Department of Veterans Affairs

OMB Approved No. 2900-0001
Respondent Burden: 1 hour 30 minutes

(DO NOT WRITE IN THIS SPACE)

VETERAN'S APPLICATION FOR COMPENSATION AND/OR PENSION, VA Form 21-526, Part A: General information

Please read the attached "General Instructions"before you fill out this form.

SECTION I Tell us what you are applying for

Check the box that says what you are applying for. Be sure to complete the other Parts you need.

1. What are you applying for? If you are unsure please refer to the "General Instructions" page 2 Section 1: Preparing your application

- [X] Compensation ► Fill out Part A of VA Form 21-526 and Parts B and C
- [ ] Pension ► Fill out Part A of VA Form 21-526 and Parts C and D
- [ ] Compensation and ► Fill out Part A of VA Form 21-526 and Parts B, C and D

2a. Have you ever filed a claim with VA

- [X] No *(If "No," skip Item 2b and go to Item 3)*
- [ ] Yes _____ *(Go to 2b)* *(If "Yes," provide file number below)*

2b. I filed a claim for

- [ ] Compensation
- [ ] Pension
- [ ] Other _____

SECTION II Tell us about you

We need information about you to process your claim faster.

3. What is your name?

First	Middle	Last	Suffix (If applicable)
John	Ellis	Doe	

4. What is your Social Security number?
123-45-6789

5. What is your sex?
[X] Male [ ] Female

6a. Did you serve under another name?

- [ ] Yes *(If "Yes," go to Item 6b)*
- [X] No *(If "No," go to Item 7)*

6b. Please list the other name(s) you served under

Give us your current mailing address in the space provided. If it will change within the next three months, give us that new address in block 29 "Remarks." Also in block 29, give us the date you think you will be at the new address.

7. What is your address?

Street address, rural route, or P.O. Box	Apt. number		
100 Veteran Avenue			
City	**State**	**ZIP Code**	**Country**
Raleigh	NC	27999	US

8. What are your telephone numbers?

Daytime (919) 777-1234
Evening (919) 777-4321

9. What is your e-mail address?
None

10. What is your date of birth?
April 1, 1980

11. Where were you born?
Raleigh, NC, US

OWCP used to be called the U.S. Bureau of Employees Compensation

12a. Are you receiving disability benefits from the Office of Workers' Compensation *(OWCP)*?

- [ ] Yes
- [X] No

(If "Yes," answer 12b and 12c also)

12b. When was the claim filed?

12c. What disability are you receiving benefits for?

13a. What is the name of your nearest relative or other person we could contact if necessary?
Jane Doe

13b. What is his/her telephone number?

Daytime (919) 777-1234
Evening (919) 777-4321

13c. What is this person's address?
100 Veteran Avenue
Raleigh, NC 27999

13d. How is this person related to you?
Spouse

SECTION III — Tell us about your active duty

1. Enter complete information for all periods of service. If more space is needed use Item 29 "Remarks".
2. Attach your original DD214 or a certified copy to this form. (We will return original documents to you.)

14a. I entered active service the **first** time. . 4/15/1998 (mo day yr)	**14b.** Place: Raleigh, NC	**14c.** My service number was . . . 123-45-6789	
14d. I left this active service. . . 12/30/2004 (mo day yr)	**14e.** Place: Ft. Bragg, NC	**14f.** Branch of Service: Army	**14g.** Grade, rank, or rating: Sgt. E-5
14h. I entered my **second** period of active service. . . (mo day yr)	**14i.** Place:	**14j.** My service number was . . .	
14k. I left this active service. . . (mo day yr)	**14l.** Place:	**14m.** Branch of Service	**14n.** Grade, rank, or rating

The VA has a registry of veterans who served in the Gulf War. This area has also been called the "Persian Gulf." If you served there, we will include your name in the registry. If you want your medical information included, you must check "Yes" in Item 16b. For more information about the registry, see page 4 of the General Instructions for VA Form 21-526.

15a. Did you serve in Vietnam?

☐ Yes ☒ No

(If "Yes," answer Item 15b also)

15b. When were you in Vietnam?

from _____ (mo day yr) to _____ (mo day yr)

16a. Were you stationed in the Gulf after August 1, 1990?

☐ Yes ☒ No

(If "Yes," answer Item 16b also)

16b. Do you want to have medical and other information about you included in the "Gulf War Veterans' Health Registry?"

☐ Yes ☐ No

17a. Have you ever been a prisoner of war?

☐ Yes ☒ No

(If "Yes," answer Items 17b, 17c, and 17d also)

17b. What country or government imprisoned you?

17c. When were you confined?

from _____ (mo day yr) to _____ (mo day yr)

17d. What was the name of the camp or sector and what are the names of the city and country near its location

SECTION IV — Tell us about your reserve duty

18a. Are you currently assigned to an active reserve unit?

☐ Yes ☒ No

(If "Yes," answer Item 18b also)

18b. What is the name, mailing address, and telephone number of your current unit?

18c. Were you previously assigned to an active reserve unit within the last 2 years?

☐ Yes ☒ No

(If "Yes," answer Item 18d also)

18d. What is the name, mailing address, and telephone number of that unit?

SECTION IV (*Continued*) Tell us about your reserve duty

18e. Do you have an inactive reserve obligation? (You perform no active duty, but you could be activated if there was a national emergency)

☐ Yes ☒ No ☐ Don't know

(If "Yes," answer Item 18f also)

18f. What is your reserve obligation termination date?

mo day yr

Instructions 18g-18k

If you are currently or have ever been a full time reservist for operational or support duty,

1. Complete 18g-18k for that service only.
2. Attach proof of reserve service.

18g. I entered reserve service. . .

mo day yr

Place:

18h. My service number was . . .

18i. I left reserve service. . .

mo day yr

Place:

18j. Branch of service

18k. Grade, rank, or rating

Instructions 18l-18p

If your disability occurred or was aggravated during any period of reserve duty,

1. Complete 18l-18p for the period when your disability occurred.
2. Attach proof that your disability occurred during reserve service.

18l. I entered reserve service. . .

mo day yr

Place:

18m. My service number was . . .

18n. I left reserve service. . .

mo day yr

Place:

18o. Branch of service

18p. Grade, rank, or rating

SECTION V Tell us about your National Guard duty

19a. Are you currently a member of the National Guard?

☐ Yes ☒ No ☐ Not assigned yet

(If "Yes," answer Item 19b also)

19b. What is the name, mailing address, and telephone number of your current unit?

19c. Were you previously assigned to a guard unit within the last 2 years?

☐ Yes ☒ No

(If "Yes," answer Item 19d also)

19d. What is the name, mailing address, and telephone number of that unit?

Instructions 19e-19i

If you were activated to Federal Active Duty under the Authority of Title 10, United States Code,

1. Complete 19e-19i for that service only
2. Attach proof of this Federal Active Duty.

19e. I entered Federal Active Duty. . .

mo day yr

Place:

19f. My service number was . . .

19g. I left Federal Active Duty. . .

mo day yr

Place:

19h. Branch of service

19i. Grade, rank, or rating

Instructions 19j-19n

If your disability occurred or was aggravated during any period of guard duty,

1. Complete 19j-19n for the period when your disability occurred
2. Attach proof that your disability occurred during National Guard Service.

19j. I entered National Guard. . .

mo day yr

Place:

19k. My service number was . . .

19l. I left National Guard. . .

mo day yr

Place:

19m. Branch of service

19n. Grade, rank, or rating

SECTION VI Tell us about your travel status	20a. Were you injured while traveling to or from your military assignment? (If "Yes," answer Items 20b thru 20e and Section I of Part B: Compensation) ☐ Yes ☒ No	20b. When did your injury happen? mo day yr	20c. Where did your injury happen? (City,State,Country)	20d. Where were you treated? (Provide name and address of Doctor's office, hospital, etc.)	20e. What agency did you file an accident report with?

SECTION VII Tell us about your military benefits

When you file this application, you are telling us that you want to get VA compensation instead of military retired pay. If you currently receive military retired pay, you should be aware that we will reduce your retired pay by the amount of any compensation that you are awarded. VA will notify the Military Retired Pay Center of all benefit changes.

You must sign 21e if you want to keep getting military retired pay instead of VA compensation.

Please see page 4 of the General Instructions for VA Form 21-526.

If you have gotten both military retired pay and VA compensation, some of the amount you get may be recouped by VA, or in the case of VSI, by the Department of Defense

21a. Are you receiving or will you receive retired or retainer pay that is based on your military service?

☐ Yes ☒ No

(If "Yes," answer Items 21b thru 21f. If "No," skip to Item 22)

21b. What branch of service is paying or will pay your retired or retainer pay?

21c. What is the monthly amount? $.

21d. What is your retirement based on?

☐ Length of service ☐ Disability ☐ TDRL (Temporary Disability Retired List)

21e. Sign here if you want to receive military retired pay *instead of* VA compensation

_____

21f. Have you received or will you receive any of the following military benefits?
(Please check the appropriate boxes and tell us the amount)

Benefit	*Amount*
(1) ☐ Lump Sum Readjustment Pay	$.
(2) ☐ Separation pay under 10 USC 1174	$.
(3) ☐ Special Separation Benefit (SSB)	$.
(4) ☐ Voluntary Separation Incentive (VSI)	$.
(5) ☐ Disability Severance Pay (name of disability_____)	$.
(6) ☐ Other (tell us the type of benefit_____)	$.

SECTION VIII Give us direct deposit information

If benefits are awarded we will need more information in order to process any payments to you. Please read the paragraph starting with, ***"All federal payments..."*** and then either:

1. Attach a voided check, or
2. Answer questions 22-24 to the right.

All federal payments beginning January 2, 1999, must be made by electronic funds transfer (EFT) also called Direct Deposit. Please attach a voided personal check or deposit slip or provide the information requested below in Items 22, 23 and 24 to enroll in Direct Deposit. If you do not have a bank account we will give you a waiver from Direct Deposit, just check the box below in Item 22. The Treasury Department is working on making bank accounts available to you. Once these accounts are available, you will be able to decide whether you wish to sign-up for one of the accounts or continue to receive a paper check. You can also request a waiver if you have other circumstances that you feel would cause you a hardship to be enrolled in Direct Deposit. You can write to: Department of Veterans Affairs, 125 S. Main Street Suite B, Muskogee OK 74401-7004, and give us a brief description of why you do not wish to participate in Direct Deposit.

22. Account number (Please check the appropriate box and provide that account number, if applicable)

☒ Checking ☐ I certify that I **do not** have an account with a financial institution or certified payment agent

☐ Savings

Account number 001233210

23. Name of financial institution
First National Bank of North Carolina

24. Routing or transit number
056123321

SECTION IX **Give us your signature**

1. Read the box that starts, "I certify and authorize the release of information:"
2. Sign the box that says, "Your signature."
3. If you sign with an "X," then you must have 2 people you know witness you as you sign. They must then sign the form and print their names and addresses also.

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 except protected health information, and I waive any privilege which makes the information confidential.

25. Your signature	**26.** Today's date
John E. Doe	04/15/2009 (mo day yr)

27a. Signature of witness (If claimant signed above using an "X")	**27b.** Printed name and address of witness
28c. Signature of witness (If claimant signed above using an "X")	**28b.** Printed name and address of witness

SECTION X

Remarks—Use this space for any additional statements that you would like to make concerning your application for Compensation and/or Pension

IMPORTANT
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 which you are not entitled to.

29. Remarks *(If you need more space to answer a question or have a comment about a specific item number on this form, please identify your answer or statement by the part and item number). (See page 5 "Tips For Filling Out Your VA Form 21-526.")*

Department of Veterans Affairs

VA Form 21-526, Part B: Compensation

Use this form to apply for compensation. Remember that you must also fill out a VA Form 21-526, Part A: General Information, for your application to be processed. Be sure to write your name and Social Security number in the space provided on page 2.

SECTION I Tell us about your disability

In the table below, tell us more about your disability or disabilities. Be sure to:

- List all disabilities you believe are related to military service.
- List all the treatments you received for your disabilities, including
  - treatments you received in a military facility before and after discharge.
  - treatments you received from civilian and VA sources before, during, and after your service.

1. What disability are you claiming?	2. When did your disability begin?	3b. When were you treated?	4a. What medical facility or doctor treated you?	4b. What is the address of that medical facility or doctor?
Hypertension	04/15/2004 (mo day yr)	from 4/15/2004 (mo day yr) to 12/30/2004 (mo day yr)	Womack Army Hospital	Ft. Bragg, NC 28777
Hypertension	4/15/2004 (mo day yr)	from 12/30/2004 (mo day yr) to Current (mo day yr)	Durham VA Medical Center	508 Fulton St. Durham, NC 27577
Right Leg- Nerve & Muscle damage due to schrapnel	10/01/2004 (mo day yr)	from 10/01/2004 (mo day yr) to 12/30/2004 (mo day yr)	Womack Army Hospital	Ft. Bragg, NC 28777
Tramatic Brain Injury (TBI)	10/01/2004 (mo day yr)	from 10/01/2004 (mo day yr) to 12/30/2004 (mo day yr)	Womack Army Hospital	Ft. Bragg, NC 28777
Tramatic Brain Injury (TBI)	10/01/2004 (mo day yr)	from 12/31/2004 (mo day yr) to Current (mo day yr)	Durham VA Medical Center	508 Fulron St. Durham, NC 27577
	(mo day yr)	from (mo day yr) to (mo day yr)		
	(mo day yr)	from (mo day yr) to (mo day yr)		
	(mo day yr)	from to		
	(mo day yr)	from (mo day yr) to (mo day yr)		

SECTION II Tell us if any of the disabilities you listed on Page 1 were because of exposures			
	5a. Were you exposed to Agent Orange or other herbicides? ☐ Yes ☒ No	**5b.** What is your disability?	**5c.** In what country were you exposed?
	6a. Were you exposed to asbestos? ☐ Yes ☒ No (If "Yes," answer Item 6b and 6c also)	**6b.** What is your disability? **6c.** When and how were you exposed?	
	7a. Were you exposed to mustard gas? ☐ Yes ☒ No (If "Yes," answer Item 7b and 7c also)	**7b.** What is your disability? **7c.** When and how were you exposed?	
	8a. Were you exposed to ionizing radiation? ☐ Yes ☒ No (If "Yes," answer Items 8b, 8c, and 8d also)	**8b.** What is your disability?	**8c.** When was your last exposure? mo day yr
	8d. How were you exposed to radiation?	☐ Atmospheric testing ☐ Nagasaki/Hiroshima ☐ Other, describe	
	9a. Were you exposed to an environmental hazard in the Gulf War? ☐ Yes ☒ No (If "Yes," answer Items 9b and 9c also)	**9b.** What is your disability?	**9c.** What was the hazard?
	10a. Did you have a separation or retirement physical examination? ☒ Yes ☐ No (If "Yes," answer Items 10b and 10c also)	**10b.** When was the exam? 12/15/2004 mo day yr	**10c.** Where did the exam occur? Fort Bragg, NC

SECTION III **Tell us how your disabilities listed on Page 1 are related to your military service**

11. Explanation

My Hypertension was not medicated until about 2 years from discharge. I had the medical doctors at Womack Army Hospital tell me to watch what I eat like salt and fried foods due to my elevated blood pressure. I have been medically supervised the last 8 months on active duty with blood pressure readings.

I was serving under orders for OIF when a road side bomb injured my right leg and caused TBI.

Your Name	Your Social Security Number
John Ellis Doe	123-45-6789

Department of Veterans Affairs

VA Form 21-526, Part C: Dependency

Use this form to tell us more about your dependents. Remember that you must also fill out a VA Form 21-526, Part A: General Information, Part B and/or Part D, for your application to be processed. Be sure to write your name and Social Security number in the space provided on page 3.

SECTION I Tell us about your marriage

NOTE: You should provide a copy of your marriage certificate

1. What is your marital status?
   ☒ Married ☐ Surviving Spouse ☐ Divorced ☐ Never married

   (If your spouse died, you are "divorced," or "never married" skip to Section III beginning on page 2)

2. When were you married?
   04/01/1999
   mo day yr

3. Where did you get married? (city/state or country)
   Raleigh, NC

4. What is your spouse's name?
   Jane Doe
   First Middle Last

5. When is your spouse's birthday?
   09/15/80
   mo day yr

6. What is your spouse's Social Security number?
   987-65-4321

7a. Is your spouse also a veteran?
   ☐ Yes ☒ No
   (If "Yes," answer Item 7b also)

7b. What is your spouse's VA file number (If any)?

8. Do you live with your spouse?
   ☒ Yes
   ☐ No

9. What is your spouse's address?
   Street address, rural route, or P.O. Box Apt. number
   City State Zip code Country

10. Tell us why you are not living with your spouse

11. How much do you contribute monthly to your spouse's support?
   $.

12. How were you married?
   a. ☒ Ceremony by a clergyman or other authorized public official
   b. ☐ Common-law
   c. ☐ Tribal
   d. ☐ Proxy
   e. ☐ Other (please describe in the space below)

SECTION II **Tell us about any previous marriages** NOTE: You should provide copies of divorce decrees or death certificates	In the table below, tell us about: • Your previous marriages, and • Your spouse's previous marriages

Your previous marriages

13a. How many times have you been married before? 0

13b. When were you married?	13c. Where were you married? (city/state or country)	13d. Who were you married to? (first, middle initial, last)	13e. When did your marriage end?	13f. Why did your marriage end? (death, divorce)	13g. Where did your marriage end? (city/state or country)
mo day yr			mo day yr		
mo day yr			mo day yr		

Your spouse's previous marriages

14a. How many times has your current spouse been married before? 0

14b. When was your spouse married?	14c. Where was your spouse married? (city/state or country)	14d. Who was your spouse married to? (first, middle initial, last)	14e. When did your spouse's marriage end?	14f. Why did your spouse's marriage end? (death, divorce)	14g. Where did your spouse's marriage end? (city/state or country)
mo day yr			mo day yr		
mo day yr			mo day yr		

SECTION III **Tell us about your other dependents**

In this section we want to know whether your parents are financially dependent on you (Question **15**) and more about your **dependent children.** VA may recognize a veteran's biological children, adopted children, and stepchildren as dependent. These children must be unmarried and:

- be under the age of 18, **or**
- be at least 18 but under 23 and pursuing an approved course of education, **or**
- have become permanently unable to support themselves before reaching the age of 18.

15. Are your parents financially dependent on you?

☐ Yes ☒ No (If "Yes," we will request additional information from you later.)

You should provide: a copy of the public record of birth for each child or a copy of the court record of adoption for each adopted child.

16. Do you have dependent children?

☒ Yes
(If "No," Skip Items 17-21f.) Go to the bottom of page 3 and write your name and Social Security number.)

☐ No

17. How many dependent children do you have?

1

Give us more information about these children in the tables on the next page (Items 18 through 21f).

SECTION III Tell us about your dependents (continued)

18a. What is the name of your unmarried child(ren)? (first, middle initial, last)	18b. Date and place of birth (city/state or country)	18c. Social Security Number	19a. Biological	19b. Adopted	19c. Stepchild	20a. 18-23 yrs. old and in school	20b. Seriously disabled before age 18	20c. Child previously married
Janice Doe	04/14/01 mo day yr Place: Raleigh, NC	989-12-4567	☒	☐	☐	☐	☐	☐
	mo day yr Place:		☐	☐	☐	☐	☐	☐
	mo day yr Place:		☐	☐	☐	☐	☐	☐
	mo day yr Place:		☐	☐	☐	☐	☐	☐

Tell us about your dependents listed above who *don't live with you*

21a. Do all the children listed above live with you?

☒ Yes (If "Yes," skip Items 21b thru 21f and write your name and Social Security number below.)

☐ No (If "No," complete Item 21b and the table below (Items 21c -21f) and write your name and Social Security number below.)

21b. How many of the children do not live with you?

_____

21c. What is the name of your child? (first, middle initial, last)	21d. What is your child's complete address?	21e. What is the name of the person your child lives with (If applicable)? (first, middle initial, last)	21f. How much do you contribute each month to the support of your child?
			$.
			$.
			$.
			$.

Your name	Your Social Security Number
John Ellis Doe	123-45-6789

OMB Approved No. 2900-0043
Respondent Burden: 15 minutes

Department of Veterans Affairs

DECLARATION OF STATUS OF DEPENDENTS

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, 58 VA21/22 Compensation, Pension, Education, and Rehabilitation Records - VA, and 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 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 unless a valid OMB 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.whitehouse.gov/library/omb/OMBINVC.html#VA. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

INSTRUCTIONS: Print all answers clearly. Make sure you sign and date this form (Items 18 and 19). Note: Unless the claimant is the veteran's surviving spouse, the veteran must sign in Item 18. When you have completed this form, mail it or take it to a VA regional office.

1A. FIRST - MIDDLE - LAST NAME OF VETERAN	2A. NAME OF CLAIMANT *(If other than veteran)*	3. FILE NUMBER
John Ellis Doe		
1B. VETERAN'S SOCIAL SECURITY NUMBER	2B. CLAIMANT'S SOCIAL SECURITY NUMBER	
123-45-6789		C - CSS 123-45-6789

4. ADDRESS OF CLAIMANT *(No. and street or rural route, city or P.O., State and ZIP Code)*
100 Veteran Avenue, Raleigh, NC 27999

5A. MARITAL STATUS *(Check one)*
☒ MARRIED ☐ DIVORCED ☐ NEVER MARRIED *(If checked, do not complete (Skip to Item 12)*
☐ WIDOWED ☐ SEPARATED

5B. IF MARRIED, SPOUSE'S DATE OF BIRTH
September 15, 1980
month day year

NOTE: You must furnish complete information about all your and your current spouse's previous marriages. If you or your spouse have been married more than three times, list additional marriages in Item 17, "Remarks, " or attach a separate sheet.

SECTION I - VETERAN'S MARRIAGES

6. HOW MANY TIMES HAVE YOU BEEN MARRIED? 1

7A. DATE AND PLACE OF MARRIAGE *(City,/State or Country)*	7B. TO WHOM MARRIED *(First, middle, last name)*	7C. SOCIAL SECURITY NUMBER	7D. HOW MARRIAGE TERMINATED *(Death, Divorce)*	7E. DATE AND PLACE TERMINATED *(City/State or Country)*
April 1, 1999 *month day year* Place: Raleigh, NC	Jane Doe	987-65-4321		
month day year Place:				*month day year* Place:
month day year Place:				*month day year* Place:

SECTION II - SPOUSE'S PREVIOUS MARRIAGES

8. HOW MANY TIMES HAS THE VETERAN'S CURRENT SPOUSE OR SURVIVING SPOUSE BEEN MARRIED? 0

9A. DATE AND PLACE OF MARRIAGE	9B. TO WHOM MARRIED *(First, middle, last name)*	9C. HOW MARRIAGE TERMINATED *(Death, Divorce)*	9D. DATE AND PLACE TERMINATED
month day year Place:			*month day year* Place:
month day year Place:			*month day year* Place:
month day year Place:			*month day year* Place:

(Continued on Reverse)

10A. IS YOUR SPOUSE ALSO A VETERAN?	10B. WHAT IS YOUR SPOUSE'S VA FILE NUMBER *(If any)*?
☐ YES ☒ NO *(If "Yes," answer Item 10B also. If "No," skip to Item 11.)*	
11. DO YOU LIVE WITH YOUR SPOUSE?	12. WHAT IS YOUR SPOUSE'S ADDRESS?
☒ YES ☐ NO *(If "Yes," skip to Item 14A. If "No, answer Items 12 and 13 also.)*	

13. HOW MUCH DO YOU CONTRIBUTE MONTHLY TO YOUR SPOUSE'S SUPPORT?

$

SECTION III - VETERAN'S UNMARRIED CHILDREN

NOTE: If any child is claimed as "seriously disabled" (Item 14H), it must be shown that the child became permanently unable to support themselves before reaching age 18. Furnish a statement from an attending physician or other medical evidence which shows the nature and extent of the physical or mental impairment.

Note: In Items 14A through 14I, check all boxes that apply.

14A. NAME OF CHILD *(first, middle initial, last)*	14B. DATE AND PLACE OF BIRTH *(city, state or country)*	14C. SOCIAL SECURITY NUMBER	14D. BIO - LOGICAL	14E. ADOPT - ED	14F. STEP - CHILD	14G. 18-23 YRS. OLD AND IN SCHOOL	14H. SERIOUSLY DISABLED	14I. CHILD PREVIOUSLY MARRIED
Janice Doe	04/14/01 *mo day yr* *PLACE:* Raleigh, NC	989-12-4567	☒	☐	☐	☐	☐	☐
	mo day yr *PLACE:*		☐	☐	☐	☐	☐	☐
	mo day yr *PLACE:*		☐	☐	☐	☐	☐	☐

Note: If any of the children listed above don't live with you, complete Items 16A through 16C.

16A. NAME OF CHILD *(first, middle initial, last)*	16B. CHILD'S COMPLETE ADDRESS	16C. NAME OF PERSON THE CHILD LIVES WITH *(If applicable)*

17. REMARKS

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

18. SIGNATURE OF CLAIMANT	19. DATE	20. TELEPHONE NUMBER (S) *(Include Area Code)*	
		A. DAYTIME	B. NIGHTTIME
John E. Doe	04/15/2009	(919) 777-1234	(919) 777-4321

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.

OMB Approved No. 2900-0075
Respondent Burden: 15 minutes

Department of Veterans Affairs

STATEMENT IN SUPPORT OF CLAIM

PRIVACY ACT INFORMATION: The law authorizes us to request the information we are asking you to provide on this form (38 U.S.C. 501(a) and (b)). The responses you submit are considered confidential (38 U.S.C. 5701). They may be disclosed outside the Department of Veterans Affairs (VA) only if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records, 58VA21/22, Compensation, Pension, Education and Rehabilitation 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.

RESPONDENT BURDEN: VA may not conduct or sponsor, and respondent is not required to respond to this collection of information unless it displays a valid OMB Control Number. Public reporting burden for this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have comments regarding this burden estimate or any other aspect of this collection of information, call 1-800-827-1000 for mailing information on where to send your comments.

FIRST NAME - MIDDLE NAME - LAST NAME OF VETERAN *(Type or print)*	SOCIAL SECURITY NO.	VA FILE NO.
John Ellis Doe	123-45-6789	C/CSS - CSS 123-45-6789

The following statement is made in connection with a claim for benefits in the case of the above-named veteran:

I am filing this claim requesting an increase in my service connected TBI condition.

I am no longer able to work in my communications field as I am limited in speaking skills. I also have more frequent headaches that last one or more days. My condition has worsened.

Medical evidence is at Durham VA Medical Center from October 2008 to current.

(CONTINUE ON REVERSE)

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

SIGNATURE	DATE SIGNED
John E. Doe	05/08/2009

ADDRESS	TELEPHONE NUMBERS *(Include Area Code)*	
	DAYTIME	EVENING
100 Veteran Avenue Raleigh, NC 27999	(919) 777-1234	(919) 777-4321

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.

OMB Approved No. 2900-0075
Respondent Burden: 15 minutes

Department of Veterans Affairs

STATEMENT IN SUPPORT OF CLAIM

PRIVACY ACT INFORMATION: The law authorizes us to request the information we are asking you to provide on this form (38 U.S.C. 501(a) and (b)). The responses you submit are considered confidential (38 U.S.C. 5701). They may be disclosed outside the Department of Veterans Affairs (VA) only if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records, 58VA21/22, Compensation, Pension, Education and Rehabilitation 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.

RESPONDENT BURDEN: VA may not conduct or sponsor, and respondent is not required to respond to this collection of information unless it displays a valid OMB Control Number. Public reporting burden for this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have comments regarding this burden estimate or any other aspect of this collection of information, call 1-800-827-1000 for mailing information on where to send your comments.

FIRST NAME - MIDDLE NAME - LAST NAME OF VETERAN *(Type or print)*	SOCIAL SECURITY NO.	VA FILE NO.
John Ellis Doe	123-45-6789	C/CSS - CSS 123-45-6789

The following statement is made in connection with a claim for benefits in the case of the above-named veteran:

I am filing this claim requesting VA to reopen my previous denial of service connection for my low back condition.

I have to put most of my body weight on the left side when walking due to my service connected right leg condition, which causes me to limp. Prolonged walking at my current job causes alot of pain in my lower back.

New and material medical evidence is at Durham VA Medical Center from October 2008 to current.

(CONTINUE ON REVERSE)

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

SIGNATURE	DATE SIGNED	
John E. Doe	05/08/2009	
ADDRESS	TELEPHONE NUMBERS *(Include Area Code)*	
	DAYTIME	EVENING
100 Veteran Avenue Raleigh, NC 27999	(919) 777-1234	(919) 777-4321

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.

OMB Approved No. 2900-0404
Respondent Burden: 45 minutes

Department of Veterans Affairs

VETERAN'S APPLICATION FOR INCREASED COMPENSATION BASED ON UNEMPLOYABILITY

NOTE: 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.

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/.

1. VA FILE NUMBER	2. VETERAN'S SOCIAL SECURITY NUMBER	3. DATE OF BIRTH
C 23 985 947	111-22-3333	July 4, 1948

4. NAME OF VETERAN *(First, Middle, Last) (Type or Print)*	5. ADDRESS OF CLAIMANT *(No. and street or rural route, city or P.O., State and ZIP Code)*
John Allen Doe	110 Veteran Avenue Raleigh, NC 27999

SECTION I - DISABILITY AND MEDICAL TREATMENT

6. WHAT SERVICE-CONNECTED DISABILITY PREVENTS YOU FROM SECURING OR FOLLOWING ANY SUBSTANTIALLY GAINFUL OCCUPATION?	7. HAVE YOU BEEN UNDER A DOCTOR'S CARE AND/OR HOSPITALIZED WITHIN THE PAST 12 MONTHS?	8. DATE(S) OF TREATMENT BY DOCTOR(S)
Diabetes II and Prostate Cancer	Yes	1/15/2003 to Current
9. NAME AND ADDRESS OF DOCTOR(S)	**10. NAME AND ADDRESS OF HOSPITAL**	**11. DATE(S) OF HOSPITALIZATION**
Allen B. Smith, MD. 508 Fulton St. Durham, NC 27577	Durham VA Medical Center 508 Fulton St. Durham, NC 27577	None

SECTION II - EMPLOYMENT STATEMENT

12. DATE YOUR DISABILITY AFFECTED FULL-TIME EMPLOYMENT	13. DATE YOU LAST WORKED FULL-TIME	14. DATE YOU BECAME TOO DISABLED TO WORK
01/15/2009	03/15/2009	04/15/2009
15A. WHAT IS THE MOST YOU EVER EARNED IN ONE YEAR?	**15B. WHAT YEAR?**	**15C. OCCUPATION DURING THAT YEAR**
$35,000.00	2007	Sales Rep.

16. LIST ALL YOUR EMPLOYMENT INCLUDING SELF-EMPLOYMENT FOR THE LAST FIVE YEARS YOU WORKED

A. NAME AND ADDRESS OF EMPLOYER	B. TYPE OF WORK	C. HOURS PER WEEK	D. DATES OF EMPLOYMENT FROM	D. DATES OF EMPLOYMENT TO	E. TIME LOST FROM ILLNESS	F. HIGHEST GROSS EARNINGS PER MONTH
Sears Co. 100 Crabtree Lane, Raleigh, NC 27610	Sales	40	01/15/1996	04/15/2009	40 hrs.	$2,917.00

G. INDICATE YOUR TOTAL EARNED INCOME FOR THE PAST 12 MONTHS	H. IF PRESENTLY EMPLOYED, INDICATE YOUR CURRENT MONTHLY EARNED INCOME
$ 31,000.00	$ 0.00

17. DID YOU LEAVE YOUR LAST JOB/SELF-EMPLOYMENT BECAUSE OF YOUR DISABILITY?	18. DO YOU RECEIVE/EXPECT TO RECEIVE DISABILITY RETIREMENT BENEFITS?	19. DO YOU RECEIVE/EXPECT TO RECEIVE WORKERS COMPENSATION BENEFITS?
[X] YES [ ] NO *(If "Yes," give the facts in Item 24)*	[ ] YES [X] NO	[ ] YES [X] NO

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

A. NAME AND ADDRESS OF EMPLOYER	B. TYPE OF WORK	C. DATE APPLIED

SECTION III - SCHOOLING AND OTHER TRAINING

21. EDUCATION *(Check highest year completed)*

GRADE SCHOOL ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 HIGH SCHOOL ☐ 1 ☐ 2 ☐ 3 ☒ 4 COLLEGE ☐ 1 ☐ 2 ☐ 3 ☐ 4

22A. DID YOU HAVE ANY OTHER EDUCATION AND TRAINING BEFORE YOU WERE TOO DISABLED TO WORK?

☐ YES ☒ NO *(If "Yes," complete Items 22B and 22C)*

22B. TYPE OF EDUCATION OR TRAINING	22C. DATES OF TRAINING	
	BEGINNING	COMPLETION

23A. HAVE YOU HAD ANY EDUCATION AND TRAINING SINCE YOU BECAME TOO DISABLED TO WORK?

☐ YES ☒ NO *(If "Yes," complete Items 23B and 23C)*

23B. TYPE OF EDUCATION OR TRAINING	23C. DATES OF TRAINING	
	BEGINNING	COMPLETION

24. REMARKS

SECTION IV - 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.

25. SIGNATURE OF CLAIMANT	26. DATE SIGNED	27. TELEPHONE NUMBER(S) *(Include Area Code)*	
		A. DAYTIME	B. NIGHTTIME
John A. Doe	04/20/2009	(919) 777-0000	(919) 777-8888

WITNESS TO SIGNATURE OF CLAIMANT IF MADE BY "X" MARK. NOTE: 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 below.

28A. SIGNATURE OF WITNESS	28B. ADDRESS OF WITNESS
29A. SIGNATURE OF WITNESS	**29B. 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.

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, Compensation, Pension, Education and Rehabilitation Records - VA, published in the Federal Register. Your obligation to respond 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 eligibility for individual unemployment (38 U.S.C. 1163). 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.whitehouse.gov/omb/library/OMBINV.html#VA. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.