of use of the vulva or vaginal canal** if she suffers damage to the vulva or vaginal canal that results in complete loss of the ability to perform sexual intercourse that is reasonably certain to continue throughout the lifetime of the member.
- **Anatomical loss of one ovary** if she suffers amputation of one or damage to one ovary that requires:
 - Ovarian salvage,
 - Reconstructive surgery,
 - Or both.
- **Anatomical loss of both ovaries** if she suffers amputation of both ovaries or damage to both ovaries that requires:
 - Ovarian salvage,
 - Reconstructive surgery,
 - Or both.
- **Permanent loss of use of both ovaries** if she suffers damage to both ovaries resulting in the need for hormonal replacement therapy that is medically required and reasonably certain to continue throughout the lifetime of the member.

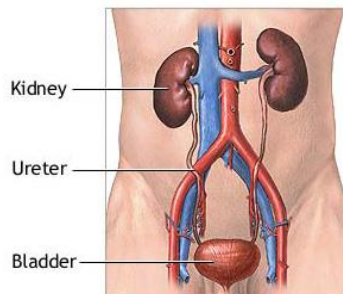
Female Genitourinary System



15 bladder, 16 mons pubis, 17 pubic symphysis, 18 urethra, 19 clitoris, 20 labia minora, 21 labia majora, 22 vagina, 23 cervix, 24 uterus, 25 ovary, 26 fimbria, 27 fallopian tube

- **Total and permanent loss of urinary system function** if the member suffers damage to the:
 - Urethra,
 - Ureter(s),
 - Both kidneys,
 - Bladder, or Urethral sphincter muscle(s)
 - That requires:
 - Urinary diversion
 - Hemodialysis
 - Or both
 - which is reasonably certain to continue throughout the lifetime of the member.

Urinary System



Other Useful Terminology Regarding Genitourinary (GU) Losses

The following medical terms are provided as examples of how some of the GU losses may be documented in medical records. These terms are only provided as a guide and are not to be considered as complete nor the only way that the GU losses are identified. These terms are provided only as a reference and are not intended to replace the genitourinary definition.

Genitourinary Loss	Medical Terms
1. Anatomical loss of the penis	Traumatic Penectomy Penoplasty or Phalloplasty
2. Permanent loss of use of the penis	Erectile Dysfunction Traumatic priapism
3. Anatomical loss of the testicle(s)	Traumatic Orchiectomy

Genitourinary Loss	Medical Terms
4. Permanent loss of use of both testicles	Castration
5. Anatomical loss of the vulva, the uterus or the vaginal canal	Traumatic vulvectomy (simple and radical) Traumatic clitoridectomy Traumatic hysterectomy (uterus only) Traumatic vaginectomy (vagina only) Vulva ablation Vulva or Vulvar degloving Vulvoplasty
6. Permanent loss of use of the vulva or the vaginal canal	Sexual dysfunction Traumatic priapism
7. Anatomical loss of the ovary(ies)	Traumatic Oophorectomy
8. Permanent loss of use of both ovaries	Castration
9. Total and permanent loss of urinary system function	Nephrostomy (Urinary Diversion) Ureterostomy (Urinary Diversion) Hemodialysis

Inability to Independently Perform Activities of Daily Living (ADL)

If the patient’s loss meets the definition for inability to perform ADL, the medical professional should:

- Fill in the predominant reason the member is unable to perform ADL (TBI or other traumatic injury)
- Describe the injury and the reason(s) why the injury caused the patient to be unable to perform ADL

Description of injury - The medical professional should describe the patient’s injuries and indicate what prevented the patient from performing the activities of daily living.
Example: The bones in both the patient legs were shattered and the patient is unable to get in or out of bed and go to and from the toilet.

For each ADL the patient is unable to perform the medical professional should:

- Fill in the start and end date of the patient’s inability to perform the ADL (if the patient is still unable to perform the ADL, check ongoing)
- Check the type(s) of assistance the patient required with the ADL (hands on, stand by or verbal)
- Describe the assistance needed with the ADL in the box provided

Assistance Needed – The medical professional should give information about the kinds of assistance needed in performing the ADL. Examples include, but are not limited to: unable to guide arms through shirtsleeves, on a feeding tube, must be sponge bathed by staff, constant bedpan usage, must be lifted into bed.

A member will be considered eligible for a TSGLI benefit for ADL if:

the member is...	AND the member's inability lasts for...
unable to independently perform* at least two of six ADL (bathing, continence, dressing, eating, toileting and transferring).	<ul style="list-style-type: none"> - at least 15 consecutive days for traumatic brain injury, OR, - at least 30 consecutive days for any other traumatic injury.

***When is the member considered to be unable to independently perform ADL?**

The member is considered unable to perform an activity independently if he or she REQUIRES assistance to perform the activity.

Requires Assistance is defined as:

- Physical assistance - when a patient requires hands-on assistance.
- Stand-by assistance - when a patient requires someone to be within arm's reach because the patient's ability fluctuates and physical or verbal assistance may be needed.
- Verbal assistance - when a patient requires verbal instruction in order to complete the ADL due to cognitive impairment. Without these verbal reminders, the patient would not remember to perform the ADL.

Without this physical, stand-by, or verbal assistance, the patient would be incapable of performing the task.

Accommodating Equipment/Adaptive Behavior - If the patient is able to perform the activity by using accommodating equipment, such as a cane, walker, commode, etc.) or the patient has developed other skills that allow him/her to perform the activity without assistance, the patient is considered able to independently perform the activity.

The table below should be used to help to determine whether a member has lost the ability to perform a particular ADL.

Patient is UNABLE to...	...if he/she requires physical, stand-by, or verbal assistance* from another person...
Bathe independently	while in a shower or bathtub or using a sponge bath, to wash at least three of the six following regions of the body in its entirety: Head and neck, back, front torso, pelvis (including the buttocks), arms, or legs.
Maintain continence independently	to manage catheter or colostomy bag. Patient is also unable to maintain continence independently if he/she unable to control bowel and bladder function.
Dress independently	to obtain clothes and shoes from a closet or drawers and put on clothes and shoes, excluding tying shoelaces or use of belts, buttons, or zippers.
Eat independently	to movet food from plate to mouth The patient is also unable to eat independently if he/she is fed intravenously or by a feeding tube.

Patient is UNABLE to...	...if he/she requires physical, stand-by, or verbal assistance* from another person...
	<p>Note: Food preparation such as cooking or cutting and taking liquid nourishment from a straw or cup is excluded. Therefore, if the member can get the food from plate to mouth but needs help preparing or cutting food, they do not meet the standard. Additionally, if they can use a straw to eat a liquid diet, even if someone needs to prepare the liquid diet, they do not meet the standard.</p>
Toilet independently	<p>to go to and from the toilet, get on and off the toilet, clean self after toileting, or get clothing off and on before and after toileting.</p> <p>The patient is also unable to toilet independently if he/she must use a bedpan or urinal.</p>
Transfer independently	to move into or out of a bed or chair.

Section 3 - Other Information

The Other Information section provides additional information about the cause of the patient's losses. If the medical professional knows that the patient's losses are due to any of the reasons listed, the medical professional should provide an explanation in the box provided.

Section 4 - Medical Professional's Comments

The Medical Professional's Comments Section provides any additional information about the patient's injuries that may be helpful in processing the patient's claim. The medical professional should fill in any pertinent details about the patient's injury that are not otherwise indicated in Sections 1 through 3 of Part B of the application.

Section 5 - Medical Professional's Information

The Medical Professional's Information Section provides information about the medical professional completing Part B of the application. The medical professional should fill in all information requested.

Section 6 - Medical Professional's Signature

This section requires the medical professional to

- indicate whether their responses in Part B are based on observation of the patient's loss directly or a review of the patient's medical records.
- indicate whether the member is medically incapacitated and unable to apply or receive TSGLI payment.
- sign this section to certify the medical information provided is accurate based on their observation or review of medical records.

Benefit for Additional Losses from a Single Traumatic Event

A new complete TSGLI application is required when the member sustains additional losses, even if the loss resulted from a previous traumatic event already submitted on a TSGLI application.

Example: A member permanently loses sight in one eye due to a traumatic event on April 1, 2021, and submits a TSGLI application for the loss. On October 1, 2021, the member loses one foot, as a direct result of a traumatic injury from the same traumatic event. The member must submit a second TSGLI application for the second loss.

Benefit for Additional Losses from Multiple Traumatic Events

A new complete TSGLI application is required when multiple traumatic events result in separate losses sustained by the member. Multiple traumatic events must occur more than seven days (168 hours) apart from the initial traumatic event to be considered separate events.

Example: A member suffers the loss of one foot on May 1, 2021 and submits a TSGLI application for the loss of foot. The same member suffers loss of sight in both eyes from another event that occurred on November 1, 2021. The member must submit a second TSGLI application for the loss of sight in both eyes from the second traumatic event.

Part 6 - Certifying a Claim for TSGLI

General Information

The TSGLI office for the member's branch of service certifies TSGLI claims, making the eligibility determination for the benefit. A list of all TSGLI branch of service offices is provided in Appendix C and on the front of the TSGLI Application Form. The certifying official must complete the TSGLI Certification Worksheet to indicate the disposition of the claim, and then forward the TSGLI application along with the worksheet and any other supporting documentation to the Office of Servicemembers' Group Life Insurance (OSGLI). Supporting documentation, in cases where the claim is denied in full or in part (the member is paid for some but not all of the losses claimed on the TSGLI Application), includes a copy of the letter the TSGLI branch of service office sent to the member explaining the losses approved and denied (partial and full denials).

Instructions for Completing the TSGLI Certification Worksheet

The TSGLI Certification Worksheet provides information about the disposition of the member's TSGLI claim as well as tools for adjudicating the TSGLI claim. The Certification Worksheet is divided into 7 Sections:

1. Traumatic Event Information
2. Certification by Branch of Service
3. Disposition of Losses Claimed
4. Certifying Signature
5. Additional Comments
6. TSGLI Service Member Address and Payment Information Update
7. Checklists

The sections that are completed depend upon the type of claim being certified.

- **For original claims and supplemental claims** - the certifying official should complete Sections 1 – 5
- **For appeals and reconsidered claims that are being approved** – the certifying official should complete Sections 1 - 6

Please note that the Service Member's social security number should be completed on the top right of all pages submitted as part of the Certification Worksheet.

Section 1 – Traumatic Event Information

The Traumatic Event Information Section provides information about the traumatic event that caused the member's loss. Entries should be completed as follows:

Type of Claim – The certifying official should indicate the type of claim as follows:

Original claim – the first claim by a member for a scheduled loss from a traumatic event

Supplemental claim – a follow-up claim on an original claim from the same traumatic event but for an additional benefit for a new scheduled loss.

Appeal - a claim that was originally denied by the branch of service TSGLI office, was reconsidered, and then reviewed by the branch's higher-level review organization for a final decision.

Reconsidered claim – a claim that was originally denied by the branch of service TSGLI office but has been submitted for review by the claimant with new and material evidence.

Guardian, Power of Attorney or Military Trustee– The certifying official should indicate whether he/she is aware of a guardian, POA, or military trustee being appointed for the member.

Date and Time of the Traumatic Event – The certifying official should enter the date and time of the event(using Zulu time) in the boxes provided.

Note: For non-penetrating blast injuries that occur more than seven full days apart AND whose cumulative concussive effects cause a single qualifying loss, the latest occurring verified blast injury should be used as the date of the traumatic event in order to give the member the longest two-year window to incur losses.

Was the member on duty when the event occurred? – The certifying official should indicate whether the member was on duty. The certifying official should base their “on duty” determination on the following guidance:

Active Duty Members:

- On Duty
 - During actual performance of military training or duties, regardless of location
 - Examples:
 1. Member participating in physical training exercises.
 2. Member driving vehicle with military supplies or for military transport.
 3. Member on patrol at stateside base or combat location.
 4. Member completing weapons training class.
 5. Member working office-type military occupational specialty (Personnel Officer, IT, etc.)
 6. Member driving personal vehicle to military office or duty location.
- Off Duty
 - During any leisure time, including time where not on official leave but rather on “liberty” (authorized absence from place of duty and not chargeable to leave account)
 - Examples:
 1. Member playing baseball. (Any sporting activity that is not official training or duty).
 2. Member driving personal vehicle to dinner with friends.
 3. Member riding motorcycle on base or off base for pleasure.
 4. Member visiting family off base.
 5. Member doing home improvements at on base or off base housing
 6. Member injured in a bar or restaurant.
 7. Member injured while eating at mess hall.

Note: For members on a Navy ship or in a combat zone, leisure activities, sleeping, or eating, would still be considered off duty.

Reserve and Guard Members:

- On Duty
 - During weekend drilling activities
 - Driving to and from weekend drilling activities
 - During annual training, if performing military training or duties
 - If activated for state or federal service, see guidance under “Active Duty Members”
 - Examples:
 1. Member participating in physical training exercises during weekend drills.
 2. Member driving vehicle with military supplies or for military transport during weekend drills.
 3. Member driving personal vehicle to and from weekend drills.
 4. Member performing military funeral honors duty.
 5. Member training in small arms fire during weekend drills or annual training.
- Off Duty
 - Anytime the member is not at weekend drills/annual training or driving to and from such training

- Anytime the member is at weekend drills/annual training AND IS NOT performing military duties but rather on “liberty” (authorized absence from place of duty and not chargeable to leave account)
- This would include sleeping, eating, or other leisure activities.
- Examples:
 1. Member playing baseball. (Any sporting activity that is not official training or duty).
 2. Member driving personal vehicle to dinner with family.
 3. Member injured on his/her private sector job.
 4. Member injured in a bar or restaurant.
 5. Member injured on vacation with family.
 6. Member injured while making home improvements.

Please note: This determination has no bearing on whether the claim is payable or not. TSGLI provides coverage for both on duty and off duty traumatic events. This information is being used solely for reporting and analysis purposes by VA.

Duty status at time of injury: The certifying official should indicate whether the member was attached to the Active, Reserve or National Guard component of their branch when their injury occurred. If the member is a Reservist or National Guard but was on active duty orders when the injury occurred, then Active Duty should be indicated.

Geographic Location and Hostile Action – the certifying official should indicate the geographic location where the event occurred and if the event occurred during hostile action. Certifying officials should attempt to avoid using latitude and longitude of event. In cases where the event occurred on a ship or airplane/helicopter, the certifying official should state the country (or state in the United States of America) in whose waters or airspace the ship or airplane/helicopter was located.

Description of Traumatic Event – The certifying official should enter a brief description of the traumatic event. Examples of traumatic events include:

- Military Motor Vehicle Accident
- Military Aircraft Accident
- Civilian Motorcycle Accident
- RPG Attack
- IED Attack
- Civilian Motor Vehicle Accident
- Civilian Aircraft Accident
- Small Arms Attack
- Training Accident (Please clarify with additional description)

Note: The certifying official should use the additional comments box in Section 3 to enter additional information about the event that does not fit in the description box.

Important Note - Verifying the Traumatic Event -The certifying official should use available sources such as the Defense Casualty Information Processing System (DCIPS) or appropriate civilian records such as a police report to verify the date and time of the traumatic event, the location of the traumatic event, the description of the traumatic event, and the status of the member at the time of the traumatic event.

Deceased Service Member - If the Service Member is deceased, the certifying official must:

- Indicate the date and cause of death on the form
- Attach Report of Casualty (DD-1300) or civilian death certificate

Attach the SOES Coverage Certificate as of the date of death or attach most recent SGLV 8286 indicating designated SGLI beneficiary (In most cases, the Service Member should have a SOES Coverage Certificate. However, if they had not certified in SOES yet at the time of death or they made a SGLI election in exigent circumstances with the paper form, the SGLV 8286 may have the most recent designation).

Note in the additional comments box in Section 3 that the DD-1300 and SOES Election Certificate or SGLV 8286 are attached to the Certification Worksheet

Section 2 – Certification by Branch of Service

The Certification by Branch of Service Section indicates whether the member qualifies for TSGLI payment and if so, for how much. The certifying official should indicate yes or no, and fill in the TSGLI payment amount they are certifying for this claim as well as prior payments made for the same traumatic event. The certifying official may use the checklists in Section 7 to help determine if the member is eligible for payment.

Section 3 – Disposition of Losses Claimed

The Disposition of Losses Claimed Section provides a list of all the TSGLI qualifying losses. The certifying official should review **both** Part A and Part B of the TSGLI application to determine which losses are being claimed by the member and whether the losses meet the standard for TSGLI payment. For each loss indicated in Parts A and B, the certifying official should:

- Indicate whether the loss is found or not found
- Enter the appropriate Disposition Code for any claimed loss identified as not found
- Enter Disposition Code 15 for any loss that is found but cannot be paid because it can't be combined with another claimed loss

Indicating If Loss is Found or Not Found

Certifiers should use the following framework to determine if the loss is found or not found:

If the Member Claims a Single Loss

The loss is FOUND if...	the loss meets the standard for TSGLI payment and the loss is payable.
The loss is NOT FOUND if...	the loss does not meet the standard for TSGLI payment.

If the Member Claims Multiple Losses

<p>The loss is FOUND if...</p>	<p>The loss meets the standard for TSGLI payment and the loss is payable,</p> <p style="text-align: center;">OR</p> <p>The loss meets the medical standard for TSGLI, but due to program limitations, the loss is not payable.</p> <p>Example of program limitations: Program maximum payment already reached Program prohibits certain losses from being combined (i.e. limb reconstruction and amputation of same limb, loss of hand and loss of fingers of same hand, hospitalization for OTI and amputation of a limb)</p>
<p>The loss is NOT FOUND if...</p>	<p>The loss does not meet the standard for TSGLI payment,</p> <p style="text-align: center;">OR</p> <p>The loss was not evaluated because the maximum payment amount was certified.</p>

Entering the Appropriate Disposition of Loss Code

The loss disposition codes listed at the end of Section 3 of the Certification Worksheet give 17 reasons for nonpayment of a claimed loss.

- **Codes 1 – 12 and 14** cover the reasons a loss is not found
- **Code 15** covers losses that are found, but cannot be combined with another loss due to program limitations.
- **Codes 13 and 16 cover losses not evaluated because the maximum payment amount for the claimed losses has already been certified.**

The certifier should enter a code for any claimed loss identified as **not found** (codes 1-14, 16) and any loss that is **found but cannot be paid** because it can't be combined with another claimed loss (code 15)

If more than one Loss Disposition Code applies to the loss, please list all that apply. If the reason is not covered by codes 1 through 16, the certifying official should use code 99 (other) and indicate the reason in the comments box.

The table below explains each of the loss disposition codes.

Code	Description	Use this code to indicate reason for non-payment if...
1	Member was not covered under SGLI at the time of the traumatic event	the member did not elect SGLI coverage and therefore was not covered by SGLI at the time of the traumatic event. <i>Note: SOES Election Certificate or copy of SGLV 8286 must be attached showing declination of coverage.</i>
2	Member's loss is not listed on TSGLI schedule of losses	the loss the member is claiming is not listed on the TSGLI Schedule of Losses. Example: A member claims severe back pain with no loss of ADL. There is no such loss on the Schedule of Losses. The certifier should use Loss Disposition Code 2 to indicate denial.
3	Medical documentation provided does not indicate the member's loss met the minimum TSGLI standard	medical documentation does not show that the loss the member is claiming meets the standard indicated in the Procedures Guide for medically qualifying for the loss Example: A hospital release summary provided indicates that the member was hospitalized for 10 days and had loss of ADL due to TBI for 10 days. The certifier should use Loss Disposition Code 3 to indicate denial.
4	Member did not suffer the loss within the prescribed period as defined by the regulation	the loss the member is claiming occurred more than 730 days from the date of the traumatic event
5	Member's loss was due to a physical or mental illness or disease other than those covered by TSGLI	the loss the member is claiming is due to an illness or disease, except in the case of illnesses or diseases caused by pyogenic infection, biological, chemical or radiological weapon, or a contaminated substance. Example: Member claims loss of right leg on Part A. Medical professional documents loss of right leg on Part B but notes it is due to diabetes, not a traumatic event. The certifier should use Loss Disposition Code 5 to indicate denial.
6	Member's loss was not a direct result of traumatic event	the loss the member is claiming was not the direct result of a traumatic injury due to a traumatic event, but was caused in whole by another factor or another factor substantially contributed to the loss Example: A member falls and hits his head. Immediately after the incident, he experiences no after effects. Two months later the member has heart surgery. After the surgery, the member falls into a coma. The member claims the coma is due to the original fall but the medical professional indicates that it was due to the surgery. The certifier should use Loss Disposition Code 6 to indicate denial.
7	Member did not survive for seven full days from the date of the traumatic event	the member sustained a Scheduled Loss but did not survive seven full days from the date of the traumatic event.

Code	Description	Use this code to indicate reason for non-payment if...
8	Member's loss was sustained while attempting to commit suicide	the loss the member is claiming is due to a suicide attempt. Example: A member attempts to hang himself. He is unsuccessful but winds up in a coma for 15 days due to the attempt. The certifier should use Loss Disposition Code 8 to indicate denial
9	Member's loss was due to a traumatic injury willfully caused by a member's own actions	the loss the member is claiming is due to their own actions Example: A member purposefully shoots himself in the leg to avoid deployment. He is hospitalized for 15 days due to this injury. The certifier should use Loss Disposition Code 9 to indicate denial.
10	Member's loss was sustained while committing, or attempting to commit a felony	the loss the member is claiming occurred while committing, attempting to commit a felony. Note: The member does not have to be convicted of the felony to apply the exclusion. Rather, the documented facts of the case must meet the legal standard for a felony in the state in which the event occurred, even if no legal action is taken.
11	Member's loss was caused by willful use of an illegal or controlled substance not prescribed by a doctor	the loss the member is claiming is due to the willful use of an illegal or controlled substance not prescribed by a doctor.
12	Member's does not meet requirements for retroactive payment because of date of loss	the loss the member is claiming occurred prior to October 7, 2001.
13	Member's loss was not evaluated because the loss cannot be combined with other losses paid.	the claimed loss is not being evaluated because the member would not be able to receive additional payment since the loss cannot be combined with other approved losses. Example 1: A member suffers an amputation of a single extremity and is also claiming 30 days ADL loss due to OTI. Once the amputation has been verified through the medical records, the branch of service processing office does not review the ADL claim as it would not result in additional benefits being paid to the member. The certifier should use Loss Disposition Code 13 to indicate the loss was not reviewed. Example 2: A member suffers multiple facial reconstruction losses including reconstruction of the jaw. Once the jaw reconstruction has been verified through the medical records to meet the TSGLI standard, the branch of service processing office does not review any of the other claimed facial reconstruction losses since the \$75,000 maximum for facial reconstruction losses has already been approved. The certifier should use Loss Disposition Code 13 to indicate these losses were not reviewed.
14	Insufficient information to support the medical professional's statement	the claim information and/or documentation does not support the claimed loss(es).
15	Payment for this loss cannot be made in combination with other losses paid	The loss the member is claiming cannot be combined with other losses (i.e. amputation and limb reconstruction of same limb)

Code	Description	Use this code to indicate reason for non-payment if...
16	Member's loss was not evaluated because the maximum payment amount was certified	<p>the member is already being paid the maximum benefit and therefore the branch of service does not medically review other losses in order to pay the claim expeditiously.</p> <p>Example: A member suffers 2nd degree burns to 20% of the body. He qualifies for the maximum TSGLI payment. The member also claims loss of ADL for 120 days. The branch of service processing office does not review the ADL claim as the member is already being paid the maximum TSGLI benefit under burns. The certifier should use Loss Disposition Code 16 to indicate denial.</p>
99	Other	the member's claim is not paid due to a reason other than indicated in Loss Disposition Codes 1-16. The certifier should explain why other was selected in the Comments box.

Sample Coding of Found/Not Found and Loss Disposition Code Boxes

Here are examples of coding for the Certification Worksheet in the following situations

- single loss claimed
- multiple losses claimed
- hospitalization and/or ADL loss

Single Loss Claimed

Example 1: Member loses left eye due to IED blast. Certifier would check Found box and would not enter anything in the Loss Disposition Code box.

<i>Loss</i>	<i>Found</i>	<i>Not Found</i>	<i>Code(s)</i>
Sight - left eye	<input checked="" type="checkbox"/>	<input type="checkbox"/>	

Example 2: Member loses peripheral vision in left eye due to IED blast. Limits to peripheral vision do not result in 30 degree or less peripheral vision. Certifier would check Not Found box and would enter Loss Disposition Code 3.

<i>Loss</i>	<i>Found</i>	<i>Not Found</i>	<i>Code(s)</i>
Sight - left eye	<input type="checkbox"/>	<input checked="" type="checkbox"/>	3

Example 3: Member goes into a coma for 30 days due to a stroke. Certifier would check Not Found for Coma 15 days and Coma 30 days box and would enter Loss Disposition Code 5 for both.

<i>Loss</i>	<i>Found</i>	<i>Not Found</i>	<i>Code(s)</i>
Coma 15 days	<input type="checkbox"/>	<input checked="" type="checkbox"/>	5
Coma 30 days	<input type="checkbox"/>	<input checked="" type="checkbox"/>	5

Note: For Single Loss Claimed situations, Loss Disposition Codes 15 & 16 do not apply.

Multiple Losses Claimed

Example 1: Member is in a motor vehicle accident and suffers amputation of both legs. Certifier would check Found boxes for amputation of left and right foot and place no entry in the Loss Disposition Codes for either one.

<i>Loss</i>	<i>Found</i>	<i>Not Found</i>	<i>Code(s)</i>
Amputation - left foot	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Amputation - right foot	<input checked="" type="checkbox"/>	<input type="checkbox"/>	

Example 2: Member is injured in a motor vehicle accident and suffers amputation of both legs as well as 2nd degree burns on 20% of body. Certifier would check Found boxes for amputation of left and right foot and burns. No Loss Disposition codes should be entered.

Loss	Found	Not Found	Code(s)
Amputation - left foot	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Amputation - right foot	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Burns to the body	<input checked="" type="checkbox"/>	<input type="checkbox"/>	

Example 3: Member is injured in a motor vehicle accident and suffers an amputation of his right arm. Member claims both amputation of right arm and amputation of right thumb. Certifier would check Found boxes for amputation of right hand and amputation of right thumb. Certifier would enter no Loss Disposition Code for amputation of right arm and Loss Disposition Code 15 for amputation of right thumb.

Loss	Found	Not Found	Code(s)
Amputation – right arm	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Amputation - right thumb	<input checked="" type="checkbox"/>	<input type="checkbox"/>	15

Example 4: Member is injured in a motor vehicle accident. Member is hospitalized for 10 days and suffers loss of two ADL for 20 days due to Other Traumatic Injury. Certifier would enter Not Found for both Hospitalization – 15 days and ADL 30 days due to OTI. Certifier would also enter Loss Disposition Code 3 for both items.

Loss	Found	Not Found	Code(s)
Hospitalization - 15 days	<input type="checkbox"/>	<input checked="" type="checkbox"/>	3
ADL 30 days due to OTI	<input type="checkbox"/>	<input checked="" type="checkbox"/>	3

Example 5: Member is injured in a motor vehicle accident and claims 2nd degree burns on 20% of body and loss of two ADL due to Other Traumatic Injury for 120 days. The branch of service does not evaluate ADL loss as burns already provides the maximum benefit. Certifier would check Found box for burns and place no Loss Disposition Code by burns. Certifier would check Not Found box for 30 days ADL due to OTI, 60 days ADL due to OTI, 90 days ADL due to OTI, and 120 days ADL due to OTI, and enter Loss Disposition Code 16 for each increment.

Loss	Found	Not Found	Code(s)
Burns to the body	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
ADL30 days due to OTI	<input type="checkbox"/>	<input checked="" type="checkbox"/>	16
ADL 60 days due to OTI	<input type="checkbox"/>	<input checked="" type="checkbox"/>	16
ADL 90 days due to OTI	<input type="checkbox"/>	<input checked="" type="checkbox"/>	16
ADL120 days due to OTI	<input type="checkbox"/>	<input checked="" type="checkbox"/>	16

Inpatient Hospitalization and ADL losses

If the member is claiming inpatient hospitalization and/or ADL loss, there are two situations that may be coded.

1. Member claims inpatient hospitalization in combination with subsequent ADL loss
2. Member claims multiple increments of ADL loss

To ensure uniformity in coding, each of these situations should be coded as follows:

1) Member claims inpatient hospitalization in combination with subsequent ADL loss – the certifier should check found or not found for both inpatient hospitalization (which replaces the first ADL milestone), and the second and any subsequent ADL milestones.

Example 1: Member is injured in a motor vehicle accident on July 4.. Member is hospitalized for 15 days and suffers loss of two ADL for an additional 45 days due to Other Traumatic Injury. Both losses meet the standard for TSGLI payment. The certifier would check found for Hospitalization – 15 days and ADL 30 and 60 days due to OTI. However, the certifier would indicate loss disposition code 15 for ADL 30 days due to OTI as it is not payable in combination with Hospitalization – 15 days.

Loss	Found	Not Found	Code(s)
Hospitalization - 15 days	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
ADL 30 days due to OTI	<input checked="" type="checkbox"/>	<input type="checkbox"/>	15
ADL 60 days due to OTI	<input checked="" type="checkbox"/>	<input type="checkbox"/>	

2) Member claims multiple increments of ADL loss – The certifier should check found or not found for each increment of ADL loss.

Example 1: Member is injured in a motor vehicle accident. Member claims loss of two ADL for 120 days due to Other Traumatic Injury, and member meets the standard for TSGLI payment for 120 days ADL. The certifier would check found for each increment of ADL loss.

Loss	Found	Not Found	Code(s)
ADL 30 days due to OTI	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
ADL 60 days due to OTI	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
ADL 90 days due to OTI	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
ADL 120 days due to OTI	<input checked="" type="checkbox"/>	<input type="checkbox"/>	

Example 2: Member is injured in a motor vehicle accident. Member claims loss of two ADL for 90 days due to TBI, but the medical professional's statement only supports 60 days of ADL loss. The certifier would check found for the first 3 increments of ADL loss, not found for the fourth increment of ADL loss and would enter Loss Disposition Code 3.

Loss	Found	Not Found	Code(s)
ADL 15 days due to TBI	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
ADL 30 days due to TBI	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
ADL 60 days due to TBI	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
ADL 90 days due to OTI	<input type="checkbox"/>	<input checked="" type="checkbox"/>	3

Section 4 - Certifying Signature

The certifying official must complete and sign this section to certify the TSGLI claim. The certifying official is the uniformed service official with decision-making authority for TSGLI claims. Each service notifies and updates VA and the Office of Servicemembers' Group Life Insurance of the name of this official, as needed. A wet signature or digital signature are both acceptable.

NOTE: In many uniformed service TSGLI Offices, staff complete the entire TSGLI Certification Worksheet, except for Section 4, and send with the a complete application package (SGLV-8600/SGLV-8600A and supporting documentation) to the certifying official for review. The certifying official then reviews and completes Section 4.

Section 5 - Additional Comments

The Additional Comments Section should be used to provide information that will clarify anything listed on the application or prior claims. This includes:

- further details of the traumatic event or exclusions,
- explanation of the losses (such as ADL) or losses found in review that are not on the application
- reconsideration and appeal information,
- and any questions or issues that may be of concern.

Section 6 – Service Member Address and Payment Information Update

The Service Member Address and Payment Information Update Section is used to ensure the address and payment information for the claim is accurate when submitting reconsiderations and appeals. If the claim is the first claim being certified for the member, do not complete Section 6.

Additionally, the certifying official should complete and submit Section 6 to OSGLI only if the original decision by the branch of service TSGLI office has been overturned to:

- Pay the claimant when previously denied
- Pay more money than originally certified for

In cases where reconsideration or appeal upholds the original decision, Section 6 does not need to be completed.

If payment is being made on reconsideration or appeal, the certifying official should contact the claimant (or guardian, power of attorney, or military trustee) to verify address, guardianship/trustee and payment option information. This section should be completed as follows:

Checkbox for prior certification – the certifying official should check this box to certify that any information not filled in on this application has not changed since the original claim was filed. If this box, is checked, nothing more needs to be completed in Section 6.

Service Member's Current Address & Contact Information – the certifying official should fill in member's contact information if it is different from the original claim. If there is no change, leave the section blank.

Guardian, Power of Attorney, or Military Trustee Information - the certifying official should fill in member's guardian/POA/military trustee information if it is different from the original claim. If there is no change, leave the section blank.

Payment Option - the certifying official should fill in member's payment option information if it is different from the original claim. If there is no change, leave the section blank.

When the the branch of service TSGLI office certifies a reconsideration or appeal as upholding the prior denial(s) or prior payment amounts, the TSGLI office still needs to email OSGLI at the appeals mailbox and include:

- A copy of the original claim
- A copy of the reconsideration or appeal
- A completed Certification Worksheet with Section 6 left blank.

The certifying official should then forward the following items to OSGLI to certify the appeal/reconsideration:

- A copy of the original claim
- A copy of the reconsideration or appeal
- A completed Certification Worksheet including Section 6

Section 7 - Checklists

The Checklists Section contains checklists that can be used by the certifying official to determine eligibility for TSGLI payment. These checklists should not be sent to OSGLI. They are for internal use to assist the TSGLI Offices in making a decision on claims.

Additional Information Required When Original, Supplemental, Reconsideration or Appealed Claims are Fully or Partially Denied

In cases where the member's original, supplemental, or reconsideration claim is denied in full or in part (the member is paid for some but not all of the losses claimed on the TSGLI Application), the TSGLI certifying official must submit, in addition to the TSGLI Application and TSGLI Certification Worksheet, a copy of the denial letter the TSGLI branch of service office sent to the member explaining the losses paid (if a partial denial) and the reason for denial of any losses that were not approved.

In cases where the member's appeal is denied in full or in part by the appellate organization, the TSGLI branch of service office must include the denial letter provided by that appellate organization with the TSGLI Application, Appeal, and TSGLI Certification Worksheet.

Submitting the Application to OSGLI

The certifying official of the member's branch of service will submit the application to OSGLI via email or fax. The email address is tsgli.appeals.claims@prudential.com. The fax number is 1-877-832-4943. The branch of service should submit all original TSGLI claims to OSGLI, even if they are denying the claim. The branch of service should submit reconsidered or appealed TSGLI claims to OSGLI if there is a change in the decision in order for OSGLI to issue payment. In cases where there is no change in the decision and the same losses were claimed, the branch of service should notify OSGLI at the same email address as noted above indicating that the case was reconsidered or appealed and the decision remains unchanged. See Part 8, specifically the section titled "Reporting of Denied Claims and Appeals" for complete reporting requirements.

NOTE: All submissions to OSGLI at the email address above should be sent using a secure method of transmission to ensure the security of the member's information.

Submitting Multiple Applications to OSGLI

Additional Losses from a Single Traumatic Event

A new complete TSGLI application is required when the member sustains additional losses, even if the loss resulted from a previous traumatic event already submitted on a TSGLI application. In these instances, the certifying official should check the box for "Supplemental Claim" in Section 1, Traumatic Event Information.

Example: A member permanently loses sight in one eye due to a traumatic event on April 1, 2021, and submits a TSGLI application for the loss. On May 1, 2021, the member loses one foot, as a direct result of a traumatic injury due to the same traumatic event. The member must submit a second TSGLI application for the second loss.

Additional Losses from Multiple Traumatic Events

A new complete TSGLI application is required when multiple traumatic events result in separate losses sustained by the Servicemember. Traumatic events must occur more than seven days (168 hours) apart from the initial traumatic event to be considered a separate traumatic event(s).

Example: A member suffers the loss of one foot on May 1, 2021 and submits a TSGLI application for the loss of foot. The same member suffers loss of sight in both eyes from another event that occurred on November 1, 2022. The member must submit a second TSGLI application for the loss of sight in both eyes.

Instructions for Using the Medical Professional's Supplemental Statement

The Medical Professional's Supplemental Statement should be used by the TSGLI certifying official to request additional information from the medical professional when it is needed to adjudicate the TSGLI claim. This information will then be made a part of the member's TSGLI claim. The statement has 4 sections:

1. Request for Supplemental Medical Information
2. Medical Professional's Supplemental Statement
3. Medical Professional's Information
4. Medical Professional's Signature

Section 1 – Request for Supplemental Medical Information

To request additional information, the certifying official should fill in:

- The member's name and social security number (on both pages of the form)
- The name, address, phone and fax number of the branch of service TSGLI office requesting the information
- The specific information requested or section of Part B that needs clarification
- The certifying official should then mail or fax the request form and the HIPAA release from the member's claim to the medical professional

Sections 2 through 4 - Medical Professional's Supplemental Statement, Information and Signature

The medical professional should complete these sections to provide and certify the requested information. The medical professional can use the form provided, submit a separate letter or member medical records and attach them to the Supplemental Medical Form. The completed statement should then be mailed or faxed to the branch of service TSGLI office.

Submitting Medical Professional's Supplemental Statement to OSGLI

The Medical Professional's Supplemental Statement, just like other additional medical evidence submitted with the claim, does NOT need to be sent to OSGLI with the Claim Form and Certification Worksheet when the claim is certified. However, it should be retained by the TSGLI Office as part of the evidence used in making a decision on the claim.

Part 7 - Payment of TSGLI Benefits

General Information

Payment of TSGLI benefits will be in accordance with the published schedule of loss in 38 CFR 9.21(c) 9.21 (see Part 4, Schedule of Losses). The Office of Servicemembers' Group Life Insurance issues payments after a claim is certified for by payment by the member's branch of service TSGLI processing office.

TSGLI Beneficiary

The beneficiary of the TSGLI benefit is the member. Per TSGLI regulations, payment can only be made to the member's guardian, power of attorney, or military trustee if the member is medical incapacitated. Medically incapacitated means the Service Member has been determined by a medical professional to be physically or mentally impaired by physical disability, mental illness, mental deficiency, advanced age, chronic use of drugs or alcohol, or other causes that prevent sufficient understanding or capacity to manage his or her own affairs competently.

If the member dies after qualifying for payment, the payment will be made to the member's listed SGLI Beneficiary(ies). The member must survive for seven days (168 hours) from the date of the traumatic event to be eligible for TSGLI.

Taxes

The IRS has determined that the TSGLI benefit is not taxable and does not need to be reported to the IRS.

Note: In cases of overpayment where the funds have not been returned, the benefit may be taxable. In such cases, the Office of Servicemembers' Group Life Insurance will issue a 1099 to beneficiary.

Methods of Payment

There are three methods of payment for TSGLI benefits:

- 1) Lump Sum - Prudential's Alliance Account®*
- 2) Electronic Funds Transfer (EFT)
- 3) Lump Sum - Check

1) Lump Sum - Prudential's Alliance Account®*

The benefit will be deposited into Prudential's Alliance Account in the member's name. The Alliance Account is a personal interest bearing account, which gives the member ready access to the money, whenever it is needed. To use the account, the member can simply write a check for the withdrawal amount. The member may write checks as the money is needed or write out one check for the entire amount and close the account. The account will continue to earn interest as long as any balance is maintained in the account. The member cannot deposit any additional monies into the Alliance Account.

*An Alliance Account is an interest bearing draft account established in the beneficiary's(ies)' name(s) with a draft book. The beneficiary can write drafts ("checks") for any amount up to the full amount of the proceeds. There are no monthly service fees or per check charges and additional checks can be ordered at no cost, but fees apply for some special services including returned checks, stop payment orders and copies of statements/checks.

The Bank of New York Mellon is the Administrator of the Prudential Alliance Account Settlement Option, a contractual obligation of The Prudential Insurance Company of America, located at 751 Broad Street, Newark, NJ 07102-3777. Draft clearing and processing support is provided by The Bank of New York Mellon. **Alliance Account balances are not insured by the Federal Deposit Insurance Corporation (FDIC).** The Bank of New York Mellon is not a Prudential Financial company.

Guardians, or Power of Attorneys: A Service Member's legal guardian or power of attorney (POA) may choose the Alliance Account payment option as long as they submit proof of that appointment (i.e. the appropriate documentation) with the claim. The guardian or POA will not have their name added to the account, but will be able to sign Alliance Account checks on behalf of the member.

Note: If the member has a military trustee, Alliance Account cannot be elected. The funds must be deposited into the trusteeship account via EFT or Check (explained below) in order for the Defense Finance and Accounting Service to conduct account reviews.

If the member has medical capacity at time of application and opens an Alliance Account and later becomes medically incapacitated, a guardian or power of attorney can submit that documentation to Alliance Account and gain access to the funds in the account. To do this, a guardian, power of attorney, or military trustee should contact Alliance Customer Service toll free at 877-255-4262 or the OSGLI Claim Department toll free at 800-419-1473.

2) Electronic Funds Transfer (EFT)

The TSGLI benefit will be electronically credited to the checking or savings bank account specified. Depending on the member's bank, payments will be credited three to five days from the date the payment is authorized.

For military trustees who choose EFT, the funds will be deposited into the trusteeship account provided in the completed Application for Trusteeship (DoD Form 2827)

Note: If the member does not choose EFT and there is no guardian power of attorney, or military trustee, the payment will be made through Prudential's Alliance Account.

Access to Funds by Other Parties: Members should be advised that once the TSGLI payment is electronically credited to the bank account specified, anyone who has access to the account (i.e. spouse or children) can access the money.

3) Lump Sum Check

Payment will be made by check only to a guardian, power of attorney, or military trustee. This option is not available to the member.

Beneficiary Financial Counseling Services (BFCS)

BFCS is available to the TSGLI recipient. BFCS provides no cost personal financial counseling to TSGLI recipients on how best to use their benefit to meet their needs. The recipient will be notified of this benefit and how to access it when they receive the TSGLI payment. Additional information on BFCS can be found at: www.benefits.va.gov/insurance/bfcs.asp

Part 8 – The Denial and Appeals Process

General Information

The following are key terms for denial and appeal processing:

1. **Denial:** The disapproval of a claim for benefits by the TSGLI branch of service office.
2. **Full Denial:** The TSGLI branch of service office denies all losses claimed by the member.
3. **Partial Denial:** The TSGLI branch of service office approves some of the losses and denies others claimed by the member.
4. **Appeal:** The actions taken by the member to seek a review of the denial decision by the TSGLI branch of service office. This can include requesting a review through the internal branch of service review process or initiating legal action in federal district court. The first level of appeal within the TSGLI branch of service office is called a reconsideration. The second and third level of appeal in the branch of service review process are handled by appellate organizations outside of the TSGLI branch of service office.

Appeal Period

The one-year appeal period only applies to subsequent claims that do not include “new and material evidence”. This means that all claims with new and material evidence are new claims and will be readjudicated no matter how long after the original decision the claim is submitted. In contrast, claims submitted after the one-year appeal period without new and material evidence are considered final decisions.

VA defines new and material evidence as evidence that was not previously part of the record before the uniformed service, is not cumulative or redundant of evidence of record at the time of the prior decision and is likely to have a substantial effect on the outcome.

New and material evidence can be neither cumulative nor redundant of the evidence of record at the time of the last final decision and must raise a reasonable possibility of substantiating the claim. Evidence is cumulative, and thus, not material, if it:

- reinforces a previously proven or conceded element of the claim
- provides additional details to support previous statements, or
- rehashes previously submitted statements

New and material evidence may take many forms. Examples include:

- written and sworn testimony of the claimant or witnesses to an event,
- a medical nexus opinion with supporting rationale, and
- unconsidered service department records.

Appeal Period Example 1 – No New and Material Evidence: Member injured in a motor vehicle accident. Member sends in police report and treatment records from hospital, all treating physicians, and outpatient therapy. Member claims loss of two ADL for 30 days due to Other Traumatic Injury. Member’s claim is denied on August 1, 2020.. On December 15, 2021, member submits additional treatment records from hospital stay that were not submitted with original claim. However, the new treatment records do not provide any new information. Rather, they reinforce the same facts as in the original claim. While the information submitted is new, it is not material. In this case, the member’s new information would not be reviewed as the one-year appeal period has already ended.

Appeal Period Example 2 – No New and Material Evidence: Member was injured in a house fire. Member sends in police report and treatment records from hospital, all treating physicians, and outpatient therapy. Member claims Burns. Member’s claim is denied on June 1, 2020. On August 17, 2021, member resubmits the original claim form with the same evidence that was provided with the original claim. The new claim does not contain new or material evidence. In this case, the member’s subsequent claim would not be reviewed as the one-year appeal period has already ended.

Appeal Period Example 3 –New and Material Evidence: Member was injured in a fall from his roof. Member sends in treatment records from hospital. Member claims loss of two ADL for 60 days due to Other Traumatic Injury. Member's claim is denied on November 8, 2020. On December 30, 2021, member submits additional outpatient therapy records for ongoing treatment for severe back injury. The outpatient therapy records were not submitted previously; so they are new. The outpatient therapy records also provide material information on the nature and length of the ADL losses. Because the evidence is new and material, the member has initiated a new claim and the one-year appeal period does not apply. The new evidence will be reviewed and a new claim adjudicated.

Most Frequent Decisions Likely to be Appealed to the Uniformed Service

The following is a list of the most frequent decisions that would need to be appealed to the uniformed services:

- 1) Decision that a member's loss did not meet the requirements for a loss under TSGLI
- 2) Decision that the member's loss did not occur within 730 days of the traumatic event causing the loss
- 3) Decision that the member's loss was not the direct result of a traumatic injury..
- 4) Decision that the member's loss was due to a physical or mental illness or disease other than those covered under TSGLI
- 5) Decision that the member's loss is due to a traumatic injury willfully caused by the member's own actions
- 6) Decision that the member's medical treatment (e.g. surgery), in and of itself, is not considered a traumatic event
- 7) Decision that the member was not covered by SGLI at the time of the traumatic event (only for injuries occurring on or after December 1, 2005), and therefore was not covered by TSGLI

1) Decision that a member's loss did not meet the requirements for a loss under TSGLI

The member's claim is denied because the member's loss did not meet the requirements outlined in the schedule of losses (see Part 4, Schedule of Losses).

Example: A member is injured in a car accident. As a result of the car accident he suffers 2nd degree burns on 10 percent of his body with none on his face. His claim is denied because the requirement for payment is that the burns not only be 2nd degree but cover 20 percent of his body. To appeal this denial of TSGLI benefits, the member must submit his appeal to the appropriate contact within his uniformed service.

2) Decision that the member's loss did not occur within 730 days of the traumatic event causing the loss

The member's claim is denied because the member's loss did not occur within 730 days of the traumatic event (see Part 1, Qualifying for TSGLI Payment)

Example: A member is injured in a training accident on April 15, 2020. As a result of the accident she suffers reduced vision in her right eye immediately after the accident, but her loss of vision does not meet the TSGLI standard. Over the next two years her vision becomes progressively worse. On June 15, 2022, her visual acuity measurement meets the standard for TSGLI and she files a claim. The claim is denied because her loss occurred more than 730 days from the traumatic event causing the loss. To appeal this denial of TSGLI benefits, the member must submit her appeal to the appropriate contact within her uniformed service.

3) Decision that the member's loss was not the direct result of a traumatic injury

The member's claim is denied because the member's loss was not the direct result of a traumatic injury and some other cause fully or substantially contributed to the loss. (see Part 1, Qualifying for TSGLI Payment).

Example: A member falls and hits his head. After the event, he appears fine and continues to function normally. A month later, he takes some prescribed medication for a heart condition and soon after falls into a coma. The member's power of attorney claims the coma is the direct result of damage to his brain due to the fall (a traumatic injury); however, the member's medical professional states that the medication from his heart condition is the likely cause of the coma (a separate cause). The claim is denied as the member's loss was not the direct result of a traumatic injury but from some other cause. To appeal this denial of TSGLI benefits, the member must submit her appeal to the appropriate contact within his uniformed service.

4) Decision that the member's loss was due to a physical or mental illness or disease other than those covered under TSGLI

The member's claim is denied because the member's loss was due to mental illness or disease and that illness or disease was not caused by:

- a pyogenic infection or,
 - biological, chemical, or radiological weapons or,
 - accidental ingestion of a contaminated substance
- (see Part 1, Injuries Excluded from TSGLI Coverage)

Example 1: A member was involved in a small arms battle where he suffered a non-life threatening injuries and also saw his friend get killed. He returns home and begins having nightmares and is so severely depressed that he cannot do two of the activities of daily living on his own (dressing and eating) for 30 days. His doctor diagnoses him with Post-Traumatic Stress Disorder (PTSD). The claim is denied because the loss (the inability to dress or eat without assistance) for 30 days is the result of a mental illness and that illness was not caused by a pyogenic infection or by biological, chemical, or radiological weapons or accidental ingestion of a contaminated substance. To appeal this denial of TSGLI benefits, the member must submit his appeal to the appropriate contact within his uniformed service.

Example 2: A member has diabetes and her condition begins to cause problems to her leg resulting in the amputation of her leg. The claim is denied because the loss was due to a disease not covered by TSGLI. To appeal this denial of TSGLI benefits, the member must submit her appeal to the appropriate contact within her uniformed service.

5) Decision that the member's loss is due to a traumatic injury caused by the member's own actions

The member's claim is denied because the member's loss was due to a traumatic injury caused by one of the following actions on the part of the member:

- Attempting to commit suicide;
- Intentionally self-inflicted injury or an attempt to inflict such injury;
- The member's willful use of an illegal or controlled substance, unless under the advice of a doctor; or
- Committing or attempting to commit a felony.

(See Part 1, Injuries Excluded from TSGLI Coverage)

Example: A member is injured in a motorcycle accident. After a police investigation, it is determined that the member was driving 100 miles per hour and rolled his motorcycle because he was high on crack cocaine. As a result of the accident he has a spine injury and is now a paraplegic. The claim is denied because the loss is due to the member's willful use of an illegal substance. To appeal this denial of TSGLI benefits, the member must submit his appeal to the appropriate contact within his uniformed service.

6) Decision that the member's medical treatment, in and of itself, is not considered a traumatic event

The member's claim is denied because the member's loss was by medical treatment and medical treatment, in and of itself, is not considered a traumatic event. (See Part 1, Injuries Excluded from TSGLI Coverage)

Example: A member goes into the hospital on June 1st for surgery related to a brain aneurysm. During the surgery, the member goes into a coma and remains in a coma for 60 days. The claim is denied because the loss is due to the medical treatment for a brain aneurysm. To appeal the denial of TSGLI benefits, the member must submit his appeal to the appropriate contact within his uniformed service.

7) Decision that the member was not covered by SGLI at the time of the traumatic event (only for injuries occurring on or after December 1, 2005), and therefore was not covered by TSGLI

The member's claim is denied because records indicate that the member declined SGLI coverage on their most recent SGLI Election and Certificate prior to their injury, and therefore the member was not covered by SGLI or TSGLI at the time of the traumatic event.

Example: A member completes a SGLI Election and Certificate using the SGLI Online Enrollment System (SOES) within months of entering service indicating that he does not want SGLI coverage. One year after entering the service, the member is injured in a vehicle rollover, and has his left leg amputated due to the accident. The claim is denied because the member was not covered by SGLI at the time of his injury. To appeal the denial of TSGLI benefits, the member must submit his appeal to the appropriate contact within his uniformed service.

The TSGLI Appeal Request Form (SGLV-8600A)

The TSGLI Appeal Request Form (SGLV-8600A) is used when filing an appeal for previously denied benefits under the Servicemembers' Group Life Insurance Traumatic Injury Protection (TSGLI) program. . The member should review their previous decision letter for instructions on where to submit their appeal and whether the SGLV-8600A is required. The form is available from their branch of service TSGLI Office or the Department of Veteran's Affairs Insurance website at www.benefits.va.gov/insurance.

To avoid delays in the review process, please highlight any new and material evidence within medical records and submit only the new evidence/documentation that supports the appeal. There is no need to resubmit all previously submitted documents as they are already part of the record and will be considered when your appeal is reviewed.

Completing Form SGLV-8600A

The first page of the application provides contact information about the TSGLI Branch of Service Offices.

Who Makes the Decision on My Appeal?

This section of the form contains nine areas:

1. Servicemember name
2. Social Security Number (last four) and Date of Birth
3. Mailing address
4. Phone number and Email address
5. Date of Traumatic Event/Injury and Location of Traumatic Event/Injury
6. List Losses from TSGLI Schedule of Losses that are being appealed (List **only** those losses that are being appealed)
7. Third Party Authorization - This is an optional section and may be left blank if the member is not allowing someone other than a guardian, power of attorney or military trustee to speak with the TSGLI office about their claim.
8. Guardian, Power of Attorney or Military Trustee information – This section should only be completed if the member is medically incapacitated and a guardian, power of attorney, or military trustee has been appointed to act on the member's behalf. Supportin documentation must be attached to the TSGLI Appeal Form.
9. Reason for appeal
 - a. There are ten basic reasons for an appeal that can be selected with one additional "Other" reason that is not listed. **(check all that apply)**
 - b. Please highlight any new and material evidence within medical records and **submit only the new and material evidence/documentation that supports the appeal**
 - c. **Do not resubmit evidence that was already submitted previously.**
10. Additional supporting information and details you specifically want considered on your appeal.
 - a. Any additional information not already provided should be explained here.
 - b. Signature/Date - The member or their agent must sign and date the TSGLI Appeal Form.

Banking Information

1. These sections of the form should be completed following the instructions for the TSGLI Application (Part 5).

Denial and Appeal Processing

Each branch of service has its own administrative appeals process for denied claims. While the appeal organizations for each branch of service vary somewhat, the overall process is the same for all branches, as described below:

Each branch of service's appellate review organizations, discussed above, are shown in the table on page 83

The information below discusses the sequence of events involved in the denial and appeal process.

Original Denied Claim

The member initially submits the TSGLI application to the branch of service. The TSGLI branch of service office sends the member a letter denying the TSGLI benefit and providing appeal rights. The branch of service forwards the certified claim as denied to OSGLI along with a copy of the original denial letter.

First Level of Appeal - Reconsideration

The member appeals in writing to the first level of the internal review process within their branch of service. This process is called a reconsideration and is done within the branch of service TSGLI office.

- If the decision is made to overturn the original denial decision on the certified claim, the claim is recertified to OSGLI and the claim is paid.
- If the decision is made to uphold the original denial decision on the certified claim, the member is sent a letter by their branch of service informing them of the decision and the next steps they can take to appeal the decision. The claim is recertified to OSGLI.

The table below explains the first level appeal process in additional detail.

If the claimant...	And...	The claimant should...	The Branch of Service will...
Is appealing an initial denial of TSGLI benefits	the appeal is being made WITHIN one year of the date of the initial denial letter	Send the appeal to the first level appeal organization for a reconsideration. This is the same office that handled the initial claim. The address is included in the initial denial letter.	Review the claim again, including any new evidence provided with the appeal and either approve or deny the claim. If denied a second time, the claimant will be advised they can send their next appeal to the second level appeal organization.
Is appealing an initial denial of TSGLI benefits	the appeal is being made AFTER one year of the date of the initial denial letter	Send the appeal to the first level appeal organization. This is the same office that handled the initial claim. The address is included in the initial denial letter.	Review the claim to determine if any new and material evidence has been submitted with the claim. If yes , the claim will be reviewed as a new claim, not an appeal. If approved, the claim will be paid. If denied, the claimant will be advised they should send their next appeal to the second level appeal organization. If no , the claim will be denied. The claimant will be advised they can appeal the decision that the claim did not include new and material evidence to the second level appeal organization.

Second Level of Appeal

If the member decides to appeal further, they make their request in writing to the second level of the internal review process within their branch of service.

- If the decision is made to overturn the original denial decision on the certified claim, the second level appeal organization will send the member a letter and direct the TSGLI branch of service processing office to recertify the claim to OSGLI and the claim will be paid.
- If the decision is made to uphold the original denial decision on the certified claim, the second level appeal organization will send the member a letter directly informing them of the decision and the next steps they can take to appeal the decision. The TSGLI branch of service recertifies the claim to OSGLI.

The table below explains the second level appeal process in additional detail.

If the claimant..	And...	The claimant should...	The Branch of Service will...
Is appealing a second denial of TSGLI benefits	the appeal is being made WITHIN one year of the date of the first appeal denial letter	Send the appeal to the second level appeal organization. The address is included in the initial appeal denial letter.	<p>Review the claim again, including any new and material evidence .</p> <p>If there is a new and material evidence, the second level appeal organization will remand the claim to the TSGLI branch of service processing office to review as a new claim. If remanded and approved, the claim will be paid. If remanded and denied, the TSGLI branch of service processing office will send the member a denial letter and the entire appeal process from reconsideration onwards restarts.</p> <p>If there is no new and material evidence, the second level appeal organization will review the claim.</p> <p>If denied a third time by the second level appeal organization, the claimant will be advised they can send their next appeal to third level appeal organization.</p>
Is appealing a second denial of TSGLI benefits	the appeal is being made AFTER one year of the date of the first appeal denial letter	Send the appeal to the second level appeal organization. The address is included in the initial appeal denial letter.	<p>Review the claim to determine if any new and material evidence has been submitted with the claim.</p> <p>If yes, the second level appeal organization will remand the claim to the TSGLI branch of service processing office to review as a new claim. If remanded and approved, the claim will be paid. If remanded and denied, the TSGLI branch of service processing office will send the member a denial letter and the entire appeal process from reconsideration onwards restarts.</p> <p>If no, the claim will be denied. The claimant will be advised they can appeal the decision that the claim did not include new and material evidence to the third level appeal organization.</p>

Third Level of Appeal

If the member decides to appeal further, they need to do so in writing to the third level of the internal review process within their branch of service.

- If the decision is made to overturn the original denial decision on the certified claim, the third level appeal organization will send the member a letter and direct the TSGLI branch of service processing office to recertify the claim to OSGLI and the claim will be paid.
- If the decision is made to uphold the original denial decision on the certified claim, the third level appeal organization will send the member a letter directly informing them of the decision and inform them that their final opportunity in the appeal process is to sue in federal court. The TSGLI branch of service recertifies the claim to OSGLI.

The table below explains the third level appeal process in additional detail.

If the claimant..	And...	The claimant should...	The Branch of Service will...
Is appealing a third denial of TSGLI benefits	the appeal is being made WITHIN one year of the date of the second appeal denial letter	Send the appeal to the third level appeal organization. The address is included in the second appeal denial letter.	<p>Review the claim again, including any new and material evidence .</p> <p>If there is a new and material evidence, the third level appeal organization will remand the claim to the TSGLI branch of service processing office to review as a new claim. If remanded and approved, the claim will be paid. If remanded and denied, the TSGLI branch of service processing office will send the member a denial letter and the entire appeal process from reconsideration onwards restarts.</p> <p>If there is a no new and material evidence, the third level appeal organization will review the claim. If denied a third time, the third level appeals organization will notify the claimant that they have exhausted the administrative appeal process and the only remaining avenue to appeal the decision is to file suit in federal district court.</p>
Is appealing a third denial of TSGLI benefits	the appeal is being made AFTER one year of the date of the second appeal denial letter	Send the appeal to the third level appeal organization. The address is included in the second appeal denial letter.	<p>Review the claim to determine if any new and material evidence has been submitted with the claim.</p> <p>If yes, the second level appeal organization will remand the claim to the TSGLI branch of service processing office to review as a new claim. If remanded and approved, the claim will be paid. If remanded and denied, the TSGLI branch of service processing office will send the member a denial letter and the entire appeal</p>

			<p>process from reconsideration onwards restarts.</p> <p>If no, the claim will be denied. third level appeals organization will notify the claimant that they have exhausted the administrative appeal process and the only remaining avenue to appeal the decision is to file suit in federal district court.</p>
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New and Material Evidence Appeal

The member can appeal a decision that their claim, submitted after one year from the date of denial, will not be reviewed on appeal due to lack of new and material evidence. The member's appeal goes to the next higher level of appeal than the prior organization which determined the claim did not include new and material evidence.

- If the decision is made to overturn the decision that the claim did not contain any new and material evidence, at any level of appeal, the claim will be remanded to the TSGLI branch of service office to review the claim again, as a new claim. If denied by the TSGLI branch of service office after reviewing the new and material evidence, the appeal process restarts on the claim.
- If the decision is made to uphold the original decision that the member did not submit any new and material evidence, the member is sent a letter informing them of the decision and directing them to appeal to the next higher level of appeal or file suit in federal district court.

The table below explains the new and material evidence appeal process in additional detail.

If the claimant..	And...	The claimant should...	The Branch of Service will...
is appealing a decision that the evidence submitted is not new and material	NA	Send the appeal to the next level appeal organization indicated in the most recent denial letter.	<p>Review the claim again to determine if any new and material evidence has been submitted with the claim.</p> <p>If yes, the claim will be reviewed or remanded to the TSGLI branch of service processing office. If reviewed/remanded and denied, the TSGLI branch of service processing office will send the member a denial letter and the entire appeal process from reconsideration onwards restarts.</p> <p>If no, the claim will be denied. The claimant will be directed to either appeal the decision to the next higher level appeal organization or if the administrative appeal process has been exhausted to file suit in federal district court.</p>

The claimant will be informed in each denial letter of their right to sue in federal district court at any time (38 USC 1975).

Organization	1st Level Review	2nd Level Review	3rd Level Review
Army	The first level of review is considered by the branches, a “reconsideration” of a claim and is done by the branch of service TSGLI office.	U.S Army TSGLI Appeals Board	U.S. Army Review Board Agency
Navy	The first level of review is considered by the branches, a “reconsideration” of a claim and is done by the branch of service TSGLI office.	TSGLI Appeals Board Navy Council of Review Boards	Board for Correction of Naval Records (BCNR)
Air Force/Space Force – Active	The first level of review is considered by the branches, a “reconsideration” of a claim and is done by the branch of service TSGLI office.	USAF Physical Disability Division, HQ AFPC/DPFD	Board for Correction of Air Force Records SAF/MRBR
Air Force - Reserve	The first level of review is considered by the branches, a “reconsideration” of a claim and is done by the branch of service TSGLI office.	USAF Physical Disability Division, HQ ARPC/DPTTB	Board for Correction of Air Force Records SAF/MRBR
Air National Guard	The first level of review is considered by the branches, a “reconsideration” of a claim and is done by the branch of service TSGLI office.	Air Force Surgeon General National Guard Bureau/A1PS	Board for Correction of Air Force Records
Marine Corps	The first level of review is considered by the branches, a “reconsideration” of a claim and is done by the branch of service TSGLI office.	TSGLI Appeals Board Navy Council of Review Boards	Board for Correction of Naval Records (BCNR)
Coast Guard	The first level of review is considered by the branches, a “reconsideration” of a claim and is done by the branch of service TSGLI office.	Coast Guard TSGLI Appeals Board	Board for Correction of Military Records of the Coast Guard (BMCR)
Public Health Service	The first level of review is considered by the branches, a “reconsideration” of a claim and is done by the branch of service TSGLI office.		
National Oceanic and Atmospheric Administration	The first level of review is considered by the branches, a “reconsideration” of a claim and is done by the branch of service TSGLI office.		

Right to Sue in Federal Court

In addition to utilizing the administrative appeals process, members have the right to file suit in federal court to contest an adverse TSGLI decision. All TSGLI denial letters inform members of this right.

Once the TSGLI branch of service processing office is informed that a member has sued in federal court, any review of the claim at any stage of internal review will be halted until the court decision is made. The TSGLI branch of service processing office or appeals organization will act upon the direction of the court when a decision has been made.

In the event a member files suit in federal court, the branch of service must provide OSGLI with any documents and records relating to the court decision and recertify the claim as a denial or approval.

Reporting of Denied Claims and Appeals

Denied Claims

Denials of TSGLI benefits by the branch of service need to be submitted to OSGLI for comprehensive record keeping purposes and reporting.

For all denials of claims (original claims and appeals):

1. The branch of service will send formal denial letters to all claimants whose TSGLI claim is denied. These letters will explain the reason for denial and an explanation of the member's appeal rights, both through the TSGLI branch of service office's internal appeal process and through the courts. The letters will provide a clear explanation of what information the member needs to submit if they desire to appeal the decision and the office to which the appeal should be directed with the branch of service.
2. The TSGLI branch of service office will provide a copy of this letter, along with the TSGLI Application/Appeals Form or other appeal initiation documents and Certification Worksheet to OSGLI when certifying the claim.
3. OSGLI will record the denial in its' records.

For denials of original claims (an initial claim from the member, a supplemental claim with additional losses that were not previously claimed, and a subsequent claim based on a new traumatic event):

1. The branch of service will send formal denial letters to all claimants whose TSGLI claim is denied. These letters will explain the reason for denial and an explanation of the member's appeal rights, both through the TSGLI branch of service office's internal appeal process and through the courts. The letters will provide a clear explanation of what information the member needs to submit if they desire to appeal the decision and the office to which the appeal should be directed with the branch of service.
2. The TSGLI branch of service office will provide a copy of this letter, along with the TSGLI Application and Certification Worksheet to OSGLI when certifying the claim.
3. OSGLI will record the denial for recordkeeping purposes.

In the case of partial denials, OSGLI will not only record the denial in its's records, but also issue payment to the member for the losses approved. In the case of full denials, OSGLI will only record the denial in its' records.

Comprehensive reports of denied claims can be obtained through OSGLI. OSGLI is the only organization maintaining centralized records on denials for all branches of service.

Branch of service points of contact are able to print their own denied claims reports on-demand through OSGLI's web reporting capabilities. If there is a new branch of service point of contact or if the point of contact is having problems with web reporting, contact the TSGLI Business Analyst at OSGLI at 800-419-1473.

Additional Information Required on Appeals

The TSGLI branch of service processing office must provide additional information on all appeal activity to OSGLI. They should provide the following information to OSGLI:

1. Name of member appealing

2. Social Security number of member appealing
3. Dates of Appeal (at each level)
4. Copy of all letters sent by the member to the branch of service
5. Review status within branch of service (level of appeal) – submit information at each level of review
6. Copy of all letters sent by the branch of service to the member in response to the appeal
7. Final decision on appeal

All required information should be sent to: tsgli.appeals.claims@prudential.com. OSGLI will take the information sent to this email box and associate it with the member's TSGLI file.

Part 9 – Records Management

General Information

TSGLI records are maintained by the branch of service and OSGLI. All records maintained by the branch of service are from claims or appeals from members. All records maintained by OSGLI are from certified claims or appeals received from the branches of service.

Claims Records – Approved or Denied

1) *Records the Branch of Service Maintains*

The branch of service maintains the following records (or copy of such records) of claims for their service:

- The member's TSGLI application
- The TSGLI Certification Worksheet identifying why the claim was approved or denied
- Any medical or other documentation used to substantiate a decision to approve or deny the claim
If the claim was denied, the letter sent to the member informing them of the denial and their appeal rights. Each branch of service retains these records based on their own Records Control Schedule. The Records Control Schedule for each branch of service is:
 - Air Force: Air Force Instruction 33-322 Records Management Program; Air Force Records Information System (AFIRMS) Records Disposition Schedule
 - Army: Army Military Human Resource Records Management Manual 600-8-104
 - Marine Corps: SECNAV Records Management Manual 5210.1, Standard Subject Identification Code (SSIC) 1850.3
 - Navy: SECNAV Records Management Manual 5210.1, Standard Subject Identification Code (SSIC) 1850.3
 - Coast Guard: Commandant Instruction M5212.12A
 - Public Health Service:
 - National Oceanic and Atmospheric Administration: NOAA Corps Directives, Chapter 1, Part 6 and NOAA Filing –Disposition Handbook

2) *Records OSGLI Maintains*

OSGLI maintains the following records (or copy of such records) for all claims (includes all branches of service):

- The member's TSGLI application
- The TSGLI Certification Worksheet identifying why the claim was approved or denied
- If the claim was approved, the explanation of benefits and evidence of payment.
- If the claim was denied, a copy of the branch's decision letter sent to the member informing them of the reason for denial and their appeal rights.
- Copy of Power of Attorney, attorney letters of representation, court orders pertaining to guardianship/conservatorship, and/or documentation of appointment of a military trustee (if these documents are applicable).

Appeal Records

1) *Records the Branch of Service Maintains* The branch of service maintains the following records (or copy of such records) on all appeals directed to them:

- The member's SGLV 8600A or letter indicating he/she is appealing the uniformed service's decision

- All materials provided by the member, the branch of service, or VA used in a review of the original decision on appeal (at all levels of appeal)
- The letter(s) sent to the member informing them of the branch of service's decision on appeal.

2) Records OSGLI Maintains

OSGLI maintains the following records (or copy of such records) for **all** appeals (includes all branches of service):

- Approved appeal claims:
 1. The member's TSGLI application
 2. The TSGLI Certification Worksheet identifying why the claim was approved on appeal
 3. The explanation of benefits and evidence of payment.
 4. Copy of Power of Attorney, attorney letters of representation ,court orders pertaining to guardianship/conservatorship, and/or documentation of appointment of a military trustee (if these documents are applicable).
- Denied appeal claims:
 1. The member's TSGLI application and 8600A (if applicable)
 2. The TSGLI Certification Worksheet identifying why the claim was denied on appeal
 3. A copy of the branch's decision letter sent to the member informing them of the denial and their appeal rights. This includes letters prepared by the branch of service TSGLI office or higher appeal organization.
 4. Copy of Power of Attorney, attorney letters of representation, court orders pertaining to guardianship/conservatorship and/or documentation for appointment of a military trustee (if these documents are applicable)

Part 10 - Appendices

Appendix A – Schedule of Losses

For losses listed in Part I, multiple injuries resulting from a single traumatic event may be combined with each other and treated as one loss for purposes of a single payment (except where noted otherwise), however, the total payment amount **MAY NOT** exceed \$100,000.

For losses listed in Part II, payment amounts **MAY NOT** be combined with payment amounts in Part I - only the higher amount will be paid. The total payment amount **MAY NOT** exceed \$100,000 for multiple injuries resulting from a single traumatic event.

Part I

Loss	Payment Amount
<p>1. Sight: <i>Total and permanent loss of sight is:</i></p> <ul style="list-style-type: none"> (i) Visual acuity in the eye of 20/200 or less/worse with corrective lenses lasting at least 120 days; (ii) Visual acuity in the eye of greater/better than 20/200 with corrective lenses and a visual field of 20 degrees or less lasting at least 120 days; or (iii) Anatomical loss of the eye (each eye is separate \$50,000 loss). 	\$50,000
<p>2. Hearing: <i>Total and permanent loss of hearing is:</i></p> <ul style="list-style-type: none"> (i) Average hearing threshold sensitivity for air conduction of at least 80 decibels, based on hearing acuity measured at 500, 1,000, and 2,000 Hertz via pure tone audiometry by air conduction, without amplification device (ii) The amount payable for loss of one ear is \$25,000. The amount payable for the loss of both ears is \$100,000. 	\$25,000 or \$100,000
<p>3. Speech: <i>Total and permanent loss of speech is:</i></p> <ul style="list-style-type: none"> (i) Organic loss of speech or the ability to express oneself, both by voice and whisper, through normal organs for speech, notwithstanding the use of an artificial appliance to simulate speech. 	\$50,000
<p>4. Quadriplegia: Total and permanent loss of voluntary movement of all four limbs resulting from damage to the spinal cord, associated nerves, or brain.</p>	\$100,000
<p>5. Hemiplegia: Total and permanent loss of voluntary movement of the upper and lower limbs on one side of the body from damage to the spinal cord, associated nerves, or brain.</p>	\$100,000
<p>6. Paraplegia: Total and permanent loss of voluntary movement of both lower limbs resulting from damage to the spinal cord, associated nerves, or brain.</p>	\$100,000

Loss	Payment Amount
<p>7. Uniplegia: Total and permanent loss of voluntary movement of one limb resulting from damage to the spinal cord, associated nerves, or brain.</p> <p><i>*Note: Payment for uniplegia of arm cannot be combined with loss 9, 10 or 14 for the same arm. Payment for uniplegia of leg cannot be combined with loss 11, 12, 13 or 15 for the same leg.</i></p>	\$50,000
<p>8. Burns: 2nd degree or worse burns to at least 20% of the body including the face OR, at least 20% of the face.</p>	\$100,000
<p>9. Amputation of hand: Amputation at or above the wrist For each hand*</p> <p><i>*Note: Payment for amputation of hand cannot be combined with payment for loss 7 or 10 for the same hand. The higher payment for amputation of hand or loss 14 will be made for the same hand.</i></p>	\$50,000
<p>10. Amputation of 4 fingers on 1 hand OR thumb alone: Amputation at or above the metacarpophalangeal joint For each hand</p> <p><i>*Note: Payment for amputation of 4 fingers on 1 hand or thumb alone cannot be combined with payment for loss 7 or 9 for the same hand. The higher payment for amputation of 4 fingers on 1 hand or thumb alone or loss 14 will be made for the same hand. Payment for loss of the thumb cannot be made in addition to payment for loss of the other 4 fingers for the same hand.</i></p>	\$50,000
<p>11. Amputation of foot: Amputation at or above the ankle For each foot*</p> <p><i>*Note: Payment for amputation of foot cannot be combined with loss 7 or 12 for the same foot. The higher payment for amputation of foot or Loss 13 will be made for the same foot. The higher payment for amputation of foot or Loss 15 will be made for the same foot.</i></p>	\$50,000
<p>12. Amputation of all toes including the big toe on 1 foot: Amputation at or above the metatarsophalangeal joint For each foot</p> <p><i>*Note: Payment for amputation of all toes including the big toe on 1 foot cannot be combined with loss 7 or 11 for the same foot. The higher payment for amputation of all toes including the big toe on 1 foot or loss 13 will be made for the same foot. The higher payment for amputation of all toes including the big toe on 1 foot or loss 15 will be made for the same foot.</i></p>	\$50,000

Loss	Payment Amount
<p>13. Amputation of big toe only, OR other 4 toes on 1 foot: Amputation at or above the metatarsophalangeal joint</p> <p>For each foot</p> <p><i>*Note:</i> The higher payment for amputation of big toe only, or other 4 toes on 1 foot, or loss 7 will be made for the same foot. The higher payment for amputation of big toe only, or other 4 toes on 1 foot, or loss 11 will be made for the same foot. The higher payment for amputation of big toe only, or other 4 toes on 1 foot, or loss 12 will be made for the same foot. The higher payment for amputation of big toe only, or other 4 toes on 1 foot, or loss 15 will be made for the same foot.</p>	<p>\$25,000</p>
<p>14. Limb reconstruction of arm (for each arm): A surgeon must certify that a member had surgery to treat at least one of the following injuries to a limb:</p> <ul style="list-style-type: none"> (A) Bony injury requiring bone grafting to re-establish stability and enable mobility of the limb; (B) Soft tissue defect requiring grafting/flap reconstruction to reestablish stability; (C) Vascular injury requiring vascular reconstruction to restore blood flow and support bone and soft tissue regeneration; or (D) Nerve injury requiring nerve reconstruction to allow for motor and sensory restoration and muscle re-ervation. <p>For each arm*</p> <p><i>*Note:</i> The amount payable for losses involving 1 of the 4 listed surgeries is \$25,000. The amount payable for losses involving 2 or more of the 4 listed surgeries is \$50,000.</p> <p><i>**Note:</i> The higher payment for limb reconstruction of arm or loss 7 will be made for the same arm. The higher payment for limb reconstruction of arm or loss 9 will be made for the same arm. The higher payment for limb reconstruction of arm or loss 10 will be made for the same arm.</p>	<p>\$50,000</p>

Loss	Payment Amount
<p>15. Limb reconstruction of leg (for each leg): A surgeon must certify that a member had at least one of the following injuries to a limb requiring the identified surgery for the same limb:</p> <ul style="list-style-type: none"> (A) Bony injury requiring bone grafting to re-establish stability and enable mobility of the limb; (B) Soft tissue defect requiring grafting/flap reconstruction to reestablish stability; (C) Vascular injury requiring vascular reconstruction to restore blood flow and support bone and soft tissue regeneration; or (D) Nerve injury requiring nerve reconstruction to allow for motor and sensory restoration and muscle re-ervation. <p>For each leg*</p> <p><i>*Note:</i> The amount payable for losses involving 1 of the 4 listed surgeries is \$25,000. The amount payable for losses involving 2 or more of the 4 listed surgeries is \$50,000.</p> <p><i>**Note:</i> The higher payment for limb reconstruction of leg or loss 7 will be made for the same leg. The higher payment for limb reconstruction of leg or loss 11 will be made for the same leg. The higher payment for limb reconstruction of leg or loss 12 will be made for the same leg. The higher payment for limb reconstruction of leg or loss 13 will be made for the same leg.</p>	<p>\$50,000</p>
<p>16. Facial Reconstruction – A surgeon must certify that a member had surgery to correct a traumatic avulsion of the face or jaw that caused a discontinuity defect to one or more of the following facial areas:</p>	
<ul style="list-style-type: none"> ▪ Jaw – Surgery to correct discontinuity loss involving bone loss of the upper or lower jaw- 	<p>\$75,000</p>
<ul style="list-style-type: none"> ▪ Nose – Surgery to correct discontinuity loss involving cartilage or tissue loss of 50% or more of the cartilaginous nose- 	<p>\$50,000</p>
<ul style="list-style-type: none"> ▪ Lips – Surgery to correct discontinuity loss involving tissue loss of 50% or more of the upper or lower lip- 	<p>\$50,000 or \$75,000</p>
<ul style="list-style-type: none"> ▪ Eyes – Surgery to correct discontinuity loss involving bone loss of 30% or more of the periorbita- 	<p>\$25,000</p>

Loss	Payment Amount
<ul style="list-style-type: none"> ▪ Facial Tissue – Surgery to correct discontinuity loss involving loss of bone or tissue of 50% or more of any of the following facial subunits: Forehead, temple, zygomatic, mandibular, infraorbital, or chin- ▪ Note 1: Losses due to facial reconstruction may be combined with each other, but the maximum benefit for facial reconstruction may not exceed \$75,000. ▪ Note 2: Any injury or combination of losses under facial reconstruction may be combined with other losses in § 9.21(c)(1)-(19) and treated as one loss, provided that all losses are the result of a single traumatic event. However, the total payment amount may not exceed \$100,000. ▪ Note 3: Bone grafts for teeth implants alone do not meet the loss standard for facial reconstruction from jaw surgery. 	\$25,000
<p>17. Coma from traumatic injury AND/OR Traumatic Brain Injury resulting in inability to perform at least 2 Activities of Daily Living (ADL)</p> <ul style="list-style-type: none"> ▪ at 15th consecutive day of coma or ADL loss ▪ at 30th consecutive day of coma or ADL loss ▪ at 60th consecutive day of coma or ADL loss ▪ at 90th consecutive day of coma or ADL loss ▪ Note: Duration of coma and inability to perform ADLs include date of onset of coma or inability to perform ADLs and the first date on which member is no longer in a coma or is able to perform ADLs. 	\$25,000 an additional \$25,000 an additional \$25,000 an additional \$25,000
<p>18. Hospitalization due to traumatic brain injury</p> <ul style="list-style-type: none"> ▪ at 15th consecutive day of hospitalization <p><i>Note 1: Payment for hospitalization replaces the first payment period in loss 17.</i></p> <p>Note 2: Duration of hospitalization includes the dates on which a member is transported from the injury site to a hospital as defined in 42 U.S.C. 1395x(e) or skilled nursing facility as defined in 42 U.S.C. 13951-3(a), admitted to the hospital or facility, transferred between a hospital or facility, leave the hospital or facility for a therapeutic trip, and discharged from the hospital or facility.</p>	\$25,000
<p>19. Genitourinary Losses</p>	
<ul style="list-style-type: none"> ▪ Anatomical loss of the penis Anatomical loss of the penis is defined as amputation of the glans penis or any portion of the shaft of the penis above the glans penis (i.e. closer to the body) or damage to the glans penis or shaft of the penis that requires reconstructive surgery. 	\$50,000

Loss	Payment Amount
<ul style="list-style-type: none"> ▪ Permanent loss of use of the penis Permanent loss of use of the penis is defined as damage to the glans penis or shaft of the penis that results in complete loss of the ability to perform sexual intercourse that is reasonably certain to continue throughout the lifetime of the member. 	\$50,000
<ul style="list-style-type: none"> ▪ Anatomical loss of one testicle Anatomical loss of the testicle(s) is defined as the amputation of, or damage to, one or both testicles that requires testicular salvage, reconstructive surgery, or both. 	\$25,000
<ul style="list-style-type: none"> ▪ Anatomical loss of both testicles See above – Same definition as anatomical loss of one testicle 	\$50,000
<ul style="list-style-type: none"> ▪ Permanent loss of use of both testicles Permanent loss of use of both testicles is defined as damage to both testicles resulting in the need for hormonal replacement therapy that is medically required and reasonably certain to continue throughout the lifetime of the member. 	\$50,000
<ul style="list-style-type: none"> ▪ Anatomical loss of the vulva, uterus, or vaginal canal Anatomical loss of the vulva, uterus, or vaginal canal is defined as the complete or partial amputation of the vulva, uterus, or vaginal canal or damage to the vulva, uterus, or vaginal canal that requires reconstructive surgery. 	\$50,000
<ul style="list-style-type: none"> ▪ Permanent loss of use of the vulva or vaginal canal Permanent loss of use of the vulva or vaginal canal is defined as damage to the vulva or vaginal canal that results in complete loss of the ability to perform sexual intercourse that is reasonably certain to continue throughout the lifetime of the member. 	\$50,000
<ul style="list-style-type: none"> ▪ Anatomical loss of one ovary Anatomical loss of the ovary(ies) is defined as the amputation of one or both ovaries or damage to one or both ovaries that requires ovarian salvage, reconstructive surgery, or both. 	\$25,000
<ul style="list-style-type: none"> ▪ Anatomical loss of both ovaries See above – Same definition as anatomical loss of one ovary 	\$50,000
<ul style="list-style-type: none"> ▪ Permanent loss of use of both ovaries Permanent loss of use of both ovaries is defined as damage to both ovaries resulting in the need for hormonal replacement therapy that is medically required and reasonably certain to continue throughout the lifetime of the member. 	\$50,000
<ul style="list-style-type: none"> ▪ Total and permanent loss of urinary system function Total and permanent loss of urinary system function is defined as damage to the urethra, ureter(s), both kidneys, bladder, or urethral sphincter muscle(s) that requires urinary diversion and/or hemodialysis, either of which is reasonably certain to continue throughout the lifetime of the member. 	\$50,000

Loss	Payment Amount
<p><i>Note 1: Losses due to genitourinary injuries may be combined with each other, but the maximum benefit for genitourinary losses may not exceed \$50,000.</i></p> <p><i>Note 2: Any genitourinary loss may be combined with other injuries listed in § 9.21(c)(19)(i)-(xiii) and treated as one loss, provided that all losses are the result of a single traumatic event. However, the total payment may not exceed \$100,000.</i></p>	

Part II

Loss	Payment Amount
<p>20. Traumatic injury resulting in inability to perform at least 2 Activities of Daily Living (ADL)</p> <ul style="list-style-type: none"> ▪ at 30th consecutive day of ADL loss ▪ at 60th consecutive day of ADL loss ▪ at 90th consecutive day of ADL loss ▪ at 120th consecutive day of ADL loss 	<p>\$25,000</p> <p>an additional \$25,000</p> <p>an additional \$25,000</p> <p>an additional \$25,000</p>
<p>21. Hospitalization due to traumatic injury</p> <ul style="list-style-type: none"> ▪ at 15th consecutive day of hospitalization <p><i>Note 1: Payment for hospitalization replaces the first payment period in loss 20.</i></p> <p><i>Note 2: Duration of hospitalization includes the dates on which a member is transported from the injury site to a hospital as defined in 42 U.S.C. 1395x(e) or skilled nursing facility as defined in 42 U.S.C. 13951-3(a), admitted to the hospital or facility, transferred between a hospital or facility, leave the hospital or facility for a therapeutic trip, and discharged from the hospital or facility.</i></p>	<p>\$25,000</p>

Appendix B –TSGLI Points of Contact

TSGLI Policy Questions Point of Contact

Kristan Hoffman
 Chief, Policy, Procedures, and Training Staff
 VA Insurance Service
kristan.hoffman@va.gov

Branch of Service Points of Contact

Service Branch	General Information	Claims Information
Army (All Components)	<p>Phone: (888) 276-9472</p> <p>Email: usarmy.knox.hrc.mbx.tagd-tsgli-claims@mail.mil</p> <p>Website: www.hrc.army.mil/content/Traumatic Servicemembers' Group Life Insurance</p>	<p>Submit Claims via fax: (502) 613-4513</p> <p>Submit Claims via email: usarmy.knox.hrc.mbx.tagd-tsgli-claims@mail.mil</p> <p>Submit Claims via postal mail: U.S. Army Human Resources Command ATTN: AHRC-PDR--C, (TSGLI) 1600 Spearhead Division Avenue - Dept 420 Ft. Knox, KY 40122-5402</p>
Navy	<p>Phone: (877) 270-2162 (Ask for the TSGLI Section),</p> <p>Email: MILL_TSGLI.FCT@navy.mil</p> <p>Website: www.mynavyhr.navy.mil/Support-Services/Casualty/TSGLI/</p>	<p>Submit Claims via fax: (901) 874-2265</p> <p>Submit Claims via email: MILL_TSGLI.FCT@navy.mil</p> <p>Submit Claims via postal mail: Commander, Navy Personnel Command Attn: PERS-00C 5720 Integrity Drive Millington, TN 38055-1300</p>
Air Force and Space Force (Active Duty)	<p>Phone: (800) 525-0102, Option 1, Option 1</p> <p>Email: AFPC.DPFCS.Pol_Trng_CaseMgt@us.af.mil</p>	<p>Submit Claims via email: AFPC.DPFCS.Pol_Trng_CaseMgt@us.af.mil</p> <p>Submit Claims via postal mail: AFPC/DPWC 550 C Street West, Suite 14 Randolph AFB, TX 78150-4716</p>
Air Force Reserve and Air National Guard	<p>Phone: (800) 525-0102, Option 3, Option 1</p> <p>Email: casualty.arpc1@us.af.mil</p>	<p>Submit Claims via fax: (720) 847-3887</p> <p>Submit Claims via email: casualty.arpc1@us.af.mil</p> <p>Submit Claims via postal mail: HQ, ARPC/DPTTB 18420 E. Silver Creek Ave BLDG 390 MS 68 Buckley AFB, CO 80011</p>

Service Branch	General Information	Claims Information
US Marine Corps	<p>Phone: (877) 216-0825 or (703) 975-4069</p> <p>Email: t-sgli@usmc.mil</p> <p>Website: www.woundedwarrior.marines.mil</p>	<p>Submit Claims via fax: (800) 770-9968</p> <p>Submit Claims via email: t-sgli@usmc.mil</p> <p>Submit Claims via postal mail: HQ, Marine Corps Attn: WWR-TSGLI 1998 Hill Street Quantico, VA 22134</p>
Coast Guard	<p>Phone: 202-795-6638</p> <p>Email: ARL-PF-CGPSC-PSDFS-COMPENSATION@uscg.mil</p>	<p>Submit Claims via email: ARL-PF-CGPSC-PSDFS-COMPENSATION@uscg.mil</p> <p>Submit Claims via postal mail: Commander CG Personnel Service Center (PSC) Attn: TSGLI Case Manager, PSC-PSD-FS-CASUALTY US Coast Guard Stop 7200 2703 Martin Luther King Jr Ave SE Washington DC 20593-7200</p>
Public Health Service	<p>Phone: (240) 276-8799</p> <p>Email: CompensationBranch@psc.hhs.gov</p>	<p>Submit Claims via fax: (240) 276-8817 or (240) 453-6030</p> <p>Submit Claims via email: CompensationBranch@psc.hhs.gov</p> <p>Submit Claims via postal mail: PHS Compensation Branch 1101 Wootton Parkway, Suite 100 Rockville, MD 20852</p>
NOAA Corps	<p>Phone: (301) 713-3444</p> <p>Email: director.cpc@noaa.gov</p>	<p>Submit Claims via fax: (301) 713-4140</p> <p>Submit Claims via email: director.cpc@noaa.gov</p> <p>Submit Claims via postal mail: US Dept. of Commerce, NOAA 8403 Colesville Rd, Suite 500, Silver Spring MD 20910</p>

Appendix C – Branch of Service Appeals Point of Contact List

All initial appeals should be sent to the branch of service TSGLI office shown on the front of the TSGLI claim form. The branch of service TSGLI office will review any additional information sent on an initial appeal and make a second determination of eligibility on the claim. If the case is appealed after this initial review, the following offices within each branch review the appeals.

Branch of Service Appeals

Branch of Service	Mailing Addresses to Send 2 nd Level Appeals	Mailing Addresses to Send 3 rd Level Appeals
Army – Active and Reserve	U.S. Army Human Resources Command ATTN : AHRC-PDR-C, Dept 420 1600 Spearhead Division Avenue Fort Knox, KY 40122-5402	Army Review Boards Agency (ARBA) Attn: Assistant Operations Officer 1901 South Bell Street, 2 nd floor Arlington, Virginia 22202-4508
Navy – Active and Reserve	TSGLI Appeals Board Navy Council of Review Boards 720 Kennon Street S.E., Room 309 Washington Navy Yard, D.C. 20374-5023	Board for Correction of Naval Records 701 South Courthouse Road Suite 1001 Arlington, VA 22204-2490
Air Force/Space Force Active	AFPC/DPFCS 550 C. Street West Joint Base San Antonio-Randolph, TX 78150	Board for Correction of Air Force Records SAF/MRBR 550-C Street West, Suite 40 Randolph AFB, TX 78150-4742
Air Force Reserve (Non-Active Duty)	USAF Physical Disability Division HQ ARPC/DPTTB 18420 E. Silver Creek Ave BLDG 390 MS 68 Buckley AFB, CO 80011	Board for Correction of Air Force Records SAF/MRBR 550-C Street West, Suite 40 Randolph AFB, TX 78150-4742
Air National Guard	Air Force Surgeon General NGB/A1PS, TSGLI Program Manager 3500 Fetchet Ave. 2nd Floor Joint Base Andrews, MD 20762-5157	Board for Correction of Air Force Records SAF/MRBR 550-C Street West, Suite 40 Randolph AFB, TX 78150-4742
Marines	TSGLI Appeals Board Navy Council of Review Boards 720 Kennon St SE Ste 309 Washington Navy Yard, DC 20374-5023	Board for Correction of Naval Records 701 South Courthouse Road Suite 1001 Arlington, VA 22204-2490
Coast Guard	TSGLI Appeals Board Commander, CG Personnel Service Center (PSC) Attn: TSGLI Case Manager, PSC-PSD-FS Casualty US Coast Guard Stop 7200 2703 Martin Luther King Jr Ave SE Washington, DC 20593-7200	DHS Office of the General Counsel Board for Correction of Military Records Mailstop #485 245 Murray Lane Washington, DC 20528

Branch of Service	Mailing Addresses to Send 2nd Level Appeals	Mailing Addresses to Send 3rd Level Appeals
Public Health Service		
National Oceanic and Atmospheric Administration Corps		