

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?

3

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.

	OMB Control No. 2900-0321 Respondent Burden: 5 minutes Evorintion Date: 02/28/2022	
	VA DATE STAMP	VETERAN'S SOCIAL SECURITY NUMBER 1 2 3 - 4 5 - 6 7 8 9
	APPOINTMENT OF VETERANS SERVICE ORGANIZATION	SECTION IV: AUTHORIZATION INFORMATION
	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	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.
	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 Claiman'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.ya.gov/vaforms. SECTION I: VETERAN'S INFORMATION	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 fling a written revocation with VA; or (2) I revoke the appointment of the service organization named in Item 15, either by
	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.	explicit revocation or the appointment of another representative.
	1. VETERANS NAME (First, Middle Initial, Last)	20. LIMITATION OF CONSENT- I authorize disclosure of records related to treatment for all conditions listed in Item 19 except:
VA FORM	JOOE Smith Smith h 2. VETERANS SOCIAL SECURITY NUMBER (SSN) 3. VA FILE NUMBER (ff applicable) 4. VETERANS DATE OF BIRTH (MM/DD/YYYY)	DRUG ABUSE INFECTION WITH THE HUMAN IMMUNODEFICIENCY VIRUS (HIV) ALCOHOLISM OR ALCOHOL ABUSE SICKLE CELL ANEMIA
21-22	1 2 3 - 6 7 8 9	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.
	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. & 1	X 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.
PPOINTMENT OF VETERANS ERVICE OFFICER	Apt/Unit Number City H a p p y T o w n State/Province M I Country ZiP Code/Postal Code 1 2 3 4 5 - 8. VETERAN'S TELEPHONE NUMBER (Include Area Code) 9. VETERAN'S EMAIL ADDRESS (Optional) 9. VETERAN'S EMAIL ADDRESS (Optional) SECTION II: CLAIMANT'S INFORMATION (If other than veteran) 10. CLAIMANT'S NAME (First, Middle Initial, Last) 10.	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 benefits from the Department of Veterans Affairs (VA) based on the service of the veteran named in Item 1. I or my appointed service organization. I understand that my appointed representative will not charge any fee or compensation for service rendered pursuant to this appointent. 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 news 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
	11. CLAIMANT'S MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country) No. 8	NOTE: THIS POWER OF ATTORNEY DOES NOT REQUIRE EXECUTION BEFORE A NOTARY PUBLIC
	Street	22A. SIGNATURE OF VETERAN OR CLAIMANT (DO NOL PRINT) Veteran Signature
	12. CLAIMANT'S TELEPHONE NUMBER (Include Area Code) 13. CLAIMANT'S EMAIL ADDRESS (Optional) 14. RELATIONSHIP TO VETERAN	23A. SIGNATURE OF VETERANS SERVICE DEGANIZATION REPRESENTATIVE NAMED IN ITEM 16A (Do Not Print) 23B. DATE SIGNED (MM/DD/YYYY)
	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)	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.
	Disabled American Veterans 16A. NAME OF OFFICIAL REPRESENTATIVE ACTING ON BEHALF OF THE 16B. JOB TITLE OF PERSON NAMED IN ITEM 16A	VA USE ONLY VA& FORM 21-22 SENT TO: DATE SENT (MM/DD/YYYY) ACKNOWLEDGED (Date) (MM/DD/YYYY) CMM/DD/YYYY) ACKNOWLEDGED (Date) (MM/DD/YYYY) CMM/DD/YYYY)
	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	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.
Δ	17. EMAIL ADDRESS OF THE ORGANIZATION NAMED IN ITEM 15 18. DATE OF THIS APPOINTMENT (MM/DD/YYYY) dav.vbadet@va.gov 01-01-1902	
	VA FORM 21-22 SUPERSEDES VA FORM 21-22, AUG 2015 Page 1	

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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	(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, n the form.	neatly and legibly to expedite processing of
1. CLAIMANT'S NAME (First, Middle Initial, Last)	
J o e S m i t h	
2. CLAIMANT'S SOCIAL SECURITY NUMBER 3. VA FILE NUMBER (If applicable) 4. VETERAM	S DATE OF BIRTH (MM-DD-YYYY)
Month	Day Year
1 2 3 - 4 5 - 6 7 8 9 1 2 3 4 5 6 7 8 9 0 1 -	- 0 1 - 1 9 0 0
5. VETERAN'S NAME (First, Middle Initial, Last) (If different from claimant)	
6. VETERAN'S SOCIAL SECURITY NUMBER 7. VETERAN'S SEX 8. VETERAN'S SERVICE NUI	MBER (If applicable)
9. CURRENT MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)	
40.8 1 2 3 4 5 6 H a p p y L a n e	
pt/Unit Number City H a p p y T o w n	
tate/Province M I Country ZIP Code/Postal Code 1 2 3 4 5 -	
10. HAS THE VETERAN EVER FILED A 11.TELEPHONE NUMBER (Include Area Code) 12. EMAIL ADDRESS (If CLAIM WITH VA?	applicable)
SECTION II: GENERAL BENEFIT ELECTION	
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 se disability compensation online at <u>www.va.gov</u> . If you give VA a completed application for the selected general benefit with completed application will be considered filed as of the date of receipt of this form. Only the <u>first</u> completed application for received after you file this form will be considered filed as of the date of receipt of this form. You may indicate you intent to this form or you may submit a separate intent to file for each general benefit. Please complete as many fields in Section II as we cannot identify the claimant and veteran.	in one year of filing this form, your each selected general benefit that is
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 for benefits: (2) I must file a complete application for each general benefit with VA before VA will process my claim; and (general benefit(s) as indicated on this form must be received within one year of the date VA receives this form for my applic this form. 14A. SIGNATURE OF CLAIMANT/AUTHORIZED REPRESENTATIVE 14B. DATE SIGNED (MM)	 a complete application for the same ation to be considered filed as of the date of
Veteran Signature	
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 attorne	ey has been completed.)
VSU can Sign here if needed	
PRIVACY ACT NOTICE: VA will not disclose information evoluted on this form to any source other than what has been authorized unde Federal Regulations 1.576 for routine uses (i.e., eivil or criminal law enforcement, congressional communications, epidemiological or research United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of benefits, we administration of VA programs and delivery of benefits. We administration of VA programs and delivery of benefits, we density of the states of the state of the states of the state of claim for an application that is received within one year of receipt to is dentify 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 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 infor determine the appropriate application and provide it to the claimant.	h studies, the collection of money owed to the erification of identity and status, and personnel ployment Records - VA, published in the Federal if this form. VA uses your Social Security number benefits for refusing to provide his or her SSN
RESPONDENT BURDEN: We need this information to determine and to provide the claimant with the appropriate application for VA bene 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 inform conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection Valid OMB control numbers can be located on the OMB Internet Page at <u>www.reginlo.gov/pablic/do/PRAMain</u> . If desired, you can call 1-80 comments or suggestions about this form.	nation, and complete this form. VA cannot on of information if this number is not displayed.
A FORM 21-0966 SUPERSEDES VA FORM 21-0966, MAR 2017.	

WHAT IS A SERVICE CONNECTED 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

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

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Departm	ent o	f Vete	rans	Affai	rs			i di o												(DO	NOT		
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IMPORTANT: Plea determine your elig Ask us a question at www.va.gov, VA	ibility fo online or	r compe	acy Ac ensation toll-free	t and F i. For at 1-8	Responde more info 00-827-1	rmatio 000 (T	den n, yı	on Pag	e 14 l	before ct us or	comp	leting	h Ask	VA: h	ttps:	//ask	va.go	<u>iv</u> . n onlir	ne				
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13B. NEW ADDR	ESS (N	umber a	ind stre	et or ru	iral route	P.O. 1	Box	, City, S	tate,	ZIP Co	de ar	nd Co	untry)										
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State/Province			Cour	itry				ZIP Co	de/Po	ostal Co	ode							- [
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13C. EFFECTIVE																							
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VA FORM

21-526EZ

APPLICATION FOR DISABILITY COMPENSATION

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

IMPORTANT: The following questions (Items 14A through 14F) should only be completed 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	d if you are currently homeless or at risk of becoming homeless.
YES (If "Yes," complete Item 14B regarding your living situation)	IAB, CHECK THE BOX THAT APPLIES TO YOUR LIVING SITUATION
	LIVING IN A HOMELESS SHELTER LIVING IN A HOMELESS SHELTER NOT CURRENTLY IN A SHELTERED ENVIRONMENT (e.g., living in a ca or tent) STAYING WITH ANOTHER PERSON FLEEING CURRENT RESIDENCE OTHER (Specify)
14C. ARE YOU CURRENTLY AT RISK OF BECOMING HOMELESS?	14D. CHECK THE BOX THAT APPLIES TO YOUR LIVING SITUATION:
YES (If "Yes," complete Item 14D regarding your living situation)	HOUSING WILL BE LOST IN 30 DAYS LEAVING PUBLICLY FUNDED SYSTEM OF CARE (e.g., homeless shelter)
X NO	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 I	INFORMATION
158. 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; Catar Israel: Egypt: Turkey: Syria; Jordan: Djibouti; Uzbekistan: the Gulf of Aden; the Gulf of Oma	websites for more information: PACT ACT (<u>https://www.va.gov/PACT</u>) and <u>tex.asp</u>)) o Item 16, Section V: Claim Information) r; the United Arab Emirates; Oman; Yemen; Lebanon; Somalia; Afghanistan;
WHEN DID YOU SERVE IN THESE LOCATIONS? (MM-YYYY) Note: Please provide an approximate time frame (month and year).	
15C. DID YOU SERVE IN ANY OF THE FOLLOWING HERBICIDE (e.g., Agent Orange) LOCAT Republic Of Vietnam to include the 12 nautical mile territorial waters: Thailand at any United Province: Guam or American Samoa. or in the Ierritorial waters thereof, Johnston Atoli or a repeated operations and maintenance with) a C-123 aircraft known to have been used to sp Please list other location(s) where you served, if not listed a VEX YES NO	I States or Royal Thai base; Laos; Cambodia at Mimot or Krek; Kampong Cham ship that called at Johnston Atoli; Korean demilitarized zone; aboard (to include oray an herbicide agent (during service in the Air Force and Air Force Reserves).
WHEN DID YOU SERVE IN THESE LOCATIONS? (MM-YYYY)	
	RADIATION MOS)-related toxin CONTAMINATED WATER AT CAMP LEJEUNE
WHEN DID YOU SERVE IN THESE LOCATIONS? (MM-YYYY) Note: Please provide an approximate time frame (month and year).	
WHEN DID YOU SERVE IN THESE LOCATIONS? (MM-YYYY) Note: Please provide an approximate time frame (month and year)	MOS)-related toxin CONTAMINATED WATER AT CAMP LEJEUNE
WHEN DID VOU SERVE IN THESE LOCATIONS? (MM-YYYY) Note: Please provide an approximate time frame (month and year)	MOS)-related toxin CONTAMINATED WATER AT CAMP LEJEUNE FROM: 190207-1902 ES AND LOCATIONS OF POTENTIAL EXPOSURE
WHEN DID YOU SERVE IN THESE LOCATIONS? (MM-YYYY) Note: Please provide an approximate time frame (month and year)	MOS)-related toxin CONTAMINATED WATER AT CAMP LEJEUNE FROM: TO: 1 9 0 2 0 7 - 1 9 0 2 ES AND LOCATIONS OF POTENTIAL EXPOSURE
WHEN DID VOU SERVE IN THESE LOCATIONS? (MM-YYYY) Note: Please provide an approximate time frame (month and year).	MOS)-related toxin CONTAMINATED WATER AT CAMP LEJEUNE FROM: TO: 1 9 0 2 0 7 - 1 9 0 2 ES AND LOCATIONS OF POTENTIAL EXPOSURE FORMATION aim Information (Addendum)) TO YOUR MILITARY SERVICE AND/OR SERVICE-CONNECTED Infinement as a prosener of war; exposure to Agent Orange, asbestos, mustard is payable under 38 U.S.C. 1151) how to complete Section V.
WHEN DID YOU SERVE IN THESE LOCATIONS? (MM-YYYY) Note: Please provide an approximate time frame (month and year). 15D. HAVE YOU BEENE XPOSED TO ANY OF THE FOLLOWING? (Check all that apply) X ASBESTOS BAD (Shipboard Hazard and Defense) MILITARY OCCUPATIONAL SPECIALTY (N OTHER (Specify) WHEN WERE YOU EXPOSED? (MM-YYYY) Note: Please provide an approximate time-frame (month and year). 0 15E. IF YOU WERE EXPOSED MULTIPLE TIMES, PLEASE PROVIDE ALL ADDITIONAL DATH (For additional space, use Section XIII: Clu 16. LIST THE CURRENT DISABILITY(IES) OR SYMPTOMS THAT YOU CLAIM ARE RELATED DISABILITY (If applicable, identily whether a disability for which compensation on total space, on a disability for which compensation on YOTE: List your claimed conditions below. See the following three examples for guidance on NOTE: List your claimed conditions below. See the following three examples for guidance on Section States (Section States)	MOS)-related toxin CONTAMINATED WATER AT CAMP LEJEUNE FROM: TO: TO: TO: TO: TO: TO: TO: TO
WHEN DID YOU SERVE IN THESE LOCATIONS? (MM-YYYY) Note: Please provide an approximate time frame (month and year). 15D. HAVE YOU BEEN EXPOSED TO ANY OF THE FOLLOWING? (Check all that apply) X ASBESTOS BAD (Shipboard Hazard and Defense) MILITARY OCCUPATIONAL SPECIALTY (N OTHER (Specify) WHEN WERE YOU EXPOSED? (MM-YYYY) Note: Please provide an approximate time-frame (month and year). 0 6 15E. IF YOU WERE EXPOSED MULTIPLE TIMES, PLEASE PROVIDE ALL ADDITIONAL DATE (For additional space, use Section XIII: Cli 16. LIST THE CURRENT DISABILITY (IES) OR SYMPTOMS THAT YOU CLAIM ARE RELATED DISABILITY (If applicable, identify whether a disability is due to a service-connected disability: consensation NOTE: List your claimed conditions below. See the following three examples for guidance on	MOS)-related toxin CONTAMINATED WATER AT CAMP LEJEUNE CONTAMINATED WATER AT CAMP LEJEUNE FROM: 1 9 0 2 0 7 - 1 9 0 2 ES AND LOCATIONS OF POTENTIAL EXPOSURE FORMATION aim Information (Addendum)) TO YOUR MILITARY SERVICE AND/OR SERVICE-CONNECTED Infinement as a presoner of war: exposure to Agent Orange, asbestos, mustard in spayable undra 38 U.S.C. 1151) how to complete Section V.
WHEN DID YOU SERVE IN THESE LOCATIONS? (MM-YYYY) Note: Please provide an approximate time frame (month and year). — 15D. HAVE YOU BEEN EXPOSED TO ANY OF THE FOLLOWING? (Check all that apply) MUSTARD GAS ASBESTOS MUSTARD GAS SHAD (Shipboard Hazard and Defense) MILITARY OCCUPATIONAL SPECIALTY (N OTHER (Specify) MILITARY OCCUPATIONAL SPECIALTY (N WHEN WERE YOU EXPOSED? (MM-YYYY) Note: Please provide an approximate time-frame (month and year). 0 6 — 15E. IF YOU WERE EXPOSED MULTIPLE TIMES, PLEASE PROVIDE ALL ADDITIONAL DATE SECTION V: CLAIM INF (For additional space, use Section XIII: Cli 16. LIST THE CURRENT DISABILITY(IES) OR SYMPTOMS THAT YOU CLAIM ARE RELATED DISABILITY (If applicable, identify whether a disability is due to a service-connected disability: consensation NOTE: List your claimed conditions below. See the following three examples for guidance on NOTE: List your claimed conditions below. See the following three eXAMPLES OF DISABILITY(IES) EXAMPLES OF DISABILITY(IES)	MOS)-related toxin CONTAMINATED WATER AT CAMP LEJEUNE FROM: TO: TO: TO: TO: TO: TO: TO: TO

VA FORM 21-526EZ, NOV 2022

Page 9

VA FORM 21-526EZ

APPLICATION FOR DISABILITY COMPENSATION

	CURRENT DISABILITY(IES)	IF DUE TO EXPOSURE, EVENT, OR INJURY, PLEASE SPECIFY (e.g., Agent Orange, radiation, burn pits)	EXPLAIN HOW THE DISABILITY RELATES TO THE IN-SERVIC EVENT/EXPOSURE/INJURY	(IES) APPROXIMATE DATI DISABILITY(IES) BEGAN OR WORSENE
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	
	sleep impairment	2nd tinnitus		1902
5.				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.				
		SABILITY(IES) LISTED IN ITEM 16 AND PRO DED ATTACH A SEPARATE SHEET AND IN ment began from 2005 to present, you do	DVIDE APPROXIMATE BEGINNING DA CLUDE YOUR NAME, SOCIAL SECURI not need to provide dates in Item 17E	TE (Month and Year) OF TY NUMBER AND ITEM NUMBER 0. C. CHECK THE BOX IF YOU D
	ENTER THE DISABILITY TREATED AND NAM	IE/LOCATION OF THE TREATMENT FACILI	(MM-YYYY)	NOT HAVE DATE(S) OF TREATMENT
VA	парру гіасе		-	X Don't have date
			-	Don't have date
				Don't have date
	TE: IF YOU WISH TO CLAIM ANY OF THE FO w.va.gov/vaforms)	LLOWING, COMPLETE AND ATTACH THE	REQUIRED FORM(S) AS STATED BELO	DW. (VA forms are available at
For		Required Form(s):		
Sup	plemental Claims	VA Form 20-0995		
Dep	pendents	VA Form 21-686c and, if claim	ng a child aged 18-23 years and in scho	ol, VA Form 21-674
Indi	vidual Unemployability	VA Form 21-8940 and 21-4192	2	
Pos	t-Traumatic Stress Disorder	VA Form 21-0781 or 21-0781a		
	cially Adapted Housing or Special Home Adapta	ation VA Form 26-4555		
Spe				
	o Allowance	VA Form 21-4502		

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

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

					The second	SE	CTION VI: S	SERVI	CEIN	FOR	MA	TION	١								
18A. DID YOU SERVE UN	DER ANO	THER	NAME	?				18B.	LIST	THE OT	THEF	RNAM	AE(S) Y	OU SE	RVED	UNDE	R:				
YES (If "Yes," compl	ete Item 1	8B)	X NO	(If	"No.	" skip	to Item 19A)														
19A. BRANCH OF SERVIC	E							19B.	COMF	ONEN	т										
X ARMY	N/	AVY				MAR	RINE CORPS														
AIR FORCE		DAST	GUARE)		SPA	CE FORCE	×	ACTI	VE		R	ESERV	'ES	C	NAT	IONA	l gua	RD		
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21A. ARE YOU CURREN THE RESERVES OR				E YOI	JEV	ERS	ERVED IN	21B.	COMF	PONEN	т	210		GATIO	N TEF	RM OF Day		/ICE		Year	
YES (If "Yes," com	plete Item	is 21B	through	121F)					NATIO			FRO		onun	_	Da	y	- 1	-	real	
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X NO (If "No." skip	to Item 22	A)							RESE	RVES		TC	D:		-			-			
21D. CURRENT OR LAST	ASSIGN	ED NA	ME AN	D ADI	RES	SS OI	F UNIT:						NED PH Area C		21		CEIVI		ACTIV	LY E DUT	(
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22A, ARE YOU CURRENT	LY ACTIV	ATED	ON FE	DERA	LI	22B. I	DATE OF ACT	VATION	I:					22C. A		_		-		ATE:	
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X NO 23A. HAVE YOU EVER BE		CONE	BOEN	VADO	+	-	hand ha			25		ATES	OFC	ONFINE	MEN	т	-	-+!			
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24A, ARE YOU RECEIVIN	IG MILITA	RYRE	TIRED	PAY		1	B. WILL YOU	RECEIV Yes," ex									ireme	ent, per	ndina		
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24C. BRANCH OF SERVI	CE							24	D. MO	NTHLY	AM	OUNT		2	25. RE	TIRED	STA	TUS			
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IMPORTANT INFORM. Submission of this appl benefits. Your retired pa compensation at the sa compensation and milit you should check the b	ication co ay may b me time ary retire	onstitu e redu <i>may</i> r d pay	utes a v uced b result i	waive y the n an o	r of i amo	milita unt o paym	ary retired pay of VA comper nent, which <u>m</u>	in an	amour awaro subjec	nt equa ded. Re at to co	al to ecei illect	VA c pt of t tion. If	the ful f you o	nsatior I amou qualify	nt of for co	militar oncurr	y ret ent r	ired pa eceipt	ay an of VA	AVB	
Note that if you check and you check the bo																			A co	mpens	ation
IMPORTANT: VA CON	PENSA	TION	PAY	S NO	N-TA	XAI	BLE. THERE	FORE,	VAC	OMPE	NS	ATIO	N PAY	MAY	BE T	THE G	REA	TER	BENE	FIT.	
🗌 26. Do NOT pay n	ne VA co	mper	nsatio	n.Id	o N	OT v	vant to receiv	ve VA d	comp	ensati	on i	n lieu	u of re	tired p	bay.						

VA FORM 21-526EZ, NOV 2022

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

IMPORTANT INFORMATION ON SEPARATION/SEVERANCE				VETERAN'S SOCIAL SECURITY NO. 1 2 3 - 4 5 - 6	7 8 9
VA compensation, if granted, may be withheld to recoup any dis separation pay, or special separation benefit, you receive from your VSI payments may be reduced if you are awarded VA com	our branch of service. In a	ddition, if you receive a Vo	untary Separation Incentive (VSI),		NER CERTIFICATION AND SIGNATURE NLY IF ITEM 33A IS BLANK)
overpayment of VSI, which may be subject to collection. 27A. HAVE YOU EVER RECEIVED SEPARATION PAY, DISABILITY SI	VERANCE PAY, OR ANY OT	HER LUMP SUM PAYMENT F	ROM YOUR BRANCH OF SERVICE?	NOTE: An alternate signer signature <u>will not</u> be accepted unless a valid to this request.	VA Form 21-0972, Alternate Signer Certification, is of record or attached
YES (If "Yes," complete Items 27B through 27D) NO				I certify that by signing on behalf of the claimant, that I am a court-appointed r claimant under a durable power of attorney; OR , a person who is responsible	representative: OR , an attorney in fact or agent authorized to act on behalf of a le for the care of the claimant, to include but not limited to a spouse or other relative esponsible for the care of an individual; AND , that the claimant is under the age of 10
27B. DATE PAYMENT RECEIVED (MM-DD-YYYY) 27C. BRANCH O	F SERVICE		27D. AMOUNT RECEIVED (Provide pre-tax amount)	OR, is mentally incompetent to provide substantially accurate information new	esponsible for the care of an individual, AND, that the claimant is under the age of the edge of the e
ARMY	NAVY	MARINE CORPS		and complete; OR, is physically unable to sign this form.	
AIR FORCE	COAST GUAF	RD SPACE FORCE	\$,00	I understand that I may be asked to confirm the truthfulness of the answers request further documentation or evidence to verify or confirm my authorization	to the best of my knowledge under penalty of perjury. I also understand that VA may
D NOAA	USPHS			Examples of evidence which VA may request include: Social Security Numbe	r (SSN) or Taxpayer Identification Number (TIN); a certificate or order from a
IMPORTANT INFORMATION ON INACTIVE DUTY TRAINING You may elect to keep the active or inactive duty training pay yo your training pay, you must waive VA benefits for the number of it will be to your advantage to waive your VA benefits and keep	u received from the militar days equal to the number	y service department. How of days for which you rece	ever, to be legally entitled to keep ved training pay. In most instances,	appointment of fiduciary; durable power of attorney showing the name and power of attorney, affidavit or notarized statement from an institution or personance provided; or any other documentation showing such authorization.	ant with a judge's signature and a date/time stamp; copy of documentation showin signature of the claimant and your authority as attorney in fact or agent; health ca son responsible for the care of the claimant indicating the capacity or responsibility
	-		1	36A. ALTERNATE SIGNER SIGNATURE (REQUIRED)	36B. DATE SIGNED (MM-DD-YYYY)
you waive VA benefits to receive training pay by checking the total number of training days waived and at the monthly rate	in effect for the fiscal year				
sult in an overpayment of compensation, which may be subje	ct to collection.				F ATTORNEY (POA) SIGNATURE
MPORTANT: VA COMPENSATION PAY IS NON-TAXABLE.	THEREFORE VA COMPE	NSATION PAY MAY BE T	HE GREATER BENEFIT.	(NOTE: POA'S CANNOT SIG	N FOR AN ORIGINAL CLAIM ONLY)
28. Do NOT pay me VA compensation. I do NOT want	to receive VA compensa	tion in lieu of training pa	1.		e this claim on behalf of the claimant and that the claimant is aware and accepts the ed the undersigned representative to state that the claimant certifies the truth and
	I: DIRECT DEPOSIT IN			completion of the information contained in this document to the best of claima	
(Note: If you have already The Department of the Treasury requires all Federal benefit payment				NOTE: A POA's signature will not be accepted unless at the time of submiss	sion of this claim a valid VA Form 21-22, Appointment of Veterans Service
deposit, provide the information requested below, and attach e	ither a voided personal che	eck or a deposit slip. If you	do not have a bank account, please	Organization as Claimant's Representative, or VA Form 21-22a, Appointment record with VA.	t of Individual As Claimant's Representative, indicating the appropriate POA is of
visit https://www.benefits.va.gov/benefits/banking.asp . This website banks and credit unions that may fit your needs. You may also call				37A. POA/AUTHORIZED REPRESENTATIVE SIGNATURE	37B. DATE SIGNED (MM-DD-YYYY)
requests for the Department of the Treasury at 1-888-224-2950. The				USO can also sign he	
have.					or both, for the willful submission of any statement or evidence of a material fact, knowing it
29. I CERTIFY THAT I DO NOT HAVE AN ACCOUNT WITH A FINA		RTIFIED PAYMENT AGENT (I	you check this box skip to Section IX)	to be false, or for the fraudulent acceptance of any payment to which you are not e	
30. ACCOUNT NUMBER (Check only one box below and provide the arcount No.: 1 2 3 4 5 6 7 8 9 9 8	_	CHECKING SAVIN	38	U.S.C. 5701). VA may disclose the information that you provide, including Social S the routine uses identified in the VA system of records, 58VA21/22/28, Compensat	sation benefits (38 U.S.C. 5101). The responses you submit are considered confidential (38 security numbers, outside VA if the disclosure is authorized under the Privacy Act, including tion, Pension, Education, and Veteran Readiness and Employment Records - VA, published
31. NAME OF FINANCIAL INSTITUTION (Provide the name of the bank want your direct deposit) Happy Place Bank		NG OR TRANSIT NUMBER (TI of your check)	e first nine numbers located at the	in the Federal Register. The requested information is considered relevant and necr verification through computer matching programs with other agencies. VA may ma communications, epidemiological or research studies; the collection of money owe	essary to determine maximum benefits under the law. Information submitted is subject to
	1 2	3 4 5 6 7	8 9	retain benefits. Information that you furnish may be utilized in computer matching p to receive VA benefits, as well as to collect any amount owed to the United States	with other Federal or State agencies for the purpose of determining your eligibility by virtue of your participation in any benefit program administered by the Department of al Security number requested under 38 U.S.C. 5101((/)1. VA may disclose Social Security
	AIM CERTIFICATION A			numbers as authorized under the Privacy Act, and, specifically may disclose them	
	MEMBER CERTIFICATIO			RESPONDENT BURDEN: We need this information to determine your eliaibility for	or compensation. Title 38, United States Code, allows us to ask for this information. We
certify and authorize the release of information. I certify that the sit erson or entity, including but not limited to any organization, servic information about me. For the limited purpose of providing VA with therwise make the information confidential and not discloseable.	e provider, employer, or gove	ernment agency, to give the l	Department of Veterans Affairs any	estimate that you will need an average of 25 minutes to review the instructions, fin information unless a valid OMB control number is displayed. You are not required	d the information, and complete this form. VA cannot conduct or sponsor a collection of to respond to a collection of information if this number is not displayed. Valid OMB control io/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send
I certify I have received the notice attached to this application titled, Veterans Disability Compensation and Related Compensation		Member of Evidence Neces	sary to Substantiate a Claim for		
I certify I have enclosed all the information or evidence that will sup as a VA medical center; OR , I have no information or evidence to gi my claim processed under the standard claim process because I pit	port my claim, to include an i ve VA to support my claim; C	OR, I have checked the box in	ds available at a Federal facility such a Item 1, on page 9, indicating I want	VA FORM 21-526EZ, NOV 2022	Page 1
33A. VETERAN/SERVICE MEMBER SIGNATURE (REQUIRED)		33B. DATE SIGNED (MM-	DD-YYYY)	at 1 - 2	
Veteran Sign		the second se	-		
	X: WITNESSES TO SI	SNATURE			
MAA. SIGNATURE OF WITNESS (Note: Only sign if veteran signed in Ite		34B. PRINTED NAME AND	ADDRESS OF WITNESS		
5A. SIGNATURE OF WITNESS (Note: Only sign if veteran signed in Ite	m 33A using an "X")	35B. PRINTED NAME AND	ADDRESS OF WITNESS		

Page 14

VA FORM 21-526EZ

APPLICATION FOR DISABILITY COMPENSATION

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VA FORM 21-526EZ, NOV 2022

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.

	OMB Control No. 2900-0075 Respondent Dartiel for Single Control No. 2000-0075 Economic Date: 66/30/2024	VETERAN'S SOCIAL SECURITY NO. XXX - XX - XXX
	VA DATE STAMP	SECTION II: REMARKS (Continued)
	(DO NOT WRITE IN THIS SPACE)	(The following statement is made in connection with a claim for benefits in the case of the above-named veteran/beneficiary)
	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: <u>https://ask.va.gov/</u> , or call us toll-free at 800-827-1000 (TTY:711). VA forms are available at <u>www.va.gov/vaforms</u> . 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 Smitth	
	2. VETERAN'S SOCIAL SECURITY NUMBER 3. VA FILE NUMBER (<i>If applicable</i>) 4. VETERAN'S DATE OF BIRTH (<i>MM/DD</i> /YYYY)	
VA FORM	1 2 3 - 4 5 - 6 7 8 9 - - 0 1 - 1 9 0 0	
	5. VETERAN'S SERVICE NUMBER (If applicable)	
21-4138	6. TELEPHONE NUMBER (Include Area Code) 7. E-MAIL ADDRESS (Ontional)	
	$\begin{array}{c c c c c c c c c c c c c c c c c c c $	
	Enter International Phone Number	
	8. MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)	
STATEMENT IN	No. & 1 2 3 4 5 6 H a p p y L a n e Street	
	Apt./Unit Number City H a p y T o w n	
SUPPORT OF	State/Province M I Country ZIP Code/Postal Code 1 2 3 4 5 -	
CLAIM	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 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 (<i>Required</i>) 10. DATE SIGNED (<i>MM/DD/YYYY</i>) Month Day Year
		Neteran or USO sign
		PENALTY: The law provides severe penalties which include fine or interiorment, 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 Regulation 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, lingation in which the United States is a party or has an interest, the administration of VA Programs and delivery of VA benefits, verification of identify and status, and personnel
		administration) as identified in the VA system of records, S8VA21/22/28, Compensation, Pension, Education, and Veteran Readiness and Employment Records - VA, published in the Federal Register. Vour obligation to respond is required to obtain or retain benefits. VA uses your S8N to identify your claim file. Providing your S8N 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 (88 U.S.C. 5701). Information submitted is the state of law in the state of law in t
		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
	VA FORM JUN 2021 21-4138 SUPERSEDES VA FORM 21-4138, DEC 2017. Page 1	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.reginto.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 21-4138, JUN 2021 Page 2

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

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OMB Approved No. 2900-0043 Respondent Burden: 30 minutes

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VA	FORM
21	-686c

APPLICTION REQUEST TO ADD AND/OR REMOVE DEPENDE

16

INTS	City or County
	15C. (1) TO WHOM MARRIED (First, Middle Initial, Last Name)
	15C. (2) DATE AND PLACE OF MARRIAGE (MM-DD-YYYY)
	City or County
	15C. (3) REASON FOR TERMINATION C Death C Divorce C Annulment C Other (Explain):
	15C. (4) DATE AND PLACE MARRIAGE TERMINATED (MM-DD-YYYY)
	City or County 15D. (1) TO WHOM MARRIED (First, Middle Initial. Last
	Name)
	15D. (2) DATE AND PLACE OF MARRIAGE (MM-DD-YYYY)
	City or County 15D. (3) REASON FOR TERMINATION
	C Death C Divorce C Annulment C Other (Explain):
	15D. (4) DATE AND PLACE MARRIAGE TERMINATED (MM-DD-YYYY)
	VA FORM 21-686c, AUG 2022

VETERAN'S SOCIAL SECURITY NO. 1 2 3 - 4 5 - 6 7 8 9	VETERAN'S SOCIAL SECURITY NO. 123
15. CURRENT SPOUSE'S PREVIOUS MARITAL INFORMATION (If no prior marriages, this section may be left blank)	SECTION (If claiming more than for
15A. (1) TO WHOM MARRIED (First, Middle Initial, Last Name)	16A. NAME OF FIRST CHILD TO ADD (First, Middle In.
	Billy
	16B. SOCIAL SECURITY NUMBER
15A. (2) DATE AND PLACE OF MARRIAGE (MM-DD-YYYY)	1 2 3
City or County State/Province Country	16D. PLACE OF BIRTH (Provide City and State. County and
15A. (3) REASON FOR TERMINATION	City or County H a p p y T c
C Death C Divorce C Annulment C Other (Explain):	16E. IF THE CHILD DOES NOT LIVE WITH THE CLAIM
15A. (4) DATE AND PLACE MARRIAGE TERMINATED (MM-DD-1YYY)	
City or County State/Province Country	16F. IF THE CHILD DOES NOT LIVE WITH THE CLAIM/ No. & Street
15B. (1) TO WHOM MARRIED (First, Middle Initial, Last Name)	Apt./Unit Number Ci
	State/Province Country
15B. (2) DATE AND PLACE OF MARRIAGE (MM-DD-YYYY)	16G. CHILD STATUS (Check all that apply)
	BIOLOGICAL 18-23 YEARS OLD AND IN S CHILD PREVIOUSLY MARRIED (If checked, provide I
City or County State/Province Country	16H. HOW AND WHEN MARRIAGE ENDED
15B. (3) REASON FOR TERMINATION	DATE (MM-DD-YYYY)
C Death C Divorce C Annulment C Other (Explain):	
15B. (4) DATE AND PLACE MARRIAGE TERMINATED (MM-DD-YYYY)	16I. IF YOU CHECKED "STEPCHILD" IN ITEM 16G, IS S YES (If "Yes." provide the date the child entered veteran
	C NO
City or County State/Province Country	17A. NAME OF SECOND CHILD TO ADD (First, Middle
15C. (1) TO WHOM MARRIED (First, Middle Initial, Last Name)	
	17B. SOCIAL SECURITY NUMBER
15C. (2) DATE AND PLACE OF MARRIAGE (MM-DD-YYYY)	
	17D. PLACE OF BIRTH (Provide City and State, County and
City or County State/Province Country	City or County
15C. (3) REASON FOR TERMINATION	17E. IF THE CHILD DOES NOT LIVE WITH THE CLAIM/
C Death C Divorce C Annulment C Other (Explain):	
15C. (4) DATE AND PLACE MARRIAGE TERMINATED (MM-DD-YYYY)	17F. IF THE CHILD DOES NOT LIVE WITH THE CLAIM, No. &
State/Province Country	Street Apt/Unit Number
City of County	State/Province Country
15D. (1) TO WHOM MARRIED (First, Middle Initial, Last Name)	17G. CHILD STATUS (Check all that apply)
	C BIOLOGICAL C 18-23 YEARS OLD AND IN S
15D. (2) DATE AND PLACE OF MARRIAGE (MM-DD-YYYY)	C CHILD PREVIOUSLY MARRIED (If checked, provide
	17H. HOW AND WHEN MARRIAGE ENDED
City or County State/Province Country	DATE (MM-DD-YYYY)
15D. (3) REASON FOR TERMINATION	
C Death C Divorce C Annulment C Other (Explain):	17I. IF YOU CHECKED "STEPCHILD" IN ITEM 17G, IS YES (If "Yes," provide the date the child entered veteral
15D. (4) DATE AND PLACE MARRIAGE TERMINATED (MM-DD-YYYY)	C NO
City or County State/Province Country	VA FORM 21-686c, AUG 2022
Page 9	

(If claiming more A. NAME OF FIRST CHILD TO ADD (First, 3 i I I y B. SOCIAL SECURITY NUMBER 1 2 3 D. PLACE OF BIRTH (Provide City and State. attribution of County H a p p y E. IF THE CHILD DOES NOT LIVE WITH T	Middle Initian	childre I, Last) 16C. 0	en, fill (outad S m	ddendu 1 i						ith ap	plica	ition)				S LOUGE
A. NAME OF FIRST CHILD TO ADD (First, B. IIIY B. SOCIAL SECURITY NUMBER 233 D, PLACE OF BIRTH (Provide City and State. ty or County H a p p y	Middle Initian	l, Last) 16C. 0	DATE O	S m	ı i		gel	c) un			up	Phot		,				
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or County H a p p y			10															
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VA FORM 21-686c

APPLICTION REQUEST TO ADD AND/OR REMOVE DEPENDENTS

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SECTION IV: VE	
(If you	ETERAN REPORTING DIVORCE FROM FORMER SPOUSE u have stepchild(ren), also complete Section V)
	nd void, use Section IX, Item 25, "Remarks" to explain.
20A. NAME OF FORMER SPOUSE (First, Middle Initial, La	
20B. PLACE OF DIVORCE (Provide city and state, county and	
City or County	State/Province Country
20C. DATE OF DIVORCE	
have descend the order to prove the second second	
	ETERAN/CLAIMANT REPORTING ON STEPCHILD(REN)
1A. (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 In	nitial, Last)
21B. ARE YOU STILL SUPPORTING YOUR STEPCHILD(F	REN) LISTED IN ITEM 21A?
C YES (If "YES," complete Items 21C through 21L)	
NO (If "NO." complete Item 21F and then continue to Security	ction VI)
1C. NAME OF STEPCHILD YOU ARE SUPPORTING	
and the last the standard standard to the	
21D. IF STEPCHILD DOES NOT LIVE WITH YOU, PROVID	IDE THE NAME OF PERSON WITH WHOM STEPCHILD RESIDES
	and had had a head and a share a share to a head of the share the
21E. IF STEPCHILD DOES NOT LIVE WITH YOU, PROVID	DE A COMPLETE ADDRESS
No. & Street	
Apt/Unit Number City	v
State/Province Country	ZIP Code/Postal Code
State/Province	ZIP Code/Postal Code
21F. DATE STEPCHILD LEFT VETERAN'S HOUSEHOLD	(MM-DD-YYYY)
21G. FINANCIAL SUPPORT PROVIDED	C More than half C Half C Less than half
21H. NAME OF STEPCHILD YOU ARE SUPPORTING	
211. IF STEPCHILD DOES NOT LIVE WITH YOU, PROVID	DE THE NAME OF PERSON WITH WHOM STEPCHILD RESIDES
211. IF STEPCHILD DOES NOT LIVE WITH YOU, PROVID	DE THE NAME OF PERSON WITH WHOM STEPCHILD RESIDES
211. IF STEPCHILD DOES NOT LIVE WITH YOU, PROVID	
21J. IF STEPCHILD DOES NOT LIVE WITH YOU, PROVID No. &	
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21J. IF STEPCHILD DOES NOT LIVE WITH YOU, PROVID No. & Street ApL/Unit Number City State/Province Country	DE A COMPLETE ADDRESS

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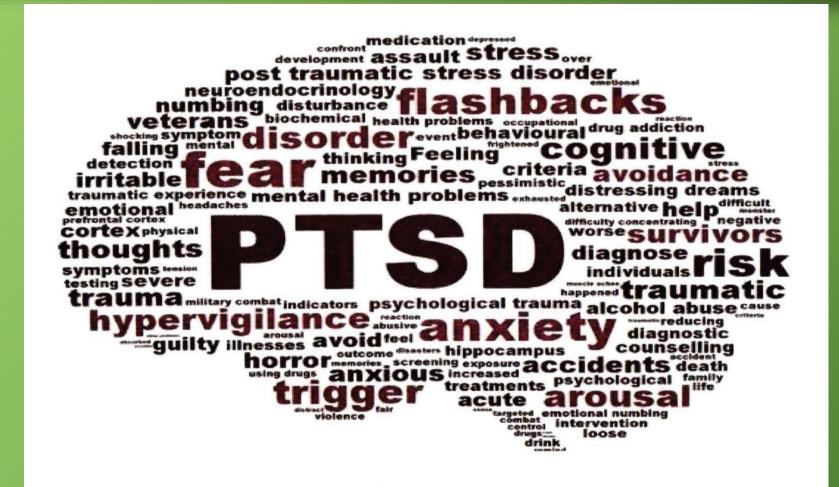
APPLICTION REQUEST TO ADD AND/OR REMOVE DEPENDENTS

SECTION VI: VETERAN/CLAIMANT REPORTING DEATH OF A DEPENDENT	
2A. (1) DEPENDENT TYPE (Check all that apply)	
C SPOUSE C MINOR CHILD (UNDER 18 YEARS OLD C STEPCHILD C ADOPTED C DEPENDENT PARE	
C CHILD PERMANENTLY INCAPABLE OF SELF-SUPPORT C 18-23 YEARS OLD AND IN SCHOOL	
22B. NAME OF DEPENDENT/First, Middle Initial, Last)	
22C. DATE OF DEATH (MM/DD/YYY)	
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)	
C SPOUSE C MINOR CHILD (UNDER 18 YEARS OLD C STEPCHILD C ADOPTED C DEPENDENT PARE	NT
C CHILD PERMANENTLY INCAPABLE OF SELF-SUPPORT C 18-23 YEARS OLD AND IN SCHOOL	
22B. NAME OF DEPENDENT (First, Middle Initial, Last)	
22C. DATE OF DEATH (MM/DD/YYY)	
22D. PLACE OF DEATH (City & State, County & State, or City & Country)	
	Country
City or County State/Province	
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 ATTE	NDING SCHOOL
24A, NAME OF SCHOOLCHILD (First, Middle Initial, Last)	
24B. DATE SCHOOLCHILD STOPPED ATTENDING SCHOOL (MM-DD-YYYY)	
	Page 13

It of the gap of 18, 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, a a court-appointed representative, a a court-appointed representative, a court-appointed representative, a a court-appointed representative, b a court-appointed representative, c a court-appointed representative, b a court-appointed representative, b a court-appointed representative, c a court-appointed representative, b a court-appointed representative, c a manager or principal officer acting on behalf of an institution which is responsible for the care of the claimant. FENALTY: 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 b o fatse, or for the fraudulent acceptance of any payment to which you are not entitled. FRIVACY 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 TI B, Code of Federal Regulations 1.576 for routine uses (i.e., will or criminal law enforcement, congressional communications,	SECTION	NIX: REMARKS	
Image: Completion of this section is REQUIRED to process your request; Image: Completion of this section is Required to process your request; Image: Completion of this section is to gather information or statements that may result in the creation of an overpayment. If such theres actions are taken you will receive additional notification from VA regarding repayment options. Image: Completion of the section of an overpayment. If such theres actions are taken you will receive additional notification from VA regarding repayment options. Image: Completion of the section of an overpayment. If such theres are taken you will receive additional notification from VA regarding repayment options. Image: Completion of the section of an overpayment. If such theres are taken you will receive additional notification from VA regarding repayment options. Image: Completion of the section of an overpayment. If such theres are taken you will receive additional notification from VA regarding repayment options. Image: Completion of the base of the taken there additional to the therefician/claimant. I certify that the claimant is: Image: Completion of the base of the claimant. I certify that lam: Image: Completion of the claimant is: Image: Completion on babel of an the base of the claimant under a durable power of attorney. Image: Completion on babel of the base of the claimant is: Image: Completion on babel of the claimant is: Image: Completion on the section on the origin the there are and the claimant. Image: Completion on the take	5. REMARKS (If any)		
(Note: Completion of this section is REQUIRED to process your request) APORTANT: The primary purpose of this form is to gather information or statements that may result in a change to your VA benefits. By gring this form you have given permission to make benefit payment changes that could result in the creation of an overpayment. If such diverse actions are taken you will receive additional notification from VA regarding repayment options. INTEREPT CERTIFY THAT the information I have given above is true and correct to the best of my knowledge and belief. CAS.GIGNATURE OF BENEFICIARY/CLAIMANT OR ALTERNATE INFORMATION OF SUBJOACTION (FOR USE BY VA ONLY) 26B. DATE (MM/DD/YYY) CALTERNATE SIGNER: By signing on behalf of the beneficiary/claimant, I certify that the claimant is:			
(Note: Completion of this section is REQUIRED to process your request) APORTANT: The primary purpose of this form is to gather information or statements that may result in a change to your VA benefits. By gring this form you have given permission to make benefit payment changes that could result in the creation of an overpayment. If such diverse actions are taken you will receive additional notification from VA regarding repayment options. INTEREPT CERTIFY THAT the information I have given above is true and correct to the best of my knowledge and belief. CALCOLD OF DENEFICIARY/CLAIMANT OR ALTERNATE (REQUIRED) (FOR USE BY VA ONLY) CALCOLD OF DENEFICIARY/CLAIMANT OR ALTERNATE (REQUIRED) (FOR USE BY VA ONLY) CALCOLD OF DENEFICIARY/CLAIMANT OR ALTERNATE (REQUIRED) (FOR USE BY VA ONLY) CALCOLD OF DENEFICIARY/CLAIMANT OR ALTERNATE (NEW Statistical statis statistatis statistical statistical statis statistica			
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If 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, Units 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 th 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 time be located on the OMB Internet Page at <u>www.reginfo.cov/public/dor/PAMain.</u> If desired, you can ca	HEREBY CERTIFY THAT the information I have given above is true and the SA. SIGNATURE OF BENEFICIARY/CLAIMANT OR ALTERNATE SIGNER' (REQUIRED) ALTERNATE SIGNER: By signing on behalf of the beneficiary/claimant, under the age of 18, mentally incompetent to provide substantially accurate informat from are true and complete, or physically unable to sign the form ALTERNATE SIGNER: By signing on behalf of the beneficiary/claimant, a court-appointed representative, a an attorney in fact or agent authorized to act on behalf of the cl a manager or principal officer acting on behalf of an institution v PENALTY: The law provides severe penalties which include fine or imprisonment, to be false, or for the fraudulent acceptance of any payment to which you are not er PRIVACY ACT INFORMATION: VA will not disclose information collected on this fals. Code of Federal Regulations 1.576 for routine uses (i.e., civi or criminal law en of money owed to the United States, liftgation in which the United States is a party if dentity and status, and personnel administration us identified in the VA system remojoyment Records - VA, published in the Federal Regulation to the or imprisonment. Records - VA, published in the Federal Regulation to the Va system.	correct to the best of my knowledge (FOR USE BY VA ONLY) I certify that the claimant is: ion needed to complete the form or to certify that I am: aimant under a durable power of atto due but not limited to a spouse or oth which is responsible for the care of the or both, for the wilfful submission of any sta- tited. Dorn to any source other than what has be forcement, congressional communications or has an interest, the administration of V or faceds, SkV212228, Compensatio respond is required to obtain or retain b the SSN of any dependents for whom b	ons. and belief. 26B. DATE (MM/DD/YYYY) 27B. DATE (MM/DD/YYY) 27B. DATE (MM/DD/YYY) 27B. DATE (MM/DD/YYY) 27B. DATE (MM/DD/YY) 27B. DATE (MM/DD/Y) 27B. DATE (MM/DD/YY) 27B. DATE (MM/DD/Y) 27B. DATE (MM/DD
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POST TRAUMATIC STRESS DISORDER



	Expiration Date: 06/30/2024 VA DATE STAMP	SECTION II: STRESSFUL INCIDENTS (Continued)
Department of Veterans Affairs	DO NOT WRITE IN THIS SPACE	
STATEMENT IN SUPPORT OF CLAIM FOR SERVICE CONNECTION		NOTE: Information about persons who were killed or injured during the first incident (attach a separate sheet if more space is needed.)
FOR POST-TRAUMATIC STRESS DISORDER (PTSD)		9A. NAME OF PERSON (First, Middle Initial, Last)
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		9B. RANK (If applicable) 9C. DATE OF INJURY/DEATH (MM/DD/YYYY) 9D. PLEASE CHECK ONE
https://www.veteranserisisline.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.		B. KANK (I) applicable) B. DATE OF INJURITIDEATH (MADDD/TTTT) BJ. FLEXES ENERGY WE MOUNDED IN ACTION AND ACTION KILLED IN ACTION KILLED IN ACTION KILLED IN ACTION KILLED IN ACTION
r uays a week, 505 uays a year. Support for user and hard of rearing 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		9E. UNIT ASSIGNMENT DURING INCIDENT (Such as, DIVISION, WING, BATTALION, CAVALRY, SHIP)
dates of assignment, and the full names and unit assignments of you know of who were killed or injured during the incident. Please		9E. UNIT ASSIGNMENT DURING INCIDENT (SUCH AS, DIVISION, WING, BATTALION, CAVALAT, SHIF) 123 Unit Hiker
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		125 OHIC HIKEL
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		10A. NAME OF PERSON (First, Middle Initial, Last)
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)		10B. RANK (If applicable) 10C. DATE OF INJURY/DEATH (MM/DD/YYYY) 10D. PLEASE CHECK ONE Month Day Year TKILLED IN ACTION
Joe Smith		
2. SOCIAL SECURITY NUMBER 3. VA FILE NUMBER (If applicable) 4. DATE OF BIRTH	(MM/DD/YYYY)	
Month	Day Year	10E. UNIT ASSIGNMENT DURING INCIDENT (Such as, DIVISION, WING, BATTALION, CAVALRY, SHIP)
1 2 3 - 4 5 - 6 7 9 8 1 2 3 4 5 6 7 8 9 0 1 - 0	0 1 - 1 9 0 0	
5. VETERAN'S SERVICE NUMBER (If applicable) 6. TELEPHONE NUMBER (Include Area Cod	de)	
1 2 3 4 5 6 7 8 9	9 0	
Enter International Phone Number (If application	ible):	11A. DATE SECOND INCIDENT OCCURRED (MM/DD/YYYY) 11B. DATES OF UNIT ASSIGNMENT (MM/DD/YYYY)
7. E-MAIL ADDRESS (Optional)		FROM: TO:
n o n e		Month Day Year Month Day Year Month Day
SECTION II: STRESSFUL INCIDENTS	et see the set of the set of	
8A. DATE FIRST INCIDENT OCCURRED (MM/DD/YYYY) 8B. DATES OF UNIT ASSIGNMENT (MM/	DD/YYYY)	11C. LOCATION OF INCIDENT (City: State, Country, Province, landmark or military installation)
FROM: TO: Month Day Year Month Day Year Month	Day Year	
8C, LOCATION OF INCIDENT (City, State, Country, Province, landmark or military installation)		
rocky mountains		11D. UNIT ASSIGNMENT DURING INCIDENT (Such as, DIVISION, WING, BATTALION, CAVALRY, SHIP)
8D. UNIT ASSIGNMENT DURING INCIDENT (Such as, DIVISION, WING, BATTALION, CAVALRY, SHIP)		
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8E. DESCRIPTION OF THE INCIDENT		
while on patrol was ambushed		
white on partor was ambushed		
		11F. MEDALS OR CITATIONS YOU RECEIVED BECAUSE OF THE INCIDENT
8F. MEDALS OR CITATIONS YOU RECEIVED BECAUSE OF THE INCIDENT		
combat badge	1	
		VA FORM 21-0781 JUN 2021

VA FORM 21-01781

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

VA FORM 21-0781 STATEMENT IN SUPPORT OF CLAIM FOR SERVICE CONNECTION FOR POST-TRAUMATIC STRESS DISORDER

		SECTION II: STRESS	FUL INCIDENTS (Continued	0
NOTE: Information about			cident (attach a separate sheet if mo	
12A. NAME OF PERSON ()				
12B. RANK (If applicable)	12C. DATE OF INJURY/DE	NUMBER OF STREET, SAME AND	12D. PLEASE CHECK ONE	
	Month Day	Year	1 -	
12E. UNIT ASSIGNMENT D	DURING INCIDENT (Such as,	DIVISION, WING, BATTAL	ION, CAVALRY, SHIP)	
13A. NAME OF PERSON ()	(Inst., Midale Initial, Last)			
13B. RANK (If applicable)	13C. DATE OF INJURY/DE	EATH (MM/DD/YYYY)	13D. PLEASE CHECK ONE	
	Month Day	Year	1	WOUNDED IN ACTION KILLED NON-BATT
			I INJURED NON-BATTLE	OTHER:
13E. UNIT ASSIGNMENT D	DURING INCIDENT (Such as,	DIVISION, WING, BATTAL	JON, CAVALRY, SHIP)	
		SECTION	N III: REMARKS	
	(NOTE: This		N III: REMARKS for any additional informati	ion, if needed)
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STATEMENT IN SUPPORT OF CLAIM FOR SERVICE CONNECTION FOR POST-TRAUMATIC STRESS DISORDER SECONDARY TO PERSONAL ASSAULT

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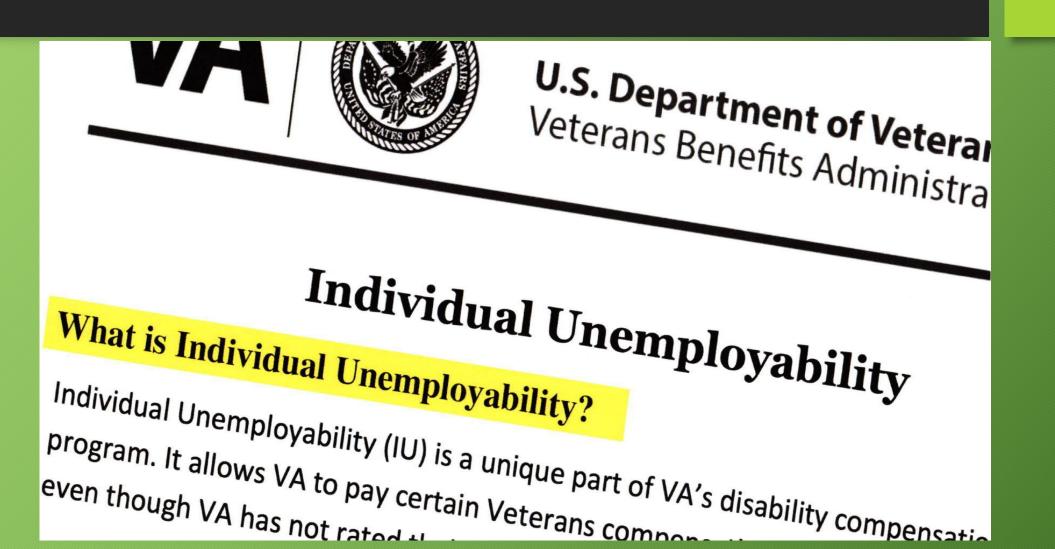
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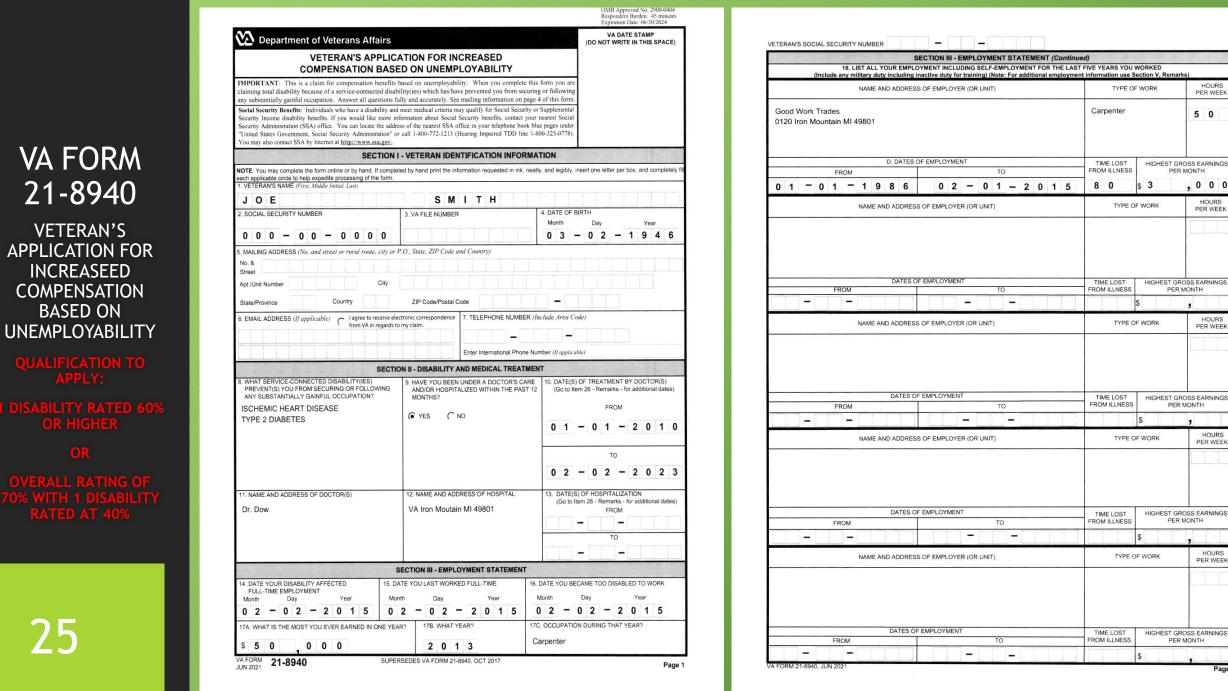
PAGE 2

	(S) (Continued)
10. Please provide in the space below any other information that you feel is impo are some examples of behavioral changes that you may have experienced follow	
 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 use of over-the-counter medications increased use of over-the-counter medications 	
SECTION III: CERTIFICATION AND	
I HEREBY CERTIFY THAT the foregoing statement(s) are true and correct t	to the best of my knowledge and belief.
I HEREBY CERTIFY THAT the foregoing statement(s) are true and correct to 11. VETERAN'S SIGNATURE (REQUIRED)	to the best of my knowledge and belief. 12. DATE SIGNED (MM-DD-YYYY)
I HEREBY CERTIFY THAT the foregoing statement(s) are true and correct to 11. VETERAN'S SIGNATURE (REQUIRED) Veteran Sign	to the best of my knowledge and belief. 12. DATE SIGNED (MM-DD-YYYY) 0 1 - 0 1 - 1 9 0 0
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VA FORM 21-0781A STATEMENT IN SUPPORT OF CLAIM FOR SERVICE CONNECTION FOR POST-TRAUMATIC STRESS DISORDER SECONDARY TO PERSONAL ASSAULT

INDIVIDUAL UNEMPLOYABILITY





HOURS

PER WEEK

HOURS

PER WEEK

HOURS

HOURS

HOURS

PER WEEK

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PER WEEK

	- EMPLOYMENT STATEMENT (Continue	
19. IF YOU ARE CURRENTLY SERVING IN THE RESERVE OR NA PERFORMING YOUR MILITARY DUTIES?	TIONAL GUARD, DOES YOUR SERVICE CONN	NECTED DISABILITY PREVENT YOU FROM
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20A. INDICATE YOUR TOTAL EARNED INCOME FOR THE PAST	12 20B IE PRESENTLY EMPLOYED	INDICATE YOUR CURRENT MONTHLY EA
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21A. DID YOU LEAVE YOUR LAST JOB/SELF-	1B. DO YOU RECEIVE/EXPECT TO RECEIVE	21C. DO YOU RECEIVE/EXPECT TO REC WORKERS COMPENSATION BENEF
EMPLOYMENT BECAUSE OF YOUR DISABILITY?	DISABILITY RETIREMENT BENEFITS?	
(YES (NO "Remarks")	(YES (NO	CYES (NO
22. HAVE YOU TRIED TO OBTAIN EMPLOYMENT SINCE YOU BE	ECAME TOO DISABLED TO WORK?	
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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 Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owel to the Unite States, lingitudino 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 personm administration of varience to explore treating benefits. Compensation, Education, and Veteran Readiness and Employment Records - VA, published in the Feder Register. Your response is required to postion or retain benefits. (Siving us your SSN account information is mandator), Applicants are required to provide their SSN under Title 38. U.S. (S101(c)(1)). VA will not deeny an individual benefits for retains benefits. (Siving us your SSN account information is mandator). Applicants are required to provide their SSN under Title 38. U.S. (S101(c)(1)). VA will not deeny an individual benefits for retains processary to determine maximum benefits provided under the law. The responses you 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. U.S. (Code, allows us to ask for this information we estimate this you will need an average of 34 minutes to review the instructions, find the information, and complete this form. Va cannot conduct or sponsora collection of information unless a valid OM	knowing it to be false or for the fraudulent acceptance of any paym	nent to which you are not entitled. I - WHERE TO SEND CORRESPC MAIL TO: Department of Veterans Affairs							S. A.	
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VA FORM 21-8940

VETERAN'S APPLICATION FOR INCREASEED COMPENSATION BASED ON UNEMPLOYABILITY

VA FORM 21-4192 WILL BE SENT TO LAST EMPLOYER

DEATH INDEMNITY COMPENSATION



U.S. Department of Veterans Affairs Veterans Benefits Administration

1

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
 - $\,\circ\,\,$ 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

VA FORM

21P-534EZ

ELIGIBILITY

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/.





DICKINSON COUNTY OFFICE OF VETERAN AFFAIRS ACCREDITED COUNTY VETERAN SERVICE OFFICERS DENISE FORMOLO AND LACEY ELLISON

