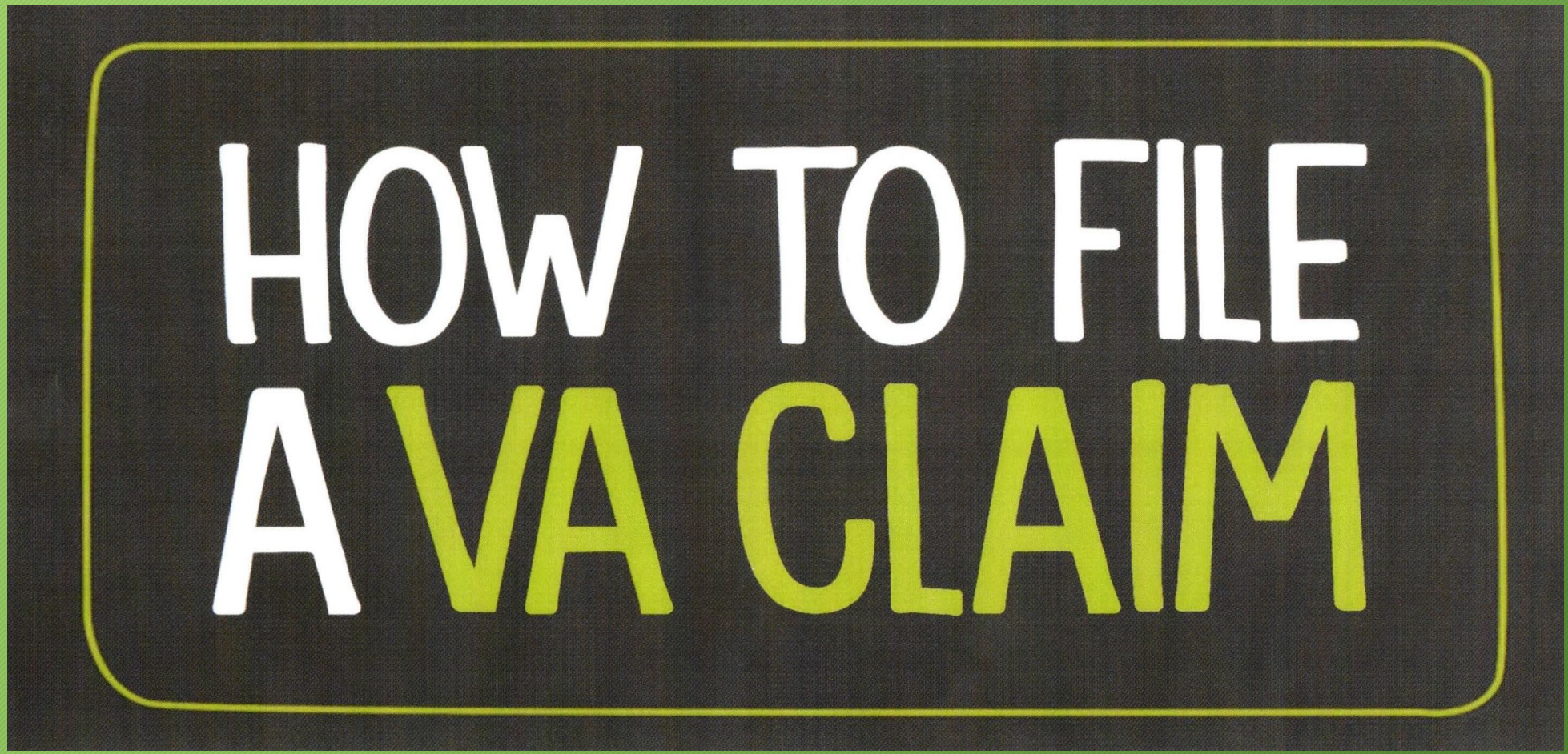

HOW TO FILE
A VA CLAIM

WHAT IS NEEDED TO FILE A CLAIM?

- DD214
- Diagnosis of Condition
- Treatment History
- Nexus Letter / Buddy Statements
- Assignment of a POA (Power of Attorney/Advocate)
- Intent to File
- Proper Forms

WHAT IS A DISABILITY?

A physical, mental, cognitive, or developmental condition that impairs, interferes with, or limits a person's ability to engage in certain tasks or actions or participate in typical daily activities and interactions.

VA FORM 21-22

APPOINTMENT OF VETERANS SERVICE OFFICER

4

OMB Control No. 2900-0321
Respondent Burden: 5 minutes
Expiration Date: 02/28/2022

Department of Veterans Affairs

VA DATE STAMP (DO NOT WRITE IN THIS SPACE)

APPOINTMENT OF VETERANS SERVICE ORGANIZATION AS CLAIMANT'S REPRESENTATIVE

IMPORTANT: Please read the Privacy Act and Respondent Burden Information on Page 3 before completing the form.

NOTE: If you prefer to have an individual assist you with your claim instead of a veterans service organization, please complete VA Form 21-22a, *Appointment of Individual as Claimant's Representative*. See Page 4 for information on how to submit the completed form, either by mail, in person at a VA regional office or electronically. VA forms are available at www.va.gov/vaforms.

SECTION I: VETERAN'S INFORMATION

NOTE: You can *either* complete the form online or by hand. If completed by hand, print the information requested in ink, neatly, and legibly to expedite processing of the form.

1. VETERAN'S NAME *(First, Middle Initial, Last)*: Joe Smith

2. VETERAN'S SOCIAL SECURITY NUMBER *(SSN)*: 123-45-6789

3. VA FILE NUMBER *(If applicable)*:

4. VETERAN'S DATE OF BIRTH *(MM/DD/YYYY)*: Month 01 – Day 01 – Year 1900

5. VETERAN'S SERVICE NUMBER *(If applicable)*:

6. INSURANCE NUMBER(S) *(If applicable) (Include letter prefix)*:

7. VETERAN'S MAILING ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*
No. & Street: 123456 Happy Lane
Apt./Unit Number:
City: Happy Town
State/Province: MI
Country:
ZIP Code/Postal Code: 12345 –

8. VETERAN'S TELEPHONE NUMBER *(Include Area Code)*:

9. VETERAN'S EMAIL ADDRESS *(Optional)*:

SECTION II: CLAIMANT'S INFORMATION *(If other than veteran)*

10. CLAIMANT'S NAME *(First, Middle Initial, Last)*:

11. CLAIMANT'S MAILING ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*
No. & Street:
Apt./Unit Number:
City:
State/Province:
Country:
ZIP Code/Postal Code –

12. CLAIMANT'S TELEPHONE NUMBER *(Include Area Code)*:

13. CLAIMANT'S EMAIL ADDRESS *(Optional)*:

14. RELATIONSHIP TO VETERAN:

SECTION III: SERVICE ORGANIZATION INFORMATION

15. NAME OF SERVICE ORGANIZATION RECOGNIZED BY THE DEPARTMENT OF VETERANS AFFAIRS *(See list on Page 3 before selecting organization)*: Disabled American Veterans

16A. NAME OF OFFICIAL REPRESENTATIVE ACTING ON BEHALF OF THE ORGANIZATION NAMED IN ITEM 15 *(This is an appointment of the entire organization and does not indicate the designation of only this specific individual to act on behalf of the organization)*: regional office

16B. JOB TITLE OF PERSON NAMED IN ITEM 16A: Veteran Service Officer

17. EMAIL ADDRESS OF THE ORGANIZATION NAMED IN ITEM 15: dav.vbadet@va.gov

18. DATE OF THIS APPOINTMENT *(MM/DD/YYYY)*: 01-01-1902

SECTION IV: AUTHORIZATION INFORMATION

19. AUTHORIZATION FOR REPRESENTATIVE'S ACCESS TO RECORDS PROTECTED BY SECTION 7332, TITLE 38, U.S.C. - By checking the box below I authorize VA to disclose to the service organization named on this appointment form any records that may be in my file relating to treatment for drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia.

☒ I **authorize** the VA facility having custody of my VA claimant records to disclose to the service organization named in Item 15 all treatment records relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia. Redisclosure of these records by my service organization representative, other than to VA or the Court of Appeals for Veterans Claims, is not authorized without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I revoke this authorization by filing a written revocation with VA; or (2) I revoke the appointment of the service organization named in Item 15, either by explicit revocation or the appointment of another representative.

20. LIMITATION OF CONSENT- I authorize disclosure of records related to treatment for all conditions listed in Item 19 except:

☐ DRUG ABUSE ☐ INFECTION WITH THE HUMAN IMMUNODEFICIENCY VIRUS (HIV)
☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

21. AUTHORIZATION TO CHANGE CLAIMANT'S ADDRESS - By checking the box below, I authorize the organization named in Item 15 to act on my behalf to change my address in my VA records.

☒ I **authorize** any official representative of the organization named in Item 15 to act on my behalf to change my address in my VA records. This authorization does not extend to any other organization without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I file a written revocation with VA; or (2) I appoint another representative, or (3) I have been determined unable to manage my financial affairs and the individual or organization named in Item 16A is not my appointed fiduciary.

I, the claimant named in Items 1 ***or*** 10, hereby **appoint** the service organization named in Item 15 as my representative to prepare, present and prosecute my claim(s) for any and all benefits from the Department of Veterans Affairs (VA) based on the service of the veteran named in Item 1. I authorize VA to release any and all of my records, to include disclosure of my Federal tax information (other than as provided in Items 19 and 20), to my appointed service organization. I understand that my appointed representative will not charge any fee or compensation for service rendered pursuant to this appointment. I understand that the service organization I have appointed as my representative may revoke this appointment at any time, subject to 38 CFR 20.6. *Additionally, in some cases a veteran's income is developed because a match with the Internal Revenue Service necessitated income verification. In such cases, the assignment of the service organization as the veteran's representative is valid for only five years from the date the claimant signs this form for purposes restricted to the verification match.* Signed and accepted subject to the foregoing conditions.

SECTION V: SIGNATURES

NOTE: THIS POWER OF ATTORNEY DOES NOT REQUIRE EXECUTION BEFORE A NOTARY PUBLIC

22A. SIGNATURE OF VETERAN OR CLAIMANT *(Do Not Print)*: Veteran Signature

22B. DATE SIGNED *(MM/DD/YYYY)*:

23A. SIGNATURE OF VETERANS SERVICE ORGANIZATION REPRESENTATIVE NAMED IN ITEM 16A *(Do Not Print)*: VSO Signature.

23B. DATE SIGNED *(MM/DD/YYYY)*:

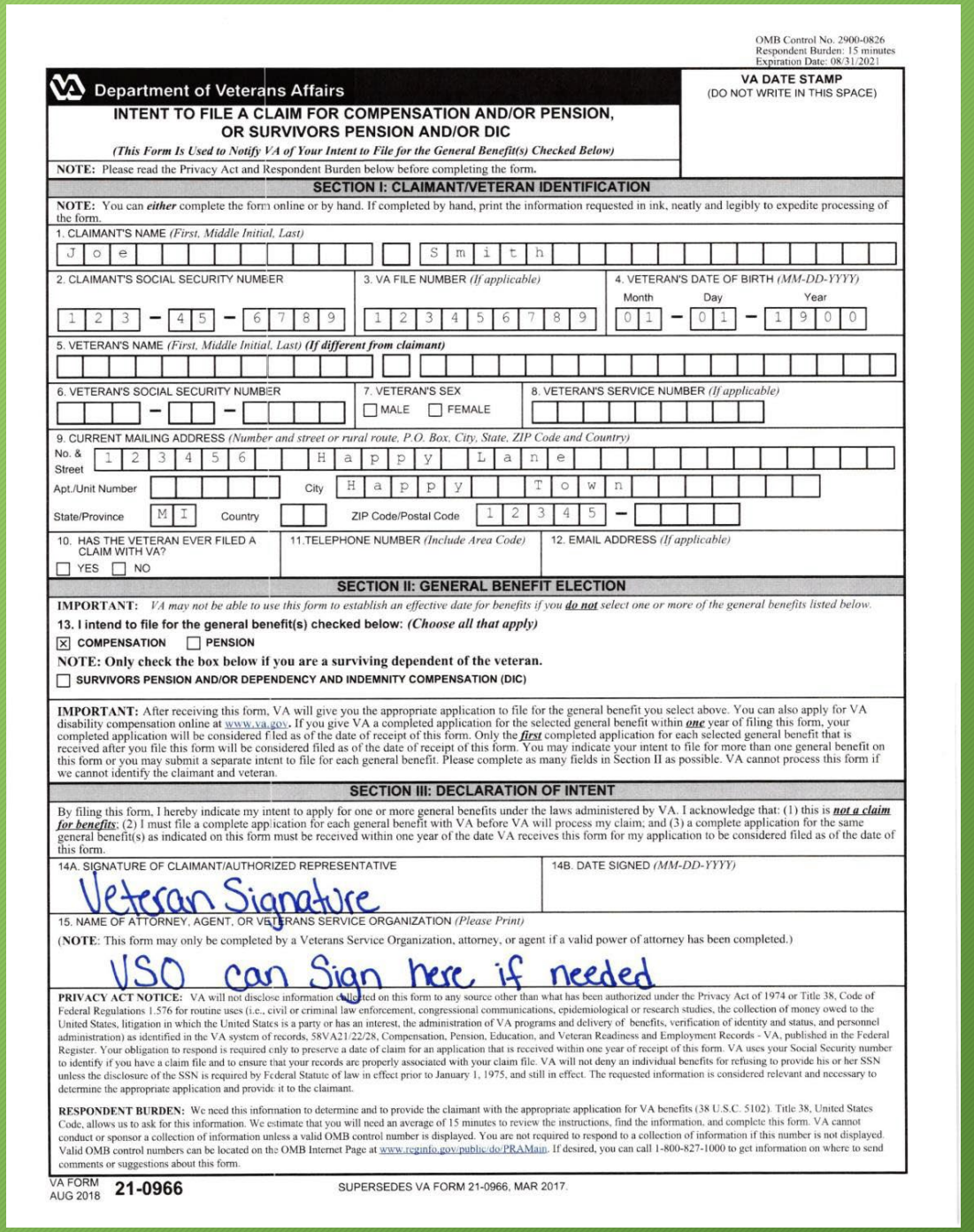
NOTE: As long as this appointment is in effect, the organization named herein will be recognized as the sole representative for preparation, presentation and prosecution of your claim before the Department of Veterans Affairs in connection with your claim or any portion thereof.

VA USE ONLY	COPY OF VA FORM 21-22 SENT TO:	DATE SENT *(MM/DD/YYYY)*	ACKNOWLEDGED *(Date) (MM/DD/YYYY)*	REVOKED *(Reason and date (MM/DD/YYYY))*
	☐ VR&E FILE ☐ EDU FILE ☐ LG FILE ☐ INSURANCE FILE			

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement of a material fact, knowing it to be false or for the fraudulent acceptance of any payment to which you are not entitled.

VA FORM 21-0966

INTENT TO FILE



OMB Control No. 2900-0826
Respondent Burden: 15 minutes
Expiration Date: 08/31/2021

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

INTENT TO FILE A CLAIM FOR COMPENSATION AND/OR PENSION, OR SURVIVORS PENSION AND/OR DIC

(This Form Is Used to Notify VA of Your Intent to File for the General Benefit(s) Checked Below)

NOTE: Please read the Privacy Act and Respondent Burden below before completing the form.

SECTION I: CLAIMANT/VETERAN IDENTIFICATION

NOTE: You can ***either*** complete the form online or by hand. If completed by hand, print the information requested in ink, neatly and legibly to expedite processing of the form.

1. CLAIMANT'S NAME *(First, Middle Initial, Last)*: Joe Smith

2. CLAIMANT'S SOCIAL SECURITY NUMBER: 123-45-6789

3. VA FILE NUMBER *(If applicable)*: 123456789

4. VETERAN'S DATE OF BIRTH *(MM-DD-YYYY)*: Month 01 – Day 01 – Year 1900

5. VETERAN'S NAME *(First, Middle Initial, Last)* ***(If different from claimant)***:

6. VETERAN'S SOCIAL SECURITY NUMBER: – –

7. VETERAN'S SEX: ☐ MALE ☐ FEMALE

8. VETERAN'S SERVICE NUMBER *(If applicable)*:

9. CURRENT MAILING ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*
No. & Street: 123456 Happy Lane
Apt./Unit Number:
City: Happy Town
State/Province: MI
Country:
ZIP Code/Postal Code: 12345 –

10. HAS THE VETERAN EVER FILED A CLAIM WITH VA? ☐ YES ☐ NO

11. TELEPHONE NUMBER *(Include Area Code)*:

12. EMAIL ADDRESS *(If applicable)*:

SECTION II: GENERAL BENEFIT ELECTION

IMPORTANT: *VA may not be able to use this form to establish an effective date for benefits if you* ***do not*** *select one or more of the general benefits listed below.*

13. I intend to file for the general benefit(s) checked below: ***(Choose all that apply)***

☒ **COMPENSATION** ☐ **PENSION**

NOTE: Only check the box below if you are a surviving dependent of the veteran.

☐ **SURVIVORS PENSION AND/OR DEPENDENCY AND INDEMNITY COMPENSATION (DIC)**

IMPORTANT: After receiving this form, VA will give you the appropriate application to file for the general benefit you select above. You can also apply for VA disability compensation online at www.va.gov. If you give VA a completed application for the selected general benefit within ***one*** year of filing this form, your completed application will be considered filed as of the date of receipt of this form. Only the ***first*** completed application for each selected general benefit that is received after you file this form will be considered filed as of the date of receipt of this form. You may indicate your intent to file for more than one general benefit on this form or you may submit a separate intent to file for each general benefit. Please complete as many fields in Section II as possible. VA cannot process this form if we cannot identify the claimant and veteran.

SECTION III: DECLARATION OF INTENT

By filing this form, I hereby indicate my intent to apply for one or more general benefits under the laws administered by VA. I acknowledge that: (1) this is ***not a claim for benefits***; (2) I must file a complete application for each general benefit with VA before VA will process my claim; and (3) a complete application for the same general benefit(s) as indicated on this form must be received within one year of the date VA receives this form for my application to be considered filed as of the date of this form.

14A. SIGNATURE OF CLAIMANT/AUTHORIZED REPRESENTATIVE: Veteran Signature

14B. DATE SIGNED *(MM-DD-YYYY)*:

15. NAME OF ATTORNEY, AGENT, OR VETERANS SERVICE ORGANIZATION *(Please Print)*

(**NOTE**: This form may only be completed by a Veterans Service Organization, attorney, or agent if a valid power of attorney has been completed.)

VSO can Sign here if needed

PRIVACY ACT NOTICE: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Veteran Readiness and Employment Records - VA, published in the Federal Register. Your obligation to respond is required only to preserve a date of claim for an application that is received within one year of receipt of this form. VA uses your Social Security number to identify if you have a claim file and to ensure that your records are properly associated with your claim file. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine the appropriate application and provide it to the claimant.

RESPONDENT BURDEN: We need this information to determine and to provide the claimant with the appropriate application for VA benefits (38 U.S.C. 5102). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 15 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

VA FORM AUG 2018 **21-0966** SUPERSEDES VA FORM 21-0966, MAR 2017.

WHAT IS A SERVICE C0NNECTED DISABILITY?

A VA service-connected disability is an injury or disease that was incurred in or aggravated beyond normal progression during active military service.

THINGS LIKE

Agent Orange Presumptive
Toxic Exposure / Burn Pits
Hearing Loss / Tinnitus
Back / Leg / Knee / Feet / Neck
Traumatic Brain Injury
Mental Health Illness
PTSD / MST

VA FORM 21-526EZ

APPLICATION FOR DISABILITY COMPENSATION

8

OMB Control No. 2900-0747
Respondent Burden: 25 minutes
Expiration Date: 11/30/2025

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

APPLICATION FOR DISABILITY COMPENSATION AND RELATED COMPENSATION BENEFITS

IMPORTANT: Please read the Privacy Act and Respondent Burden on Page 14 before completing the form. Use this form to determine your eligibility for compensation. For more information, you can contact us online through Ask VA: https://ask.va.gov. Ask us a question online or call us toll-free at 1-800-827-1000 (TTY: 711). If you prefer you may complete and submit the form online at www.va.gov. VA forms are available at www.va.gov/vaforms.

1. SELECT THE TYPE OF CLAIM PROGRAM/PROCESS THAT APPLIES TO YOU. **NOTE**: Your claim will be processed as described on pages 1 through 8 unless one of the following special programs is selected. See Instruction pages 1 through 3 for definitions of the Fully Developed Claim (FDC) Program (Optional Expedited Process) or the Standard Claim Process.

- [X] FDC PROGRAM
- [ ] STANDARD CLAIM PROCESS
- [ ] IDES (Select this option ***only*** if you have been referred to the IDES Program by your Military Service Department)
- [ ] BDD Program Claim (Select this option ***only*** if you meet the criteria for the BDD Program specified on Instruction Page 5)

SECTION I: VETERAN'S IDENTIFICATION INFORMATION
(If claim is not an original claim, only Section I, IV (if applicable), V and a signature are required)

NOTE: You may *either* complete the form online or by hand. If completed by hand, print the information requested in ink, neatly, and legibly, insert one letter per box, and completely fill in each applicable check box to help expedite processing of the form.

2. VETERAN/SERVICEMEMBER'S NAME (First, Middle Initial, Last)
Joe Smith

3. SOCIAL SECURITY NUMBER (SSN)
123 – 45 – 6789

4. HAVE YOU EVER FILED A CLAIM WITH VA?
[ ] YES [X] NO (If "Yes," provide your file number in Item 5)

5. VA FILE NUMBER

6. DATE OF BIRTH (MM-DD-YYYY)
01 – 01 – 1900

7. SERVICE NUMBER (If applicable)
123456789

8. **BDD CLAIMS ONLY: PROVIDE THE DATE OR ANTICIPATED DATE OF RELEASE FROM ACTIVE DUTY** (MM-DD-YYYY)

9. TELEPHONE NUMBER (Optional) (Include Area Code)
123 – 456 – 7890
Enter International Phone Number (If applicable)

10. CURRENT MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)
No. & Street: 123456 Happy Lane
Apt./Unit Number:
City: Happy Town
State/Province: MI
Country:
ZIP Code/Postal Code: 12345 –

11. EMAIL ADDRESS (Optional) [ ] I agree to receive electronic correspondence from VA in regards to my claim.
none

[ ] 12. IF YOU ARE CURRENTLY A VA EMPLOYEE, CHECK THE BOX (Includes Work Study/Internship) (If you are not a VA employee skip to Section II, if applicable).

SECTION II: CHANGE OF ADDRESS
NOTE: If you are temporarily or permanently changing your address, complete Items 13A through 13C.

13A. TYPE OF ADDRESS CHANGE (Complete if applicable) (Check only one box)
[ ] TEMPORARY [ ] PERMANENT

13B. NEW ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)
No. & Street:
Apt./Unit Number:
City:
State/Province:
Country:
ZIP Code/Postal Code: –

13C. EFFECTIVE DATE(S) OF NEW ADDRESS (If your change of address is **temporary**, complete both the beginning and ending date of your temporary address) (If your change of address is **permanent**, please enter your effective date in the beginning date only)
BEGINNING DATE: Month – Day – Year
ENDING DATE: Month – Day – Year

SECTION III: HOMELESS INFORMATION
IMPORTANT: The following questions (Items 14A through 14F) should **only** be completed if you are currently homeless or at risk of becoming homeless. If this item does not apply to you, skip to Section IV.

14A. ARE YOU CURRENTLY HOMELESS?
[ ] YES (If "Yes," complete Item 14B regarding your living situation)
[X] NO

14B. CHECK THE BOX THAT APPLIES TO YOUR LIVING SITUATION:
[ ] LIVING IN A HOMELESS SHELTER
[ ] NOT CURRENTLY IN A SHELTERED ENVIRONMENT (e.g., living in a car or tent)
[ ] STAYING WITH ANOTHER PERSON
[ ] FLEEING CURRENT RESIDENCE
[ ] OTHER (Specify)

14C. ARE YOU CURRENTLY AT RISK OF BECOMING HOMELESS?
[ ] YES (If "Yes," complete Item 14D regarding your living situation)
[X] NO

14D. CHECK THE BOX THAT APPLIES TO YOUR LIVING SITUATION:
[ ] HOUSING WILL BE LOST IN 30 DAYS
[ ] LEAVING PUBLICLY FUNDED SYSTEM OF CARE (e.g., homeless shelter)
[ ] OTHER (Specify)

14E. POINT OF CONTACT (Name of person VA can contact in order to get in touch with you)

14F. POINT OF CONTACT TELEPHONE NUMBER (Include Area Code)
– –
Enter International Phone Number (If applicable)

SECTION IV: EXPOSURE INFORMATION
15A. ARE YOU CLAIMING ANY CONDITIONS RELATED TO TOXIC EXPOSURES? **NOTE**: See Page 4 of the Instructions for further information on the evidence needed to support your claim for presumptive service connection. (You can also refer to the following websites for more information: PACT ACT (https://www.va.gov/PACT) and PUBLIC HEALTH MILITARY EXPOSURES (https://www.publichealth.va.gov/exposures/index.asp))
[ ] YES (If "Yes," complete Items 15B, 15C, 15D and 15E) [X] NO (If "No," skip to Item 16, Section V: Claim Information)

15B. DID YOU SERVE IN ANY OF THE FOLLOWING GULF WAR HAZARD LOCATIONS?
Iraq; Kuwait; Saudi Arabia; the neutral zone between Iraq and Saudi Arabia; Bahrain; Qatar; the United Arab Emirates; Oman; Yemen; Lebanon; Somalia; Afghanistan; Israel; Egypt; Turkey; Syria; Jordan; Djibouti; Uzbekistan; the Gulf of Aden; the Gulf of Oman; the Persian Gulf; the Arabian Sea; and the Red Sea.
[ ] YES [X] NO
WHEN DID YOU SERVE IN THESE LOCATIONS? (MM-YYYY) Note: Please provide an approximate time frame (month and year). FROM: – TO: –

15C. DID YOU SERVE IN ANY OF THE FOLLOWING HERBICIDE (e.g., Agent Orange) LOCATIONS?
Republic of Vietnam to include the 12 nautical mile territorial waters; Thailand at any United States or Royal Thai base; Laos; Cambodia at Mimot or Krek; Kampong Cham Province; Guam or American Samoa; or in the territorial waters thereof; Johnston Atoll or a ship that called at Johnston Atoll; Korean demilitarized zone; aboard (to include repeated operations and maintenance with) a C-123 aircraft known to have been used to spray an herbicide agent (during service in the Air Force and Air Force Reserves).
[X] YES [ ] NO
Please list other location(s) where you served, if not listed above:
WHEN DID YOU SERVE IN THESE LOCATIONS? (MM-YYYY) Note: Please provide an approximate time frame (month and year). FROM: – TO: –

15D. HAVE YOU BEEN EXPOSED TO ANY OF THE FOLLOWING? (Check all that apply)
[X] ASBESTOS [ ] MUSTARD GAS [ ] RADIATION
[ ] SHAD (Shipboard Hazard and Defense) [ ] MILITARY OCCUPATIONAL SPECIALTY (MOS)-related toxin [ ] CONTAMINATED WATER AT CAMP LEJEUNE
[ ] OTHER (Specify)
WHEN WERE YOU EXPOSED? (MM-YYYY) Note: Please provide an approximate time-frame (month and year). FROM: 06 – 1902 TO: 07 – 1902

15E. IF YOU WERE EXPOSED MULTIPLE TIMES, PLEASE PROVIDE ALL ADDITIONAL DATES AND LOCATIONS OF POTENTIAL EXPOSURE

SECTION V: CLAIM INFORMATION
(For additional space, use Section XIII: Claim Information (Addendum))

16. LIST THE CURRENT DISABILITY(IES) OR SYMPTOMS THAT YOU CLAIM ARE RELATED TO YOUR MILITARY SERVICE AND/OR SERVICE-CONNECTED DISABILITY (If applicable, identify whether a disability is due to a service-connected disability; confinement as a prisoner of war; exposure to Agent Orange, asbestos, mustard gas, ionizing radiation, or Gulf War environmental hazards; or a disability for which compensation is payable under 38 U.S.C. 1151)
NOTE: List your claimed conditions below. **See the following three examples for guidance on how to complete Section V.**

EXAMPLES OF DISABILITY(IES)	EXAMPLES OF EXPOSURE TYPE	EXAMPLES OF HOW THE DISABILITY(IES) RELATES TO SERVICE	EXAMPLES OF DATES
Example 1. HEARING LOSS	NOISE	HEAVY EQUIPMENT OPERATOR IN SERVICE	JULY 1968
Example 2. DIABETES	AGENT ORANGE	SERVICE IN VIETNAM WAR	DECEMBER 1972
Example 3. LEFT KNEE, SECONDARY TO RIGHT KNEE		INJURED LEFT KNEE WHEN BRACE ON RIGHT KNEE FAILED	6/11/2008

VA FORM 21-526EZ

APPLICATION FOR DISABILITY COMPENSATION

9

VETERAN'S SOCIAL SECURITY NO. 1 2 3 – 4 5 – 6 7 8 9

SECTION V: CLAIM INFORMATION (Continued)
(For additional space, use Section XIII: Claim Information (Addendum))

	CURRENT DISABILITY(IES)	IF DUE TO EXPOSURE, EVENT, OR INJURY, PLEASE SPECIFY (e.g., Agent Orange, radiation, burn pits)	EXPLAIN HOW THE DISABILITY(IES) RELATES TO THE IN-SERVICE EVENT/EXPOSURE/INJURY	APPROXIMATE DATE DISABILITY(IES) BEGAN OR WORSENED
1.	hearing loss right ear	noise	in service-machanic	1902
2.	hearing loss left ear	noise	in service-machanic	1902
3.	prostate cancer	agent orange exposure	service in Vietnam	1967
4.	tinnitus	noise	in service-machanic	1902
5.	sleep impairment	2nd tinnitus		1902
6.	Chronic Rhinitis	toxic exposure	in service/Iraq	2005
7.	sleep apnea	2nd to chronic Rhinitis		2005
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				

17. LIST VA MEDICAL CENTER(S) (VAMC) AND DEPARTMENT OF DEFENSE (DOD) MILITARY TREATMENT FACILITIES (MTF) WHERE YOU RECEIVED TREATMENT AFTER DISCHARGE FOR YOUR CLAIMED DISABILITY(IES) LISTED IN ITEM 16 AND PROVIDE APPROXIMATE BEGINNING DATE (Month and Year) OF TREATMENT. IF ADDITIONAL SPACE IS NEEDED ATTACH A SEPARATE SHEET AND INCLUDE YOUR NAME, SOCIAL SECURITY NUMBER AND ITEM NUMBER.

NOTE: If treatment began from 2005 to present, you **do not** need to provide dates in Item 17B.

A. ENTER THE DISABILITY TREATED AND NAME/LOCATION OF THE TREATMENT FACILITY	B. DATE OF TREATMENT (MM-YYYY)	C. CHECK THE BOX IF YOU DO NOT HAVE DATE(S) OF TREATMENT
VA Happy Place	–	☒ Don't have date
	–	☐ Don't have date
	–	☐ Don't have date

NOTE: IF YOU WISH TO CLAIM ANY OF THE FOLLOWING, COMPLETE AND ATTACH THE REQUIRED FORM(S) AS STATED BELOW. (VA forms are available at www.va.gov/vaforms)

For:	Required Form(s):
Supplemental Claims	VA Form 20-0995
Dependents	VA Form 21-686c and, if claiming a child aged 18-23 years and in school, VA Form 21-674
Individual Unemployability	VA Form 21-8940 and 21-4192
Post-Traumatic Stress Disorder	VA Form 21-0781 or 21-0781a
Specially Adapted Housing or Special Home Adaptation	VA Form 26-4555
Auto Allowance	VA Form 21-4502
Veteran/Spouse Aid and Attendance benefits	VA Form 21-2680 or, if based on nursing home attendance, VA Form 21-0779

VETERAN'S SOCIAL SECURITY NO. 1 2 3 – 4 5 – 6 7 8 9

VETERAN'S SOCIAL SECURITY NO. 1 2 3 – 4 5 – 6 7 8 9

SECTION VI: SERVICE INFORMATION

18A. DID YOU SERVE UNDER ANOTHER NAME?
☐ YES (If "Yes," complete Item 18B) ☒ NO (If "No," skip to Item 19A)

18B. LIST THE OTHER NAME(S) YOU SERVED UNDER:

19A. BRANCH OF SERVICE
☒ ARMY ☐ NAVY ☐ MARINE CORPS
☐ AIR FORCE ☐ COAST GUARD ☐ SPACE FORCE
☐ NOAA ☐ USPHS

19B. COMPONENT
☒ ACTIVE ☐ RESERVES ☐ NATIONAL GUARD

20A. MOST RECENT ACTIVE SERVICE DATES
ENTRY DATE: Month 0 1 – Day 0 1 – Year 1 9 0 0
EXIT DATE: 0 1 – 0 1 – 2 0 0 5

20B. PLACE OF LAST OR ANTICIPATED SEPARATION
F o r t S i l l

20C. DID YOU SERVE IN A COMBAT ZONE SINCE 9-11-2001?
☒ YES ☐ NO

20D. ADDITIONAL PERIODS OF SERVICE (Indicate enlistment and discharge date(s), if applicable)
FROM: Month – Day – Year
TO: Month – Day – Year

21A. ARE YOU CURRENTLY SERVING OR HAVE YOU EVER SERVED IN THE RESERVES OR NATIONAL GUARD?
☐ YES (If "Yes," complete Items 21B through 21F)
☒ NO (If "No," skip to Item 22A)

21B. COMPONENT
☐ NATIONAL GUARD
☐ RESERVES

21C. OBLIGATION TERM OF SERVICE
FROM: Month – Day – Year
TO: Month – Day – Year

21D. CURRENT OR LAST ASSIGNED NAME AND ADDRESS OF UNIT:

21E. CURRENT OR ASSIGNED PHONE NUMBER OF UNIT (Include Area Code)

21F. ARE YOU CURRENTLY RECEIVING INACTIVE DUTY TRAINING PAY?
☐ YES ☐ NO

22A. ARE YOU CURRENTLY ACTIVATED ON FEDERAL ORDERS WITHIN THE NATIONAL GUARD OR RESERVES?
☐ YES (If "Yes," complete Items 22B & 22C)
☒ NO

22B. DATE OF ACTIVATION: Month – Day – Year

22C. ANTICIPATED SEPARATION DATE: Month – Day – Year

23A. HAVE YOU EVER BEEN A PRISONER OF WAR?
☐ YES (If "Yes," complete Item 23B)
☒ NO

23B. DATES OF CONFINEMENT
FROM: Month – Day – Year
TO: Month – Day – Year
Month – Day – Year
Month – Day – Year

SECTION VII: SERVICE PAY (Retired Pay, Separation Pay, and Disability Severance Pay)

24A. ARE YOU RECEIVING MILITARY RETIRED PAY?
☐ YES (If "Yes," complete Items 24C and 24D)
☐ NO

24B. WILL YOU RECEIVE MILITARY RETIRED PAY IN THE FUTURE?
☐ YES (If "Yes," explain below (e.g. future Reserve/National Guard retirement, pending MEB/PEB and also complete Items 24C and 24D)
☒ NO

24C. BRANCH OF SERVICE
☐ ARMY ☐ NAVY ☐ MARINE CORPS
☐ AIR FORCE ☐ COAST GUARD ☐ SPACE FORCE
☐ NOAA ☐ USPHS

24D. MONTHLY AMOUNT
$, .00

25. RETIRED STATUS
☐ RETIRED ☐ PERMANENT DISABILITY RETIRED LIST
☐ TEMPORARY DISABILITY RETIRED LIST

IMPORTANT INFORMATION ON MILITARY RETIRED PAY (Includes all Uniformed Services Retired Pay):
Submission of this application constitutes a waiver of military retired pay in an amount equal to VA compensation awarded, if you are entitled to both benefits. Your retired pay may be reduced by the amount of VA compensation awarded. Receipt of the full amount of military retired pay and VA compensation at the same time ***may*** result in an overpayment, which ***may*** be subject to collection. If you qualify for concurrent receipt of VA compensation and military retired pay, the waiver of retired pay will not apply. If you do not want to waive any retired pay to receive VA compensation, you should check the box in **Item 26**.

Note that if you check the box in Item 26, you will not receive VA compensation, if granted. If you are currently in receipt of VA compensation and you check the box in Item 26, your VA compensation will be terminated, if you are also eligible for military retired pay.

IMPORTANT: VA COMPENSATION PAY IS NON-TAXABLE. THEREFORE, VA COMPENSATION PAY MAY BE THE GREATER BENEFIT.

☐ **26. Do NOT pay me VA compensation. I do NOT want to receive VA compensation in lieu of retired pay.**

VA FORM 21-526EZ

APPLICATION FOR DISABILITY COMPENSATION

10

VETERAN'S SOCIAL SECURITY NO. 1 2 3 – 4 5 – 6 7 8 9

IMPORTANT INFORMATION ON SEPARATION/SEVERANCE PAY:
VA compensation, if granted, may be withheld to recoup any disability severance or separation pay such as involuntary separation pay, voluntary separation pay, or special separation benefit, you receive from your branch of service. In addition, if you receive a Voluntary Separation Incentive (VSI), your VSI payments may be reduced if you are awarded VA compensation. Receipt of VA compensation and VSI at the same time may result in an overpayment of VSI, which **may** be subject to collection.

27A. HAVE YOU EVER RECEIVED SEPARATION PAY, DISABILITY SEVERANCE PAY, OR ANY OTHER LUMP SUM PAYMENT FROM YOUR BRANCH OF SERVICE?
☐ YES (If "Yes," complete Items 27B through 27D)
☐ NO

27B. DATE PAYMENT RECEIVED (MM-DD-YYYY)	27C. BRANCH OF SERVICE	27D. AMOUNT RECEIVED (Provide pre-tax amount)
– –	☐ ARMY ☐ NAVY ☐ MARINE CORPS ☐ AIR FORCE ☐ COAST GUARD ☐ SPACE FORCE ☐ NOAA ☐ USPHS	$, .00

IMPORTANT INFORMATION ON INACTIVE DUTY TRAINING PAY:
You may elect to keep the active or inactive duty training pay you received from the military service department. However, to be legally entitled to keep your training pay, you must waive VA benefits for the number of days equal to the number of days for which you received training pay. In most instances, it will be to your advantage to waive your VA benefits and keep your training pay.

If you waive VA benefits to receive training pay by checking the box in **Item 28**, VA will retroactively adjust your VA award to withhold benefits equal to the total number of training days waived and at the monthly rate in effect for the fiscal year period for which you received training pay. This action may result in an overpayment of compensation, which ***may*** be subject to collection.

IMPORTANT: VA COMPENSATION PAY IS NON-TAXABLE. THEREFORE VA COMPENSATION PAY MAY BE THE GREATER BENEFIT.

☐ **28. Do NOT pay me VA compensation. I do NOT want to receive VA compensation in lieu of training pay.**

SECTION VIII: DIRECT DEPOSIT INFORMATION
(Note: If you have already signed up for direct deposit, skip to Section IX)

The Department of the Treasury requires all Federal benefit payments be made by electronic funds transfer (EFT), also called direct deposit. **To enroll in direct deposit, provide the information requested below, and attach either a voided personal check or a deposit slip.** If you ***do not*** have a bank account, please visit https://www.benefits.va.gov/benefits/banking.asp. This website provides information about the Veterans Benefits Banking Program (VBBP), and a link to banks and credit unions that may fit your needs. You may also call 1-800-827-1000. If you elect not to enroll, you must contact representatives handling waiver requests for the Department of the Treasury at 1-888-224-2950. They will encourage your participation in EFT and address any questions or concerns you may have.

☐ 29. I CERTIFY THAT I DO NOT HAVE AN ACCOUNT WITH A FINANCIAL INSTITUTION OR CERTIFIED PAYMENT AGENT (If you check this box skip to Section IX)

30. ACCOUNT NUMBER (Check only **one** box below and provide the account number)
Account No.: 1 2 3 4 5 6 7 8 9 9 8 7 6 5 4 ☐ CHECKING ☐ SAVINGS

31. NAME OF FINANCIAL INSTITUTION (Provide the name of the bank where you want your direct deposit)	32. ROUTING OR TRANSIT NUMBER (The first nine numbers located at the bottom left of your check)
Happy Place Bank	1 2 3 4 5 6 7 8 9

SECTION IX: CLAIM CERTIFICATION AND SIGNATURE
VETERAN/SERVICEMEMBER CERTIFICATION AND SIGNATURE

I certify and authorize the release of information. I certify that the statements in this document are true and complete to the best of my knowledge. I authorize any person or entity, including but not limited to any organization, service provider, employer, or government agency, to give the Department of Veterans Affairs any information about me. For the limited purpose of providing VA with this information as it may relate to my claim, I waive any privilege that may apply and would otherwise make the information confidential and not discloseable.

I certify I have received the notice attached to this application titled, ***Notice to Veteran/Service Member of Evidence Necessary to Substantiate a Claim for Veterans Disability Compensation and Related Compensation Benefits.***

I certify I have enclosed all the information or evidence that will support my claim, to include an identification of relevant records available at a Federal facility such as a VA medical center; **OR,** I have no information or evidence to give VA to support my claim; **OR**, I have checked the box in Item 1, on page 9, indicating I want my claim processed under the standard claim process because I plan to submit additional evidence in support of my claim.

33A. VETERAN/SERVICE MEMBER SIGNATURE (**REQUIRED**)	33B. DATE SIGNED (MM-DD-YYYY)
Veteran Sign	– –

SECTION X: WITNESSES TO SIGNATURE

34A. SIGNATURE OF WITNESS (**Note**: Only sign if veteran signed in Item 33A using an "X")	34B. PRINTED NAME AND ADDRESS OF WITNESS

35A. SIGNATURE OF WITNESS (**Note**: Only sign if veteran signed in Item 33A using an "X")	35B. PRINTED NAME AND ADDRESS OF WITNESS

VETERAN'S SOCIAL SECURITY NO. 1 2 3 – 4 5 – 6 7 8 9

SECTION XI: ALTERNATE SIGNER CERTIFICATION AND SIGNATURE
(NOTE: REQUIRED ONLY IF ITEM 33A IS BLANK)

NOTE: An alternate signer signature **will not** be accepted unless a valid VA Form 21-0972, *Alternate Signer Certification*, is of record or attached to this request.

I certify that by signing on behalf of the claimant, that I am a court-appointed representative; **OR**, an attorney in fact or agent authorized to act on behalf of a claimant under a durable power of attorney; **OR**, a person who is responsible for the care of the claimant, to include but not limited to a spouse or other relative; **OR**, a manager or principal officer acting on behalf of an institution which is responsible for the care of an individual; **AND**, that the claimant is under the age of 18; **OR**, is mentally incompetent to provide substantially accurate information needed to complete the form, or to certify that the statements made on the form are true and complete; **OR**, is physically unable to sign this form.

I understand that I may be asked to confirm the truthfulness of the answers to the best of my knowledge under penalty of perjury. I also understand that VA may request further documentation or evidence to verify or confirm my authorization to sign or complete an application on behalf of the claimant if necessary. Examples of evidence which VA may request include: Social Security Number (SSN) or Taxpayer Identification Number (TIN); a certificate or order from a court with competent jurisdiction showing your authority to act for the claimant with a judge's signature and a date/time stamp; copy of documentation showing appointment of fiduciary; durable power of attorney showing the name and signature of the claimant and your authority as attorney in fact or agent; health care power of attorney, affidavit or notarized statement from an institution or person responsible for the care of the claimant indicating the capacity or responsibility of care provided; or any other documentation showing such authorization.

36A. ALTERNATE SIGNER SIGNATURE (**REQUIRED**)	36B. DATE SIGNED (MM-DD-YYYY)
	– –

SECTION XII: POWER OF ATTORNEY (POA) SIGNATURE
(NOTE: POA'S CANNOT SIGN FOR AN ORIGINAL CLAIM ONLY)

I certify that the claimant has authorized the undersigned representative to file this claim on behalf of the claimant and that the claimant is aware and accepts the information provided in this document. I certify that the claimant has authorized the undersigned representative to state that the claimant certifies the truth and completion of the information contained in this document to the best of claimant's knowledge.

NOTE: A POA's signature ***will not*** be accepted unless at the time of submission of this claim a valid VA Form 21-22, *Appointment of Veterans Service Organization as Claimant's Representative*, or VA Form 21-22a, *Appointment of Individual As Claimant's Representative*, indicating the appropriate POA is of record with VA.

37A. POA/AUTHORIZED REPRESENTATIVE SIGNATURE	37B. DATE SIGNED (MM-DD-YYYY)
VSO can also sign here	– –

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false, or for the fraudulent acceptance of any payment to which you are not entitled.

PRIVACY ACT NOTICE: The form will be used to determine allowance to compensation benefits (38 U.S.C. 5101). The responses you submit are considered confidential (38 U.S.C. 5701). VA may disclose the information that you provide, including Social Security numbers, outside VA if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Veteran Readiness and Employment Records - VA, published in the Federal Register. The requested information is considered relevant and necessary to determine maximum benefits under the law. Information submitted is subject to verification through computer matching programs with other agencies. VA may make a "routine use" disclosure for: civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration. Your response is required in order to obtain or retain benefits. Information that you furnish may be utilized in computer matching programs with other Federal or State agencies for the purpose of determining your eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of your participation in any benefit program administered by the Department of Veterans Affairs. Social Security information: You are required to provide the Social Security number requested under 38 U.S.C. 5101(c)(1). VA may disclose Social Security numbers as authorized under the Privacy Act, and, specifically may disclose them for purposes stated above.

RESPONDENT BURDEN: We need this information to determine your eligibility for compensation. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 25 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

WHAT ARE SECONDARY CONDITIONS?

VA Secondary conditions are non-service connected diseases or injuries that are proximately due to or the result of a service connected disease or injury.

WHAT ARE SECONDARY CONDITIONS?

EXAMPLE: TENSION HEADACHES SECONDARY TO SERVICE CONNECTED PTSD

They can arise from medications or surgery in the treatment for a service connected condition or from pain or depression caused by service connected disabilities.

VA FORM 21-4138

STATEMENT IN SUPPORT OF CLAIM

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OMB Control No. 2900-0075
Respondent Burden: 15 minutes
Expiration Date: 06/30/2024

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

STATEMENT IN SUPPORT OF CLAIM

INSTRUCTIONS: Before completing this form, read the Privacy Act and Respondent Burden on page 2. Use this form to submit a statement to support a claim. For more information you can contact us through Ask VA: https://ask.va.gov/, or call us toll-free at 800-827-1000 (TTY:711). VA forms are available at www.va.gov/vaforms. After completing the form, mail to: **Department of Veterans Affairs, Evidence Intake Center, P.O. Box 4444, Janesville, WI 53547-4444.**

SECTION I: VETERAN/BENEFICIARY'S IDENTIFICATION INFORMATION

NOTE: You may complete the form online or by hand. If completed by hand, print the information requested in ink, neatly and legibly, and insert one letter per box to help expedite processing of the form.

1. VETERAN/BENEFICIARY'S NAME *(First, Middle Initial, Last)*: Joe Smith

2. VETERAN'S SOCIAL SECURITY NUMBER: 123-45-6789

3. VA FILE NUMBER *(If applicable)*:

4. VETERAN'S DATE OF BIRTH *(MM/DD/YYYY)*: Month 01 – Day 01 – Year 1900

5. VETERAN'S SERVICE NUMBER *(If applicable)*:

6. TELEPHONE NUMBER *(Include Area Code)*: 123-456-7890

Enter International Phone Number *(If applicable)*:

7. E-MAIL ADDRESS *(Optional)*: none

8. MAILING ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*

No. & Street: 123456 Happy Lane

Apt./Unit Number:

City: Happy Town

State/Province: MI

Country:

ZIP Code/Postal Code: 12345 –

SECTION II: REMARKS

(The following statement is made in connection with a claim for benefits in the case of the above-named veteran/beneficiary)

While in the service I was.....

SECTION II: REMARKS *(Continued)*

(The following statement is made in connection with a claim for benefits in the case of the above-named veteran/beneficiary)

SECTION III: DECLARATION OF INTENT

I CERTIFY THAT the statements on this form are true and correct to the best of my knowledge and belief.

9. SIGNATURE OF VETERAN/BENEFICIARY ***(Required)***: Veteran or VSO sign

10. DATE SIGNED *(MM/DD/YYYY)*: Month – Day – Year

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false.

PRIVACY ACT INFORMATION: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA Programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Veteran Readiness and Employment Records - VA, published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. The VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine maximum benefits under the law. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN: We need this information to obtain evidence in support of your claim for benefits (38 U.S.C. 501(a) and (b)). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 15 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form

DEPENDENTS

For VA benefits a dependent is: a SPOUSE, Unmarried CHILDREN, under the age of 18, or any age if medically deemed unable to care for themselves before turning the age of 18, or under the age of 23 and attending VA accredited education program, or a PARENT that is financially dependent on the veteran.

VA FORM 21-686c

APPLICTION REQUEST TO ADD AND/OR REMOVE DEPENDENTS

ALSO NEEDED:
PREVIOUS MARRIAGE INFORMATION
MARRIAGE LICENSE
BIRTH CERTIFICATES
SSN CARDS

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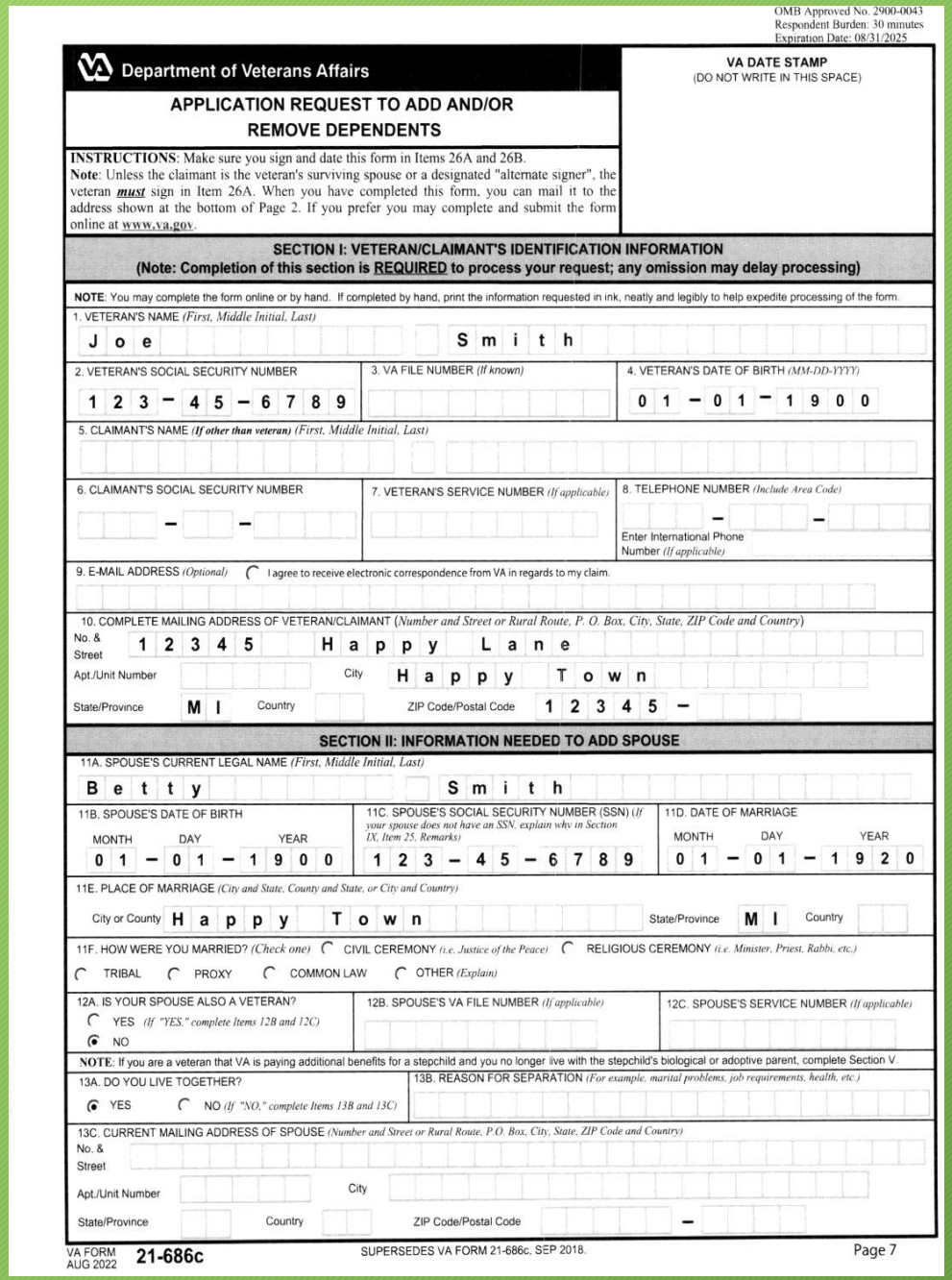

OMB Approved No. 2900-0043
Respondent Burden: 30 minutes
Expiration Date: 08/31/2025

Department of Veterans Affairs

APPLICATION REQUEST TO ADD AND/OR REMOVE DEPENDENTS

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

INSTRUCTIONS: Make sure you sign and date this form in Items 26A and 26B.
Note: Unless the claimant is the veteran's surviving spouse or a designated "alternate signer", the veteran ***must*** sign in Item 26A. When you have completed this form, you can mail it to the address shown at the bottom of Page 2. If you prefer you may complete and submit the form online at www.va.gov.

SECTION I: VETERAN/CLAIMANT'S IDENTIFICATION INFORMATION
(Note: Completion of this section is REQUIRED to process your request; any omission may delay processing)

NOTE: You may complete the form online or by hand. If completed by hand, print the information requested in ink, neatly and legibly to help expedite processing of the form.

1. VETERAN'S NAME *(First, Middle Initial, Last)*: Joe Smith

2. VETERAN'S SOCIAL SECURITY NUMBER: 123-45-6789

3. VA FILE NUMBER *(If known)*:

4. VETERAN'S DATE OF BIRTH *(MM-DD-YYYY)*: 01-01-1900

5. CLAIMANT'S NAME *(If other than veteran)* *(First, Middle Initial, Last)*:

6. CLAIMANT'S SOCIAL SECURITY NUMBER:

7. VETERAN'S SERVICE NUMBER *(If applicable)*:

8. TELEPHONE NUMBER *(Include Area Code)*
Enter International Phone Number *(If applicable)*

9. E-MAIL ADDRESS *(Optional)* ○ I agree to receive electronic correspondence from VA in regards to my claim.

10. COMPLETE MAILING ADDRESS OF VETERAN/CLAIMANT *(Number and Street or Rural Route, P. O. Box, City, State, ZIP Code and Country)*
No. & Street: 12345 Happy Lane
Apt./Unit Number:
City: Happy Town
State/Province: MI
Country:
ZIP Code/Postal Code: 12345-

SECTION II: INFORMATION NEEDED TO ADD SPOUSE

11A. SPOUSE'S CURRENT LEGAL NAME *(First, Middle Initial, Last)*: Betty Smith

11B. SPOUSE'S DATE OF BIRTH (MONTH DAY YEAR): 01-01-1900

11C. SPOUSE'S SOCIAL SECURITY NUMBER (SSN) *(If your spouse does not have an SSN, explain why in Section IX, Item 25, Remarks)*: 123-45-6789

11D. DATE OF MARRIAGE (MONTH DAY YEAR): 01-01-1920

11E. PLACE OF MARRIAGE *(City and State, County and State, or City and Country)*
City or County: Happy Town State/Province: MI Country:

11F. HOW WERE YOU MARRIED? *(Check one)* ○ CIVIL CEREMONY *(i.e. Justice of the Peace)* ○ RELIGIOUS CEREMONY *(i.e. Minister, Priest, Rabbi, etc.)*
○ TRIBAL ○ PROXY ○ COMMON LAW ○ OTHER *(Explain)*

12A. IS YOUR SPOUSE ALSO A VETERAN?
○ YES *(If "YES," complete Items 12B and 12C)*
◉ NO

12B. SPOUSE'S VA FILE NUMBER *(If applicable)*:

12C. SPOUSE'S SERVICE NUMBER *(If applicable)*:

NOTE: If you are a veteran that VA is paying additional benefits for a stepchild and you no longer live with the stepchild's biological or adoptive parent, complete Section V.

13A. DO YOU LIVE TOGETHER?
◉ YES ○ NO *(If "NO," complete Items 13B and 13C)*

13B. REASON FOR SEPARATION *(For example, marital problems, job requirements, health, etc.)*:

13C. CURRENT MAILING ADDRESS OF SPOUSE *(Number and Street or Rural Route, P.O. Box, City, State, ZIP Code and Country)*
No. & Street:
Apt./Unit Number:
City:
State/Province:
Country:
ZIP Code/Postal Code:

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VETERAN'S SOCIAL SECURITY NO. 123-45-6789

NOTE: You ***must*** provide complete information about ***your prior marriages*** and ***your current spouse's prior marriages***.

14. VETERAN/CLAIMANT'S PREVIOUS MARITAL INFORMATION
(If no prior marriages, this section may be left blank)

14A. (1) TO WHOM MARRIED *(First, Middle Initial, Last Name)*: Mary Smith

14A. (2) DATE AND PLACE OF MARRIAGE *(MM-DD-YYYY)*: 01-01-1918
City or County: Sad Town State/Province: MI Country:

14A. (3) REASON FOR TERMINATION
○ Death ○ Divorce ○ Annulment ○ Other (Explain):

14A. (4) DATE AND PLACE MARRIAGE TERMINATED *(MM-DD-YYYY)*:
City or County: Sad Town State/Province: MI Country:

14B. (1) TO WHOM MARRIED *(First, Middle Initial, Last Name)*:

14B. (2) DATE AND PLACE OF MARRIAGE *(MM-DD-YYYY)*:
City or County: State/Province: Country:

14B. (3) REASON FOR TERMINATION
○ Death ○ Divorce ○ Annulment ○ Other (Explain):

14B. (4) DATE AND PLACE MARRIAGE TERMINATED *(MM-DD-YYYY)*:
City or County: State/Province: Country:

14C. (1) TO WHOM MARRIED *(First, Middle Initial, Last Name)*:

14C. (2) DATE AND PLACE OF MARRIAGE *(MM-DD-YYYY)*:
City or County: State/Province: Country:

14C. (3) REASON FOR TERMINATION
○ Death ○ Divorce ○ Annulment ○ Other (Explain):

14C. (4) DATE AND PLACE MARRIAGE TERMINATED *(MM-DD-YYYY)*:
City or County: State/Province: Country:

14D. (1) TO WHOM MARRIED *(First, Middle Initial, Last Name)*:

14D. (2) DATE AND PLACE OF MARRIAGE *(MM-DD-YYYY)*:
City or County: State/Province: Country:

14D. (3) REASON FOR TERMINATION
○ Death ○ Divorce ○ Annulment ○ Other (Explain):

14D. (4) DATE AND PLACE MARRIAGE TERMINATED *(MM-DD-YYYY)*:
City or County: State/Province: Country:

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VA FORM 21-686c

APPLICTION REQUEST TO ADD AND/OR REMOVE DEPENDENTS

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VETERAN'S SOCIAL SECURITY NO. 123-45-6789

15. CURRENT SPOUSE'S PREVIOUS MARITAL INFORMATION
(If no prior marriages, this section may be left blank)

15A. (1) TO WHOM MARRIED *(First, Middle Initial, Last Name)*

15A. (2) DATE AND PLACE OF MARRIAGE *(MM-DD-YYYY)* – –
City or County State/Province Country

15A. (3) REASON FOR TERMINATION
○ Death ○ Divorce ○ Annulment ○ Other (Explain):

15A. (4) DATE AND PLACE MARRIAGE TERMINATED *(MM-DD-YYYY)* – –
City or County State/Province Country

15B. (1) TO WHOM MARRIED *(First, Middle Initial, Last Name)*

15B. (2) DATE AND PLACE OF MARRIAGE *(MM-DD-YYYY)* – –
City or County State/Province Country

15B. (3) REASON FOR TERMINATION
○ Death ○ Divorce ○ Annulment ○ Other (Explain):

15B. (4) DATE AND PLACE MARRIAGE TERMINATED *(MM-DD-YYYY)* – –
City or County State/Province Country

15C. (1) TO WHOM MARRIED *(First, Middle Initial, Last Name)*

15C. (2) DATE AND PLACE OF MARRIAGE *(MM-DD-YYYY)* – –
City or County State/Province Country

15C. (3) REASON FOR TERMINATION
○ Death ○ Divorce ○ Annulment ○ Other (Explain):

15C. (4) DATE AND PLACE MARRIAGE TERMINATED *(MM-DD-YYYY)* – –
City or County State/Province Country

15D. (1) TO WHOM MARRIED *(First, Middle Initial, Last Name)*

15D. (2) DATE AND PLACE OF MARRIAGE *(MM-DD-YYYY)* – –
City or County State/Province Country

15D. (3) REASON FOR TERMINATION
○ Death ○ Divorce ○ Annulment ○ Other (Explain):

15D. (4) DATE AND PLACE MARRIAGE TERMINATED *(MM-DD-YYYY)* – –
City or County State/Province Country

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VETERAN'S SOCIAL SECURITY NO. 123-45-6789

SECTION III: INFORMATION NEEDED TO ADD CHILD(REN)
(If claiming more than four children, fill out addendum (Page 15) and submit with application)

16A. NAME OF **FIRST** CHILD TO ADD *(First, Middle Initial, Last)*
Billy Smith

16B. SOCIAL SECURITY NUMBER
123 – –

16C. DATE OF BIRTH *(MM-DD-YYYY)*
01 – 01 – 1921

16D. PLACE OF BIRTH *(Provide City and State, County and State, or City and Country)*
City or County Happy Town State/Province MI Country

16E. IF THE CHILD DOES NOT LIVE WITH THE CLAIMANT PROVIDE NAME OF PERSON THE CHILD RESIDES WITH

16F. IF THE CHILD DOES NOT LIVE WITH THE CLAIMANT, PROVIDE COMPLETE PHYSICAL ADDRESS WHERE CHILD RESIDES
No. & Street
Apt./Unit Number City
State/Province Country ZIP Code/Postal Code –

16G. CHILD STATUS *(Check all that apply)*
● BIOLOGICAL ○ 18-23 YEARS OLD AND IN SCHOOL *(If checked, fill out VA Form 21-674)* ○ ADOPTED ○ CHILD PERMANENTLY INCAPABLE OF SELF-SUPPORT
○ CHILD PREVIOUSLY MARRIED *(If checked, provide the date marriage ended and how the marriage ended in Item 16H)* ○ STEPCHILD *(If checked, complete Item 16I)*

16H. HOW AND WHEN MARRIAGE ENDED
DATE *(MM-DD-YYYY)* – –
○ DIVORCE ○ OTHER *(Explain)*
○ ANNULLED

16I. IF YOU CHECKED "STEPCHILD" IN ITEM 16G, IS STEPCHILD THE BIOLOGICAL CHILD OF YOUR SPOUSE?
○ YES *(If "Yes," provide the date the child entered veteran's household)* DATE *(MM-DD-YYYY)* – –
○ NO

17A. NAME OF **SECOND** CHILD TO ADD *(First, Middle Initial, Last)*

17B. SOCIAL SECURITY NUMBER – –

17C. DATE OF BIRTH *(MM-DD-YYYY)* – –

17D. PLACE OF BIRTH *(Provide City and State, County and State, or City and Country)*
City or County State/Province Country

17E. IF THE CHILD DOES NOT LIVE WITH THE CLAIMANT PROVIDE NAME OF PERSON THE CHILD RESIDES WITH

17F. IF THE CHILD DOES NOT LIVE WITH THE CLAIMANT, PROVIDE COMPLETE PHYSICAL ADDRESS WHERE CHILD RESIDES
No. & Street
Apt./Unit Number City
State/Province Country ZIP Code/Postal Code –

17G. CHILD STATUS *(Check all that apply)*
○ BIOLOGICAL ○ 18-23 YEARS OLD AND IN SCHOOL *(If checked, fill out VA Form 21-674)* ○ ADOPTED ○ CHILD PERMANENTLY INCAPABLE OF SELF-SUPPORT
○ CHILD PREVIOUSLY MARRIED *(If checked, provide the date marriage ended and how the marriage ended in Item 17H)* ○ STEPCHILD *(If checked, complete Item 17I)*

17H. HOW AND WHEN MARRIAGE ENDED
DATE *(MM-DD-YYYY)* – –
○ DIVORCE ○ OTHER *(Explain)*
○ ANNULLED

17I. IF YOU CHECKED "STEPCHILD" IN ITEM 17G, IS STEPCHILD THE BIOLOGICAL CHILD OF YOUR SPOUSE?
○ YES *(If "Yes," provide the date the child entered veteran's household)* DATE *(MM-DD-YYYY)* – –
○ NO

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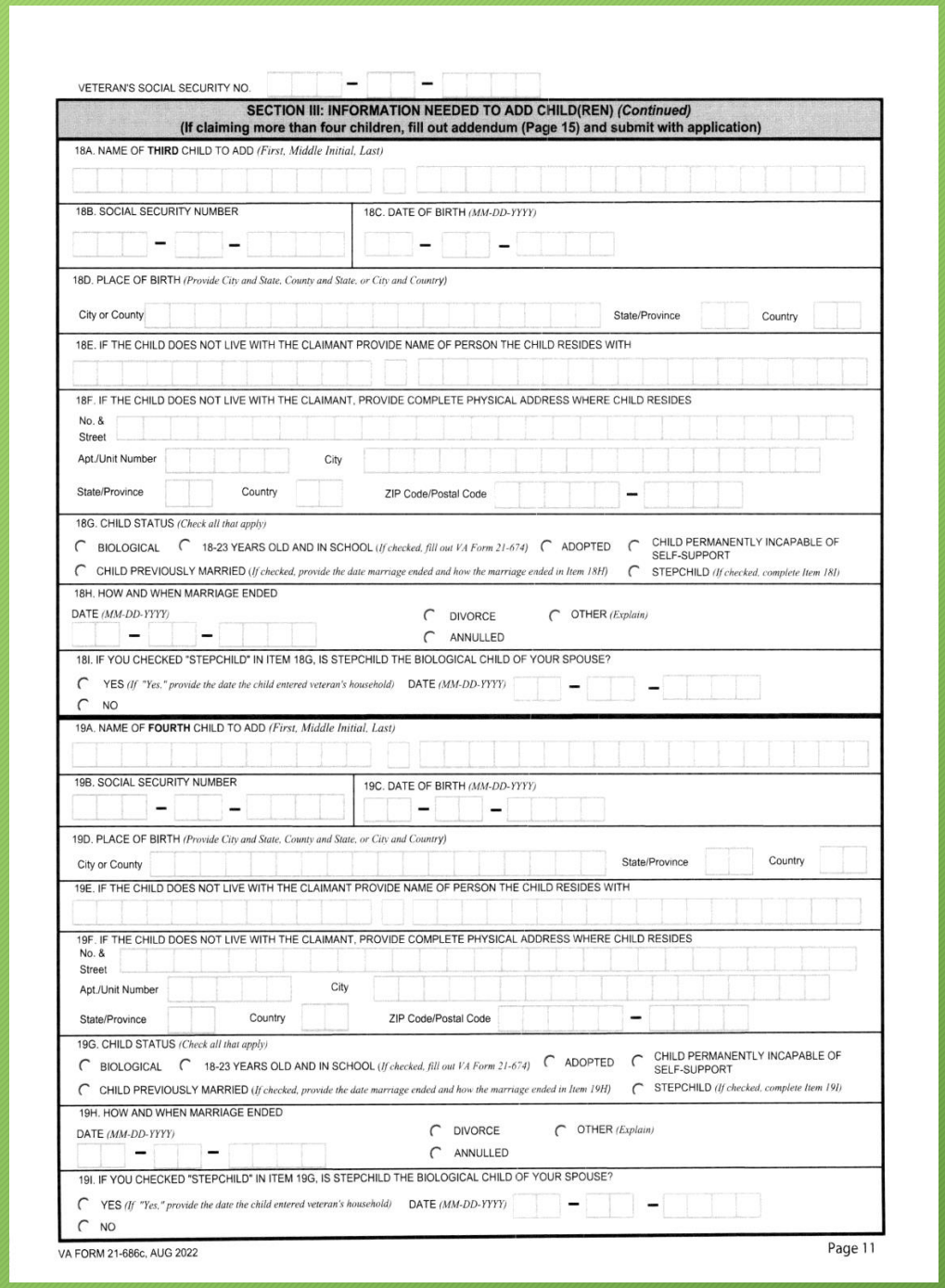
VA FORM 21-686c

APPLICTION REQUEST TO ADD AND/OR REMOVE DEPENDENTS



VETERAN'S SOCIAL SECURITY NO. – –

SECTION III: INFORMATION NEEDED TO ADD CHILD(REN) *(Continued)*
(If claiming more than four children, fill out addendum (Page 15) and submit with application)

18A. NAME OF **THIRD** CHILD TO ADD *(First, Middle Initial, Last)*

18B. SOCIAL SECURITY NUMBER – –

18C. DATE OF BIRTH *(MM-DD-YYYY)* – –

18D. PLACE OF BIRTH *(Provide City and State, County and State, or City and Country)*
City or County State/Province Country

18E. IF THE CHILD DOES NOT LIVE WITH THE CLAIMANT PROVIDE NAME OF PERSON THE CHILD RESIDES WITH

18F. IF THE CHILD DOES NOT LIVE WITH THE CLAIMANT, PROVIDE COMPLETE PHYSICAL ADDRESS WHERE CHILD RESIDES
No. & Street
Apt./Unit Number City
State/Province Country ZIP Code/Postal Code –

18G. CHILD STATUS *(Check all that apply)*
○ BIOLOGICAL ○ 18-23 YEARS OLD AND IN SCHOOL *(If checked, fill out VA Form 21-674)* ○ ADOPTED ○ CHILD PERMANENTLY INCAPABLE OF SELF-SUPPORT
○ CHILD PREVIOUSLY MARRIED *(If checked, provide the date marriage ended and how the marriage ended in Item 18H)* ○ STEPCHILD *(If checked, complete Item 18I)*

18H. HOW AND WHEN MARRIAGE ENDED
DATE *(MM-DD-YYYY)* – – ○ DIVORCE ○ OTHER *(Explain)* ○ ANNULLED

18I. IF YOU CHECKED "STEPCHILD" IN ITEM 18G, IS STEPCHILD THE BIOLOGICAL CHILD OF YOUR SPOUSE?
○ YES *(If "Yes," provide the date the child entered veteran's household)* DATE *(MM-DD-YYYY)* – –
○ NO

19A. NAME OF **FOURTH** CHILD TO ADD *(First, Middle Initial, Last)*

19B. SOCIAL SECURITY NUMBER – –

19C. DATE OF BIRTH *(MM-DD-YYYY)* – –

19D. PLACE OF BIRTH *(Provide City and State, County and State, or City and Country)*
City or County State/Province Country

19E. IF THE CHILD DOES NOT LIVE WITH THE CLAIMANT PROVIDE NAME OF PERSON THE CHILD RESIDES WITH

19F. IF THE CHILD DOES NOT LIVE WITH THE CLAIMANT, PROVIDE COMPLETE PHYSICAL ADDRESS WHERE CHILD RESIDES
No. & Street
Apt./Unit Number City
State/Province Country ZIP Code/Postal Code –

19G. CHILD STATUS *(Check all that apply)*
○ BIOLOGICAL ○ 18-23 YEARS OLD AND IN SCHOOL *(If checked, fill out VA Form 21-674)* ○ ADOPTED ○ CHILD PERMANENTLY INCAPABLE OF SELF-SUPPORT
○ CHILD PREVIOUSLY MARRIED *(If checked, provide the date marriage ended and how the marriage ended in Item 19H)* ○ STEPCHILD *(If checked, complete Item 19I)*

19H. HOW AND WHEN MARRIAGE ENDED
DATE *(MM-DD-YYYY)* – – ○ DIVORCE ○ OTHER *(Explain)* ○ ANNULLED

19I. IF YOU CHECKED "STEPCHILD" IN ITEM 19G, IS STEPCHILD THE BIOLOGICAL CHILD OF YOUR SPOUSE?
○ YES *(If "Yes," provide the date the child entered veteran's household)* DATE *(MM-DD-YYYY)* – –
○ NO

VETERAN'S SOCIAL SECURITY NO. – –

SECTION IV: VETERAN REPORTING DIVORCE FROM FORMER SPOUSE
(If you have stepchild(ren), also complete Section V)

NOTE: If marriage ended as an annulment or declared void, use Section IX, Item 25, "Remarks" to explain.

20A. NAME OF FORMER SPOUSE *(First, Middle Initial, Last)*

20B. PLACE OF DIVORCE *(Provide city and state, county and state, or city and country)*
City or County State/Province Country

20C. DATE OF DIVORCE – –

SECTION V: VETERAN/CLAIMANT REPORTING ON STEPCHILD(REN)

21A. (1) DID YOU HAVE A STEPCHILD(REN) THAT WAS THE BIOLOGICAL OR ADOPTED CHILD(REN) OF THE FORMER SPOUSE LISTED IN ITEM 20A?
○ YES *(If "YES," list the name(s) of the stepchild(ren) here)*:
○ NO *(If "NO," skip to Section VI)*

21A. (2) NAME(S) OF STEPCHILD(REN) *(First, Middle Initial, Last)*

21B. ARE YOU STILL SUPPORTING YOUR STEPCHILD(REN) LISTED IN ITEM 21A?
○ YES *(If "YES," complete Items 21C through 21L)*
○ NO *(If "NO," complete Item 21F and then continue to Section VI)*

21C. NAME OF STEPCHILD YOU ARE SUPPORTING

21D. IF STEPCHILD DOES NOT LIVE WITH YOU, PROVIDE THE NAME OF PERSON WITH WHOM STEPCHILD RESIDES

21E. IF STEPCHILD DOES NOT LIVE WITH YOU, PROVIDE A COMPLETE ADDRESS
No. & Street
Apt./Unit Number City
State/Province Country ZIP Code/Postal Code –

21F. DATE STEPCHILD LEFT VETERAN'S HOUSEHOLD *(MM-DD-YYYY)* – –

21G. FINANCIAL SUPPORT PROVIDED ○ More than half ○ Half ○ Less than half

21H. NAME OF STEPCHILD YOU ARE SUPPORTING

21I. IF STEPCHILD DOES NOT LIVE WITH YOU, PROVIDE THE NAME OF PERSON WITH WHOM STEPCHILD RESIDES

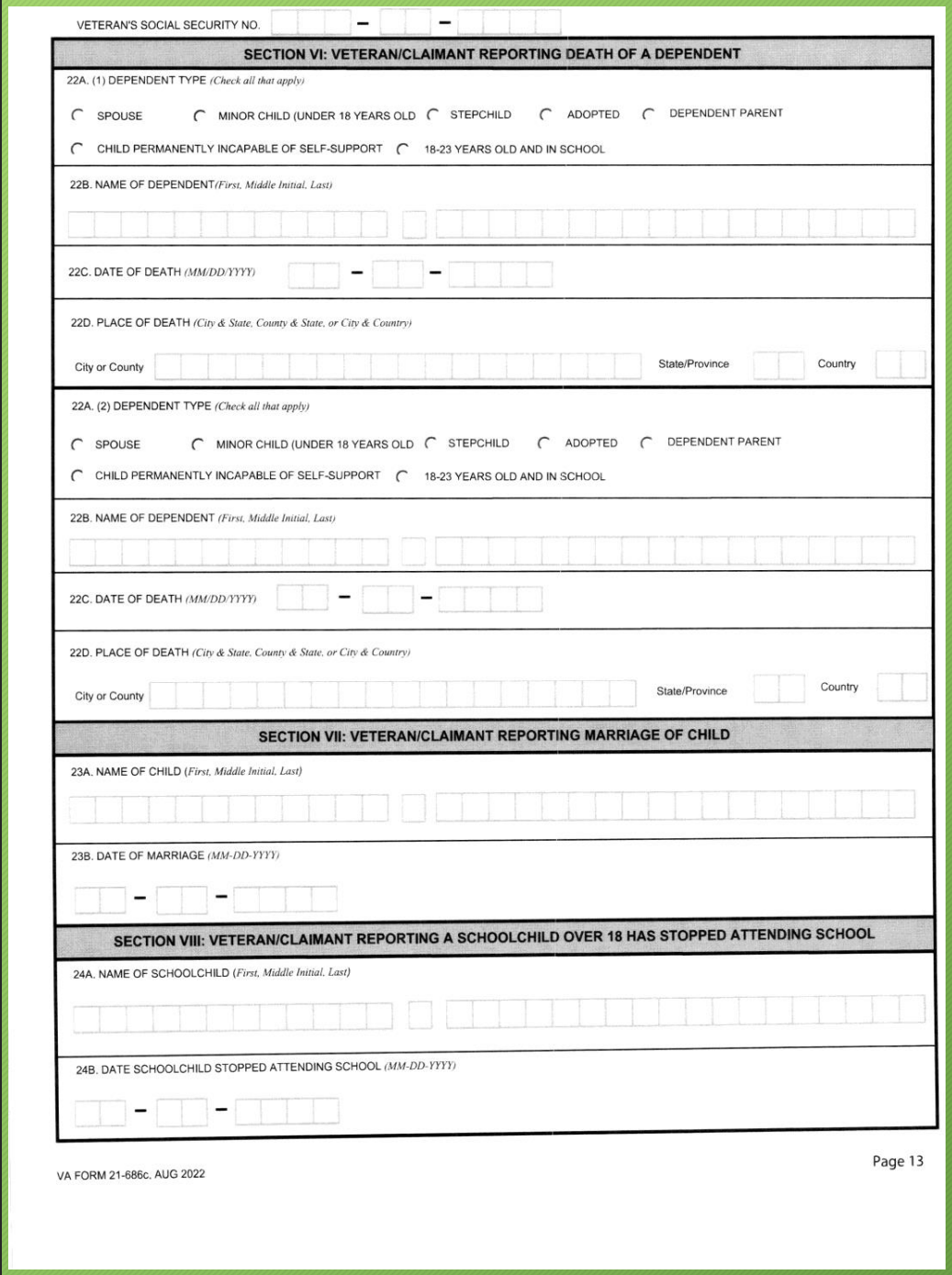
21J. IF STEPCHILD DOES NOT LIVE WITH YOU, PROVIDE A COMPLETE ADDRESS
No. & Street
Apt./Unit Number City
State/Province Country ZIP Code/Postal Code –

21K. DATE STEPCHILD LEFT VETERAN'S HOUSEHOLD *(MM-DD-YYYY)* – –

21L. FINANCIAL SUPPORT PROVIDED ○ More than half ○ Half ○ Less than half

VA FORM 21-686c

APPLICTION REQUEST TO ADD AND/OR REMOVE DEPENDENTS



VETERAN'S SOCIAL SECURITY NO. ___ – ___ – ____

SECTION VI: VETERAN/CLAIMANT REPORTING DEATH OF A DEPENDENT

22A. (1) DEPENDENT TYPE *(Check all that apply)*

○ SPOUSE ○ MINOR CHILD (UNDER 18 YEARS OLD ○ STEPCHILD ○ ADOPTED ○ DEPENDENT PARENT

○ CHILD PERMANENTLY INCAPABLE OF SELF-SUPPORT ○ 18-23 YEARS OLD AND IN SCHOOL

22B. NAME OF DEPENDENT *(First, Middle Initial, Last)*

22C. DATE OF DEATH *(MM/DD/YYYY)* ___ – ___ – ____

22D. PLACE OF DEATH *(City & State, County & State, or City & Country)*

City or County State/Province Country

22A. (2) DEPENDENT TYPE *(Check all that apply)*

○ SPOUSE ○ MINOR CHILD (UNDER 18 YEARS OLD ○ STEPCHILD ○ ADOPTED ○ DEPENDENT PARENT

○ CHILD PERMANENTLY INCAPABLE OF SELF-SUPPORT ○ 18-23 YEARS OLD AND IN SCHOOL

22B. NAME OF DEPENDENT *(First, Middle Initial, Last)*

22C. DATE OF DEATH *(MM/DD/YYYY)* ___ – ___ – ____

22D. PLACE OF DEATH *(City & State, County & State, or City & Country)*

City or County State/Province Country

SECTION VII: VETERAN/CLAIMANT REPORTING MARRIAGE OF CHILD

23A. NAME OF CHILD *(First, Middle Initial, Last)*

23B. DATE OF MARRIAGE *(MM-DD-YYYY)* ___ – ___ – ____

SECTION VIII: VETERAN/CLAIMANT REPORTING A SCHOOLCHILD OVER 18 HAS STOPPED ATTENDING SCHOOL

24A. NAME OF SCHOOLCHILD *(First, Middle Initial, Last)*

24B. DATE SCHOOLCHILD STOPPED ATTENDING SCHOOL *(MM-DD-YYYY)* ___ – ___ – ____

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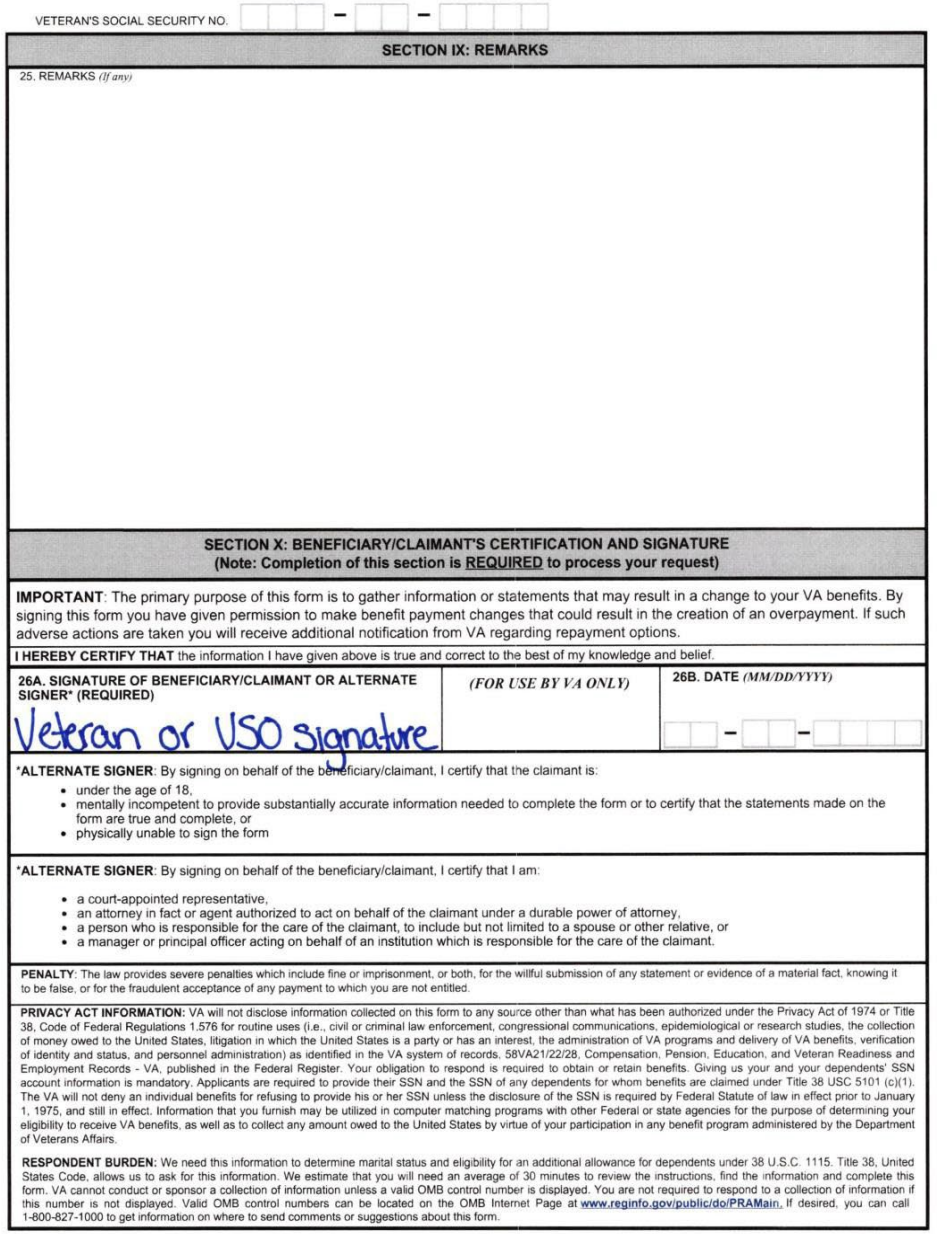

VETERAN'S SOCIAL SECURITY NO. ___ – ___ – ____

SECTION IX: REMARKS

25. REMARKS *(If any)*

SECTION X: BENEFICIARY/CLAIMANT'S CERTIFICATION AND SIGNATURE
(Note: Completion of this section is REQUIRED to process your request)

IMPORTANT: The primary purpose of this form is to gather information or statements that may result in a change to your VA benefits. By signing this form you have given permission to make benefit payment changes that could result in the creation of an overpayment. If such adverse actions are taken you will receive additional notification from VA regarding repayment options.

I HEREBY CERTIFY THAT the information I have given above is true and correct to the best of my knowledge and belief.

26A. SIGNATURE OF BENEFICIARY/CLAIMANT OR ALTERNATE SIGNER* (REQUIRED)	*(FOR USE BY VA ONLY)*	26B. DATE *(MM/DD/YYYY)*
Veteran or VSO signature		___ – ___ – ____

***ALTERNATE SIGNER**: By signing on behalf of the beneficiary/claimant, I certify that the claimant is:

- under the age of 18,
- mentally incompetent to provide substantially accurate information needed to complete the form or to certify that the statements made on the form are true and complete, or
- physically unable to sign the form

***ALTERNATE SIGNER**: By signing on behalf of the beneficiary/claimant, I certify that I am:

- a court-appointed representative,
- an attorney in fact or agent authorized to act on behalf of the claimant under a durable power of attorney,
- a person who is responsible for the care of the claimant, to include but not limited to a spouse or other relative, or
- a manager or principal officer acting on behalf of an institution which is responsible for the care of the claimant.

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false, or for the fraudulent acceptance of any payment to which you are not entitled.

PRIVACY ACT INFORMATION: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Veteran Readiness and Employment Records - VA, published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. Giving us your and your dependents' SSN account information is mandatory. Applicants are required to provide their SSN and the SSN of any dependents for whom benefits are claimed under Title 38 USC 5101 (c)(1). The VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by Federal Statute of law in effect prior to January 1, 1975, and still in effect. Information that you furnish may be utilized in computer matching programs with other Federal or state agencies for the purpose of determining your eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of your participation in any benefit program administered by the Department of Veterans Affairs.

RESPONDENT BURDEN: We need this information to determine marital status and eligibility for an additional allowance for dependents under 38 U.S.C. 1115. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 30 minutes to review the instructions, find the information and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

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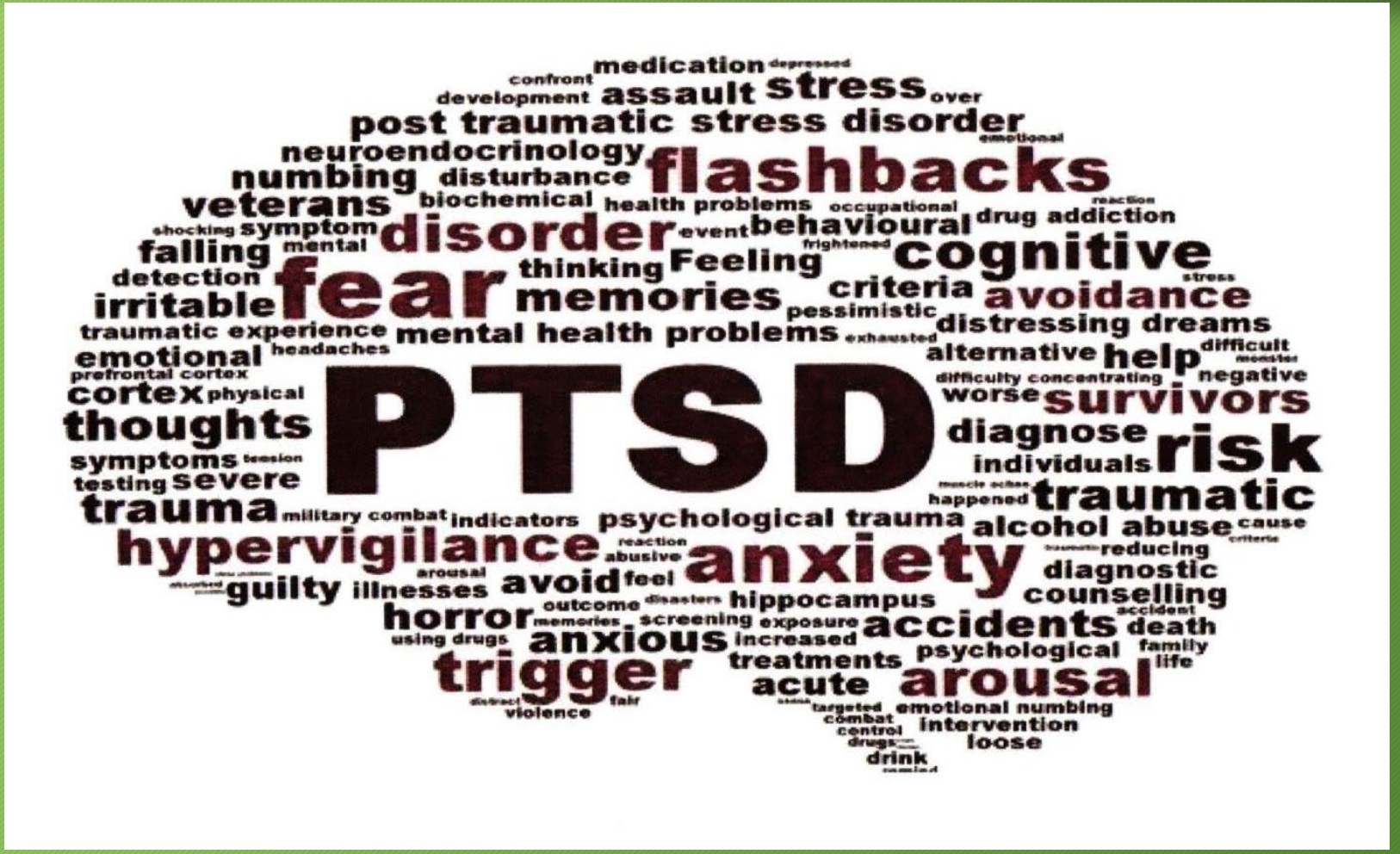
POST TRAUMATIC STRESS DISORDER



VA FORM 21-01781

STATEMENT IN SUPPORT OF CLAIM FOR SERVICE CONNECTION FOR POST-TRAUMATIC STRESS DISORDER

20

OMB Approved No. 2900-0659
Respondent Burden: 1 hour 10 minutes
Expiration Date: 06/30/2024

Department of Veterans Affairs

VA DATE STAMP
DO NOT WRITE IN THIS SPACE

STATEMENT IN SUPPORT OF CLAIM FOR SERVICE CONNECTION FOR POST-TRAUMATIC STRESS DISORDER (PTSD)

IMPORTANT: If you or someone you know is in crisis, call the Veterans Crisis Line at 1-800-273-8255 and press 1, or visit https://www.veteranscrisisline.net/ to chat online, or send a text message to **838255** to receive confidential support 24 hours a day, 7 days a week, 365 days a year. Support for deaf and hard of hearing individuals is available.

INSTRUCTIONS: List the stressful incident or incidents that occurred in service that you feel contributed to your current condition. For each incident, provide a description of what happened, the date, the geographic location, your unit assignment and dates of assignment, and the full names and unit assignments of you know of who were killed or injured during the incident. Please provide dates within at least a 60-day range and do not use nicknames. It is important that you complete the form in detail and be as specific as possible so that research of military records can be thoroughly conducted. For more information you can contact VA online through Ask VA: https://ask.va.gov/ or call us toll-free at 800-827-1000 (TTY: 711). VA forms are available at www.va.gov/vaforms. After completing the form, mail to: **Department of Veterans Affairs, Evidence Intake Center, P.O. Box 4444, Janesville, WI 53547-4444.**

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

NOTE: You can *either* complete the form online or by hand. Please print the information requested in ink, neatly and legibly to help process the form.

1. VETERAN NAME *(First, Middle Initial, Last)*: Joe Smith

2. SOCIAL SECURITY NUMBER: 123-45-6798

3. VA FILE NUMBER *(If applicable)*: 123456789

4. DATE OF BIRTH *(MM/DD/YYYY)*: Month 01 – Day 01 – Year 1900

5. VETERAN'S SERVICE NUMBER *(If applicable)*: 123456789

6. TELEPHONE NUMBER *(Include Area Code)*: 1234567890
Enter International Phone Number *(If applicable)*:

7. E-MAIL ADDRESS *(Optional)*: none

SECTION II: STRESSFUL INCIDENTS

8A. DATE ***FIRST*** INCIDENT OCCURRED *(MM/DD/YYYY)*: Month 01 – Day 01 – Year 1900

8B. DATES OF UNIT ASSIGNMENT *(MM/DD/YYYY)*: FROM: Month 01 – Day 01 – Year 1900 TO: Month 01 – Day 01 – Year 1901

8C. LOCATION OF INCIDENT *(City, State, Country, Province, landmark or military installation)*: rocky mountains

8D. UNIT ASSIGNMENT DURING INCIDENT *(Such as, DIVISION, WING, BATTALION, CAVALRY, SHIP)*: 123 Unit Hiker

8E. DESCRIPTION OF THE INCIDENT: while on patrol was ambushed.....

8F. MEDALS OR CITATIONS YOU RECEIVED BECAUSE OF THE INCIDENT: combat badge

VETERAN'S SOCIAL SECURITY NO.: – –

SECTION II: STRESSFUL INCIDENTS *(Continued)*

NOTE: Information about persons who were killed or injured during the first incident *(attach a separate sheet if more space is needed.)*

9A. NAME OF PERSON *(First, Middle Initial, Last)*: Micky Olson

9B. RANK *(If applicable)*:

9C. DATE OF INJURY/DEATH *(MM/DD/YYYY)*: Month – Day – Year

9D. PLEASE CHECK ONE: ☐ KILLED IN ACTION ☒ WOUNDED IN ACTION ☐ KILLED NON-BATTLE ☐ INJURED NON-BATTLE ☐ OTHER:

9E. UNIT ASSIGNMENT DURING INCIDENT *(Such as, DIVISION, WING, BATTALION, CAVALRY, SHIP)*: 123 Unit Hiker

10A. NAME OF PERSON *(First, Middle Initial, Last)*:

10B. RANK *(If applicable)*:

10C. DATE OF INJURY/DEATH *(MM/DD/YYYY)*: Month – Day – Year

10D. PLEASE CHECK ONE: ☐ KILLED IN ACTION ☐ WOUNDED IN ACTION ☐ KILLED NON-BATTLE ☐ INJURED NON-BATTLE ☐ OTHER:

10E. UNIT ASSIGNMENT DURING INCIDENT *(Such as, DIVISION, WING, BATTALION, CAVALRY, SHIP)*:

11A. DATE ***SECOND*** INCIDENT OCCURRED *(MM/DD/YYYY)*: Month – Day – Year

11B. DATES OF UNIT ASSIGNMENT *(MM/DD/YYYY)*: FROM: Month – Day – Year TO: Month – Day – Year

11C. LOCATION OF INCIDENT *(City, State, Country, Province, landmark or military installation)*:

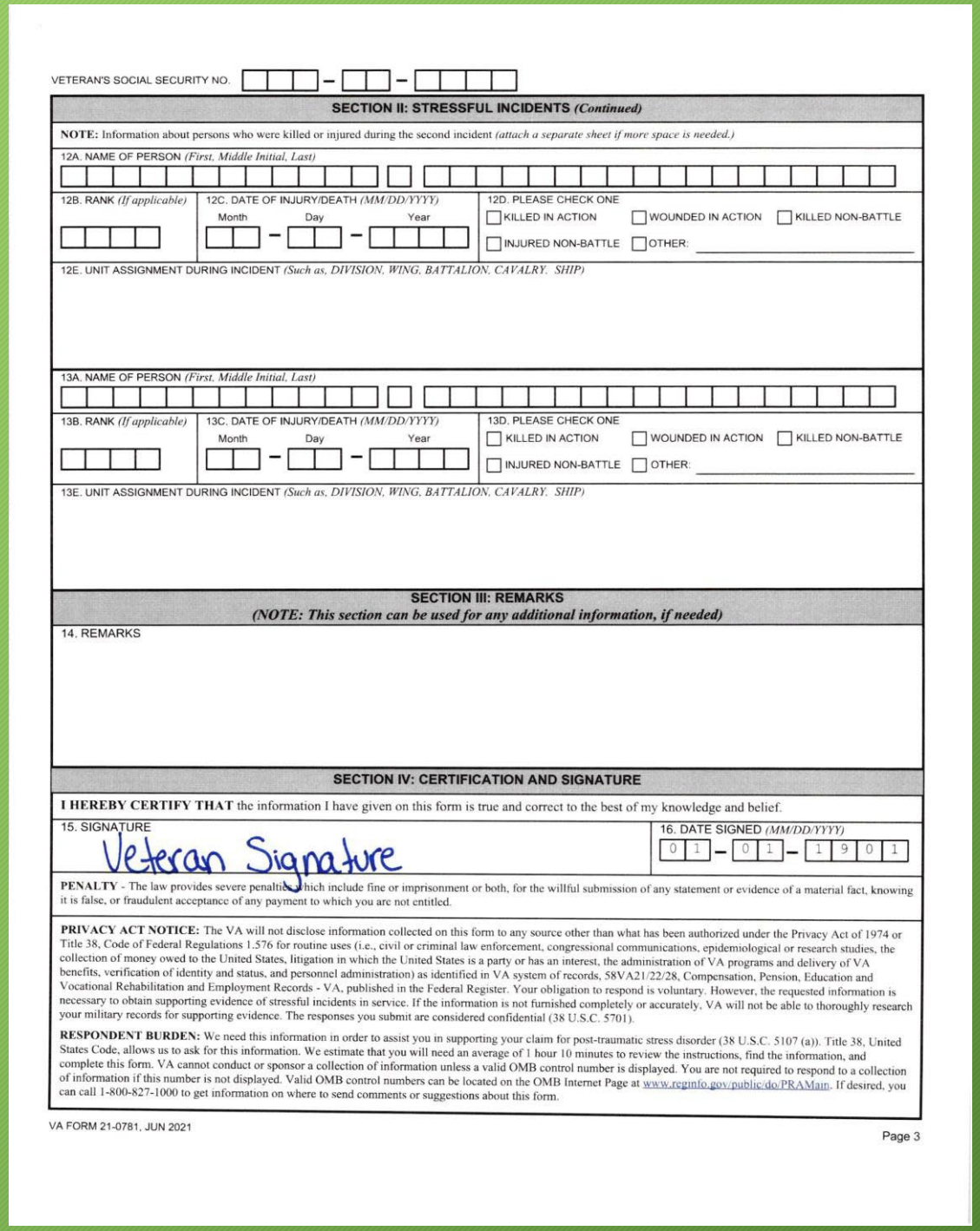
11D. UNIT ASSIGNMENT DURING INCIDENT *(Such as, DIVISION, WING, BATTALION, CAVALRY, SHIP)*:

11E. DESCRIPTION OF THE INCIDENT:

11F. MEDALS OR CITATIONS YOU RECEIVED BECAUSE OF THE INCIDENT:

VA FORM 21-0781

STATEMENT IN SUPPORT OF CLAIM FOR SERVICE CONNECTION FOR POST-TRAUMATIC STRESS DISORDER



VETERAN'S SOCIAL SECURITY NO. ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION II: STRESSFUL INCIDENTS *(Continued)*

NOTE: Information about persons who were killed or injured during the second incident *(attach a separate sheet if more space is needed.)*

12A. NAME OF PERSON *(First, Middle Initial, Last)*

12B. RANK *(If applicable)*	12C. DATE OF INJURY/DEATH *(MM/DD/YYYY)* Month – Day – Year	12D. PLEASE CHECK ONE
		☐ KILLED IN ACTION ☐ WOUNDED IN ACTION ☐ KILLED NON-BATTLE ☐ INJURED NON-BATTLE ☐ OTHER:

12E. UNIT ASSIGNMENT DURING INCIDENT *(Such as, DIVISION, WING, BATTALION, CAVALRY, SHIP)*

13A. NAME OF PERSON *(First, Middle Initial, Last)*

13B. RANK *(If applicable)*	13C. DATE OF INJURY/DEATH *(MM/DD/YYYY)* Month – Day – Year	13D. PLEASE CHECK ONE
		☐ KILLED IN ACTION ☐ WOUNDED IN ACTION ☐ KILLED NON-BATTLE ☐ INJURED NON-BATTLE ☐ OTHER:

13E. UNIT ASSIGNMENT DURING INCIDENT *(Such as, DIVISION, WING, BATTALION, CAVALRY, SHIP)*

SECTION III: REMARKS
(NOTE: This section can be used for any additional information, if needed)

14. REMARKS

SECTION IV: CERTIFICATION AND SIGNATURE

I HEREBY CERTIFY THAT the information I have given on this form is true and correct to the best of my knowledge and belief.

15. SIGNATURE	16. DATE SIGNED *(MM/DD/YYYY)*
Veteran Signature	01 – 01 – 1901

PENALTY - The law provides severe penalties which include fine or imprisonment or both, for the willful submission of any statement or evidence of a material fact, knowing it is false, or fraudulent acceptance of any payment to which you are not entitled.

PRIVACY ACT NOTICE: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in VA system of records, 58VA21/22/28, Compensation, Pension, Education and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary. However, the requested information is necessary to obtain supporting evidence of stressful incidents in service. If the information is not furnished completely or accurately, VA will not be able to thoroughly research your military records for supporting evidence. The responses you submit are considered confidential (38 U.S.C. 5701).

RESPONDENT BURDEN: We need this information in order to assist you in supporting your claim for post-traumatic stress disorder (38 U.S.C. 5107 (a)). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 1 hour 10 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

VA FORM 21-0781, JUN 2021

Page 3

VA FORM 21-0781A

STATEMENT IN SUPPORT OF CLAIM FOR SERVICE CONNECTION FOR POST-TRAUMATIC STRESS DISORDER SECONDARY TO PERSONAL ASSAULT

22

OMB Approved No. 2900-0659
Respondent Burden: 1 hour and 10 minutes
Expiration Date: 06/30/2024

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

STATEMENT IN SUPPORT OF CLAIM FOR SERVICE CONNECTION FOR POST-TRAUMATIC STRESS DISORDER (PTSD) SECONDARY TO PERSONAL ASSAULT

IMPORTANT: If you or someone you know is in crisis, call the Veterans Crisis Line at 988 and then press 1, or visit https://www.veteranscrisisline.net/ to chat online, or send a text message to **838255** to receive confidential support 24 hours a day, 7 days a week, 365 days a year. Support for deaf and hard of hearing individuals is available.

INSTRUCTIONS: List the stressful incident or incidents that occurred in service that you feel contributed to your current condition. For each incident, provide a description of what happened, the date, the geographic location, your unit assignment and dates of assignment. Please complete the form in detail and be as specific as possible so that research of military records can be thoroughly conducted. For more information, you can contact VA online through Ask VA: https://ask.va.gov/ or call us toll-free at 800-827-1000 (TTY: 711). VA forms are available at www.va.gov/vaforms After completing the form, mail to: **Department of Veterans Affairs, Evidence Intake Center, P.O. Box 4444, Janesville, WI 53547-4444.**

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

NOTE: You may complete the form online or by hand. If completed by hand, print the information requested in ink, neatly and legibly and insert one letter per box to help expedite processing of the form.

1. VETERAN'S NAME *(First, Middle Initial, Last)*: Joe Smith

2. SOCIAL SECURITY NUMBER: 123-45-6789

3. VA FILE NUMBER *(If applicable)*: 123456789

4. DATE OF BIRTH *(MM-DD-YYYY)*: 01-01-1900

5. VETERAN'S SERVICE NUMBER *(If applicable)*: 123456789

6. TELEPHONE NUMBER *(Include Area Code)*: 123-456-7890

Enter International Phone Number *(If applicable)*:

7. E-MAIL ADDRESS *(Optional)*: none

SECTION II: STRESSFUL INCIDENT(S)

8A. DATE ***FIRST*** INCIDENT OCCURRED *(MM-DD-YYYY)*: 01-01-1900

8B. DATES OF UNIT ASSIGNMENT *(MM-DD-YYYY)*: FROM: 01-01-1900 TO: 01-01-1901

8C. LOCATION OF INCIDENT *(City, State, Country, Province, landmark or military installation)*: Happy Town, MI

8D. UNIT ASSIGNMENT DURING INCIDENT *(Such as, DIVISION, WING, BATTALION, CAVALRY, SHIP)*: 123456 Shoot'em up Troop

8E. DESCRIPTION OF THE INCIDENT: was assaulted by a person while in my barracks.....

SECTION II: STRESSFUL INCIDENT(S) *(Continued)*

8E. DESCRIPTION OF INCIDENT (Continued)

9. OTHER SOURCES OF INFORMATION: Identify any other sources (military or non-military) that may provide information concerning the incident in Items 9A through 9F. If you reported the incident to military or civilian authorities or sought help from a rape crisis center, counseling facility, or health clinic, etc., please provide the names and addresses and we will assist you in getting the information. If the source provided treatment and you would like us to obtain the treatment records, complete and sign VA Form 21-4142, *Authorization and Consent to Release Information to the Department of Veterans Affairs (VA)* and VA Form 21-4142a, *General Release for Medical Provider Information to the Department of Veterans Affairs (VA)*, and fill in each provider. If you confided in roommates, family members, chaplains, clergy, or fellow service persons, you may want to ask them for a statement concerning their knowledge of the incident. Use VA Form 21-10210, *Lay/Witness Statement*, to provide these statements to the VA. These statements will help us in deciding your claim. Other sources of information also include personal diaries or journals. VA forms are available at www.va.gov/vaforms.

9A. NAME (First, Middle Initial, Last): Micky Olson

9B. MAILING ADDRESS (*Number and street or rural route, P. O. Box, City, State, ZIP Code and Country*)

No. & Street: 123 Olson Street

Apt./Unit Number: City: Happy Town

State/Province: MI Country: ZIP Code/Postal Code: 12345 –

9C. NAME (First, Middle Initial, Last):

9D. MAILING ADDRESS (*Number and street or rural route, P. O. Box, City, State, ZIP Code and Country*)

No. & Street:

Apt./Unit Number: City:

State/Province: Country: ZIP Code/Postal Code: –

9E. NAME (First, Middle Initial, Last):

9F. MAILING ADDRESS (*Number and street or rural route, P. O. Box, City, State, ZIP Code and Country*)

No. & Street:

Apt./Unit Number: City:

State/Province: Country: ZIP Code/Postal Code: –

VA FORM 21-0781A

STATEMENT IN SUPPORT OF CLAIM FOR SERVICE CONNECTION FOR POST-TRAUMATIC STRESS DISORDER SECONDARY TO PERSONAL ASSAULT

23

VETERAN'S SOCIAL SECURITY NO. ___ – ___ – ____

SECTION II: STRESSFUL INCIDENT(S) *(Continued)*

10. Please provide in the space below any other information that you feel is important for us to know that may help your claim. The following are some examples of behavioral changes that you may have experienced following the incident(s):

- visits to a medical or counseling clinic or dispensary without a specific diagnosis or specific ailment
- sudden requests for a change in occupational series or duty assignment
- increased use of leave without an apparent reason
- changes in performance and performance evaluations
- episodes of depression, panic attacks, or anxiety without an identifiable cause
- increased or decreased use of prescription medications
- increased use of over-the-counter medications
- substance abuse such as alcohol or drugs
- increased disregard for military or civilian authority
- obsessive behavior such as overeating or under eating
- pregnancy tests around the time of the incident
- tests for HIV or sexually transmitted diseases
- unexplained economic or social behavior changes
- breakup of a primary relationship

SECTION III: CERTIFICATION AND SIGNATURE

I HEREBY CERTIFY THAT the foregoing statement(s) are true and correct to the best of my knowledge and belief.

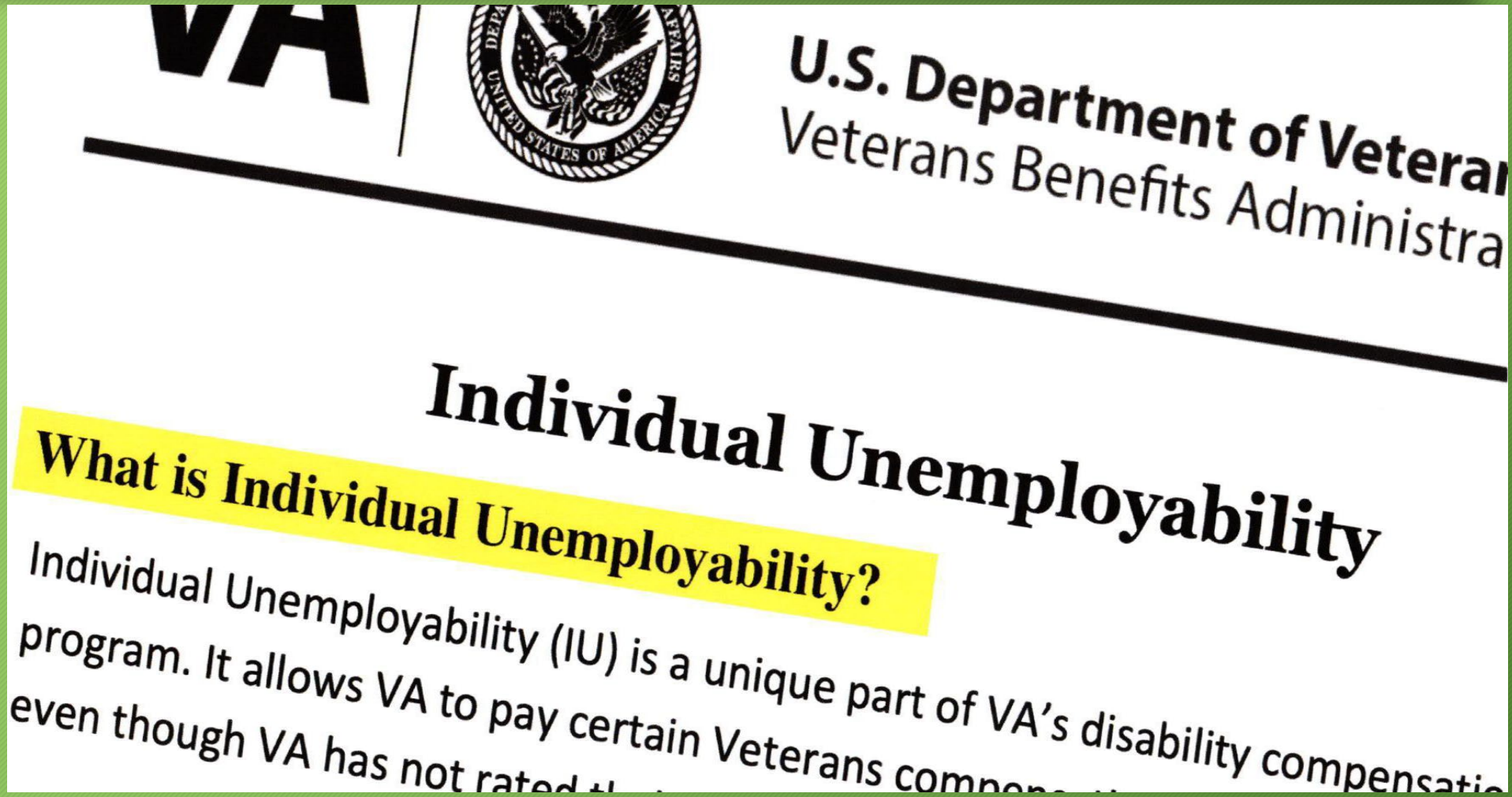
11. VETERAN'S SIGNATURE **(REQUIRED)**	12. DATE SIGNED *(MM-DD-YYYY)*
Veteran Sign	01 – 01 – 1900

PENALTY - The law provides severe penalties which include fine or imprisonment or both, for the willful submission of any statement or evidence of a material fact, knowing it is false, or fraudulent acceptance of any payment to which you are not entitled.

PRIVACY ACT NOTICE: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in VA system of records, 58VA21/22/28, Compensation, Pension, Education and Veteran Readiness and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary. However, the requested information is necessary to obtain supporting evidence of stressful incidents in service. If the information is not furnished completely or accurately, VA will not be able to thoroughly research your military records and other sources for supporting evidence. The responses you submit are considered confidential (38 U.S.C. 5701).

RESPONDENT BURDEN: We need this information in order to assist you in supporting your claim for post-traumatic stress disorder (38 U.S.C. 5107 (a)). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 1 hour and 10 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at **www.reginfo.gov/public/do/PRAMain**. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

INDIVIDUAL UNEMPLOYABILITY



VA

U.S. Department of Veterar
Veterans Benefits Administra

Individual Unemployability

What is Individual Unemployability?

Individual Unemployability (IU) is a unique part of VA's disability compensatio
program. It allows VA to pay certain Veterans compens
even though VA has not rated

VA FORM 21-8940

VETERAN'S APPLICATION FOR INCREASEED COMPENSATION BASED ON UNEMPLOYABILITY

QUALIFICATION TO APPLY:

1 DISABILITY RATED 60% OR HIGHER

OR

OVERALL RATING OF 70% WITH 1 DISABILITY RATED AT 40%

25

OMB Approved No. 2900-0404
Respondent Burden: 45 minutes
Expiration Date: 06/30/2024

Department of Veterans Affairs

VA DATE STAMP (DO NOT WRITE IN THIS SPACE)

VETERAN'S APPLICATION FOR INCREASED COMPENSATION BASED ON UNEMPLOYABILITY

IMPORTANT: This is a claim for compensation benefits based on unemployability. When you complete this form you are claiming total disability because of a service-connected disability(ies) which has/have prevented you from securing or following any substantially gainful occupation. Answer all questions fully and accurately. See mailing information on page 4 of this form.

Social Security Benefits: Individuals who have a disability and meet medical criteria may qualify for Social Security or Supplemental Security Income disability benefits. If you would like more information about Social Security benefits, contact your nearest Social Security Administration (SSA) office. You can locate the address of the nearest SSA office in your telephone book blue pages under "United States Government, Social Security Administration" or call 1-800-772-1213 (Hearing Impaired TDD line 1-800-325-0778). You may also contact SSA by Internet at http://www.ssa.gov/.

SECTION I - VETERAN IDENTIFICATION INFORMATION

NOTE: You may complete the form online or by hand. If completed by hand print the information requested in ink, neatly, and legibly, insert one letter per box, and completely fill each applicable circle to help expedite processing of the form.

1. VETERAN'S NAME *(First, Middle Initial, Last)*: JOE SMITH

2. SOCIAL SECURITY NUMBER: 000-00-0000

3. VA FILE NUMBER:

4. DATE OF BIRTH (Month Day Year): 03-02-1946

5. MAILING ADDRESS *(No. and street or rural route, city or P.O., State, ZIP Code and Country)*
No. & Street:
Apt./Unit Number: City:
State/Province: Country: ZIP Code/Postal Code:

6. EMAIL ADDRESS *(If applicable)* ( ) I agree to receive electronic correspondence from VA in regards to my claim.

7. TELEPHONE NUMBER *(Include Area Code)*
Enter International Phone Number *(If applicable)*

SECTION II - DISABILITY AND MEDICAL TREATMENT

8. WHAT SERVICE-CONNECTED DISABILITY(IES) PREVENT(S) YOU FROM SECURING OR FOLLOWING ANY SUBSTANTIALLY GAINFUL OCCUPATION?
ISCHEMIC HEART DISEASE
TYPE 2 DIABETES

9. HAVE YOU BEEN UNDER A DOCTOR'S CARE AND/OR HOSPITALIZED WITHIN THE PAST 12 MONTHS?
(•) YES ( ) NO

10. DATE(S) OF TREATMENT BY DOCTOR(S) (Go to Item 26 - Remarks - for additional dates)
FROM: 01-01-2010
TO: 02-02-2023

11. NAME AND ADDRESS OF DOCTOR(S)
Dr. Dow

12. NAME AND ADDRESS OF HOSPITAL
VA Iron Moutain MI 49801

13. DATE(S) OF HOSPITALIZATION (Go to Item 26 - Remarks - for additional dates)
FROM:
TO:

SECTION III - EMPLOYMENT STATEMENT

14. DATE YOUR DISABILITY AFFECTED FULL-TIME EMPLOYMENT (Month Day Year): 02-02-2015

15. DATE YOU LAST WORKED FULL-TIME (Month Day Year): 02-02-2015

16. DATE YOU BECAME TOO DISABLED TO WORK (Month Day Year): 02-02-2015

17A. WHAT IS THE MOST YOU EVER EARNED IN ONE YEAR? $ 50,000

17B. WHAT YEAR? 2013

17C. OCCUPATION DURING THAT YEAR? Carpenter

VETERAN'S SOCIAL SECURITY NUMBER: – –

SECTION III - EMPLOYMENT STATEMENT *(Continued)*

18. LIST ALL YOUR EMPLOYMENT INCLUDING SELF-EMPLOYMENT FOR THE LAST FIVE YEARS YOU WORKED
(Include any military duty including inactive duty for training) (Note: For additional employment information use Section V, Remarks)

NAME AND ADDRESS OF EMPLOYER (OR UNIT)	TYPE OF WORK	HOURS PER WEEK	DATES OF EMPLOYMENT FROM	DATES OF EMPLOYMENT TO	TIME LOST FROM ILLNESS	HIGHEST GROSS EARNINGS PER MONTH
Good Work Trades 0120 Iron Mountain MI 49801	Carpenter	50	01-01-1986	02-01-2015	80	$ 3,000

VA FORM 21-8940

VETERAN'S APPLICATION FOR INCREASEED COMPENSATION BASED ON UNEMPLOYABILITY

VA FORM 21-4192 WILL BE SENT TO LAST EMPLOYER

26

VETERAN'S SOCIAL SECURITY NUMBER – –

SECTION III - EMPLOYMENT STATEMENT *(Continued)*

19. IF YOU ARE CURRENTLY SERVING IN THE RESERVE OR NATIONAL GUARD, DOES YOUR SERVICE CONNECTED DISABILITY PREVENT YOU FROM PERFORMING YOUR MILITARY DUTIES?
○ YES ◉ NO

20A. INDICATE YOUR TOTAL EARNED INCOME FOR THE PAST 12 MONTHS	20B. IF PRESENTLY EMPLOYED, INDICATE YOUR CURRENT MONTHLY EARNED INCOME
$ 30,000	$,

21A. DID YOU LEAVE YOUR LAST JOB/SELF-EMPLOYMENT BECAUSE OF YOUR DISABILITY?	21B. DO YOU RECEIVE/EXPECT TO RECEIVE DISABILITY RETIREMENT BENEFITS?	21C. DO YOU RECEIVE/EXPECT TO RECEIVE WORKERS COMPENSATION BENEFITS?
◉ YES ○ NO *(If "Yes," explain in Item 26, "Remarks")*	○ YES ◉ NO	○ YES ◉ NO

22. HAVE YOU TRIED TO OBTAIN EMPLOYMENT SINCE YOU BECAME TOO DISABLED TO WORK?
○ YES ◉ NO *(If "Yes," complete Items 22A, 22B, and 22C)*

22A. NAME AND ADDRESS OF EMPLOYER	22B. TYPE OF WORK	22C. DATE APPLIED (MM/DD/YYYY)
		– –
NAME AND ADDRESS OF EMPLOYER	TYPE OF WORK	DATE APPLIED (MM/DD/YYYY)
		– –
NAME AND ADDRESS OF EMPLOYER	TYPE OF WORK	DATE APPLIED (MM/DD/YYYY)
		– –

SECTION IV - SCHOOLING AND OTHER TRAINING

23. EDUCATION *(Check highest year completed)*
GRADE SCHOOL ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 HIGH SCHOOL ○ 9 ○ 10 ○ 11 ◉ 12 COLLEGE ○ Fresh ○ Soph ○ Jr ○ Sr

24A. DID YOU HAVE ANY OTHER EDUCATION AND TRAINING BEFORE YOU WERE TOO DISABLED TO WORK?
○ YES ◉ NO (If "Yes," complete Items 24B and 24C)

24B. TYPE OF EDUCATION OR TRAINING	24C. DATES OF TRAINING	
	BEGINNING (MM/DD/YYYY)	COMPLETION (MM/DD/YYYY)
	– –	– –

25A. HAVE YOU HAD ANY EDUCATION AND TRAINING SINCE YOU BECAME TOO DISABLED TO WORK?
○ YES ◉ NO (If "Yes," complete Items 25B and 25C)

25B. TYPE OF EDUCATION OR TRAINING	25C. DATES OF TRAINING	
	BEGINNING (MM/DD/YYYY)	COMPLETION (MM/DD/YYYY)
	– –	– –

VETERAN'S SOCIAL SECURITY NUMBER – –

SECTION V - REMARKS

NOTE: This section can be used for any additional information, if needed.

26. REMARKS

SECTION VI - AUTHORIZATION, CERTIFICATION, AND SIGNATURE

AUTHORIZATION FOR RELEASE OF INFORMATION: I authorize the person or entity, including but not limited to any organization, service provider, employer, or Government agency, to give the Department of Veterans Affairs any information about me except protected health information, and I waive any privilege which makes the information confidential.
CERTIFICATION OF STATEMENTS: I CERTIFY THAT as a result of my service-connected disabilities, I am unable to secure or follow *any* substantially gainful occupation and that the statements in this application are true and complete to the best of my knowledge and belief. I understand that these statements will be considered in determining my eligibility for VA benefits based on unemployability because of service-connected disability.

I UNDERSTAND THAT IF I AM GRANTED SERVICE-CONNECTED TOTAL DISABILITY BENEFITS BASED ON MY UNEMPLOYABILITY, I MUST IMMEDIATELY INFORM VA IF I RETURN TO WORK. I ALSO UNDERSTAND THAT TOTAL DISABILITY BENEFITS PAID TO ME AFTER I BEGIN WORK MAY BE CONSIDERED AN OVERPAYMENT REQUIRING REPAYMENT TO VA.

27. SIGNATURE OF CLAIMANT *(Required)*	28. DATE SIGNED (MM/DD/YYYY)
Veteran Signature	– –

WITNESSES NEEDED IF "X" MARK IS MADE (Signature made by mark must be witnessed by two persons to whom the person making the statement is personally known and the signature and address of such witnesses must be shown in Items 29A & 29B and 30A & 30B.

29A. SIGNATURE OF WITNESS *(Sign in ink)*	29B. ADDRESS OF WITNESS
30A. SIGNATURE OF WITNESS *(Sign in ink)*	30B. ADDRESS OF WITNESS

PENALTY: The law provides severe penalties which include fine or imprisonment or both for the willful submission of any statement or evidence of a material fact, knowing it to be false or for the fraudulent acceptance of any payment to which you are not entitled.

SECTION VII - WHERE TO SEND CORRESPONDENCE

MAIL TO:

Department of Veterans Affairs
Evidence Intake Center
PO Box 4444
Janesville, WI 53547-4444

PRIVACY ACT NOTICE: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Veteran Readiness and Employment Records - VA, published in the Federal Register. Your response is required to obtain or retain benefits. Giving us your SSN account information is mandatory. Applicants are required to provide their SSN under Title 38, U.S.C. 5101(c)(1). VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine maximum benefits provided under the law. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN: We need this information to determine your eligibility for compensation. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 45 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

DEATH INDEMNITY COMPENSATION

VA FORM 21P-534EZ

ELIGIBILITY

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U.S. Department of Veterans Affairs
Veterans Benefits Administration

Dependency and Indemnity Compensation

What is Dependency and Indemnity Compensation?

Dependency and Indemnity Compensation (DIC) is a monthly benefit. It is paid to eligible survivors of:

- Service members who died while on active duty, active duty for training or inactive duty training, OR
- Veterans who died as a result of a service-connected injury or disease, OR
- Veterans who did not die as a result of a service-connected injury or disease, but were totally disabled by a service-connected disability:
  - For at least 10 years before death, OR
  - Since their release from active duty and for at least five years before death, OR
  - For at least one year before death, if they were a former prisoner of war and died after Sept. 30, 1999.

Who is eligible?

Surviving Spouses

You may be eligible for DIC benefits if you are a surviving spouse who:

- Married a Service member who died on active duty, active duty for training or inactive duty training, OR
- Married the deceased Veteran before Jan. 1, 1957, OR
- Married a Veteran who died from a service-connected injury or disease, if the marriage began within 15 years of discharge, OR
- Married the deceased Veteran for at least one year, OR
- Had a child with the Veteran and cohabitated with the Veteran until their death.
  - Note: If you have a child with the Veteran but were separated, you must not be at fault for the separation and not be remarried to be eligible.

- A surviving spouse who remarries after the Veteran's death may still be eligible for benefits:
  - If you remarried on or after January 1, 2004, and were at least 57 years old, you may still be eligible
  - If you remarried on or after December 16, 2003, were at least 57 years old, and your claim was received before December 16, 2004, you may still be eligible.
  - If you remarried on or after January 5, 2021, and were at least 55 years old, you may still be eligible.

Additional information is available at www.va.gov/disability/dependency-indemnity-compensation/

Surviving Children

If you are a surviving child, you may be eligible for DIC if the Veteran parent:

- Died in the line of duty, OR
- Died as a result of a service-connected injury or disease.

You also must be unmarried and either:

- Under the age of 18, OR
- Between the ages of 18 and 23 and currently attending school.

Certain helpless adult children may also be eligible. You can call 800-827-1000 for eligibility requirements.

Parents

If you are a surviving parent, you may be eligible for DIC if the Veteran child:

- Died in the line of duty, OR
- Died as a result of a service-connected injury or disease.

You can find more information about Parents' DIC at www.va.gov/disability/dependency-indemnity-compensation/.

ANY QUESTIONS

DICKINSON COUNTY OFFICE OF VETERAN AFFAIRS

ACCREDITED COUNTY VETERAN SERVICE OFFICERS

DENISE FORMOLO AND LACEY ELLISON