Department of Veterans Affairs

VETERAN'S APPLICATION FOR COMPENSATION OR PENSION VA FORM NUMBER 21-526

A. QUESTIONS? GET FREE INFORMATION: If you have any questions about this form, how to fill it out, or need information about any other VA benefits, call us.

NATIONWIDE TOLL-FREE

1-800 -827 -1000
(Hearing Impaired-TDD 1-800-829-4833)

B. YOU SHOULD USE THIS FORM

(1) Apply for all VA benefits due to injury you received or illness you had while you were in military service (called Compensation Benefits);

(2) Apply for VA benefits due to disabilities not due to your military service (called Pension Benefits).

(3) Apply for both Compensation and Pension at the same time.

C. WHEN YOU ARE DONE WITH THIS FORM: Mail it or take it to a VA Regional Office.

D. REGIONAL OFFICE ADDRESS: You should call the VA toll-free number, 1-800-827-1000, for the address or location of the nearest Regional Office. You might find that office's address in the blue pages of your telephone book. It may be under "United States Government, Veterans Affairs."

IMPORTANT

E. PLEASE FOLLOW THE DETAILED INSTRUCTIONS for this form. They begin on page 3.

F. PRINT ALL ANSWERS CLEARLY. If you must write the answers, do so very clearly and plainly. If an answer is "None" or "0", write that. YOUR ANSWER TO EVERY QUESTION IS IMPORTANT to help us complete your claim.

G. YOU MUST SIGN AND DATE this application at the bottom of page 11.

H. MAKE A PHOTOCOPY OF THIS APPLICATION for your records before you mail it. Also, tear off and keep this instruction page and all other instruction pages.

NOTE: You may use this page for notes about your claim. Keep It for your records.

(Detach and retain Instructions for future reference)

INSTRUCTIONS FOR COMPLETING APPLICATION FOR COMPENSATION OR PENSION

GENERAL INSTRUCTIONS

(PLEASE READ VERY CAREFULLY)

If additional space is needed for any item, use Item 40, "Remarks," on pages 10 and 11, or number a separate sheet of paper to correspond to the items you are answering and attach the sheet to the application.

A. DISABILITY COMPENSATION is paid for disability resulting from service in the armed forces. An additional amount of compensation may be payable for a spouse, child, and/or dependent parent when a veteran is entitled to compensation based on disability(ies) evaluated as 30 percent or more disabling. The additional benefit for a spouse is payable in a higher amount when he/she is a patient in a nursing home or is so disabled as to require the regular aid and attendance of another person. IF YOU ARE NOT CLAIMING COMPENSATION OR A SERVICE-CONNECTED DISABILITY, SKIP ITEMS 19, 20 AND 21.

DISABILITY PENSION is paid for permanent and total disability not the result of service in the armed forces. Pension can only be paid to a veteran of wartime service or to a veteran who served in one of the following periods after June 26, 1950, and before February 1, 1955; after August 4, 1964, and before May 8, 1975; after August 1, 1990, and before a date to be determined by the President or by law.

Benefits may only be paid from the first day of the month following the date of receipt of your application in VA unless you were incapacitated because of a disability which prevented you from filing a claim for a period of at least 30 days beginning with the date you became permanently and totally disabled. If you want this claim considered as a claim for retroactive payment, indicate so in Item 40, "Remarks," and identify the specific disability which prevented you from filing.

B. AUTHORIZATION FOR RELEASE OF INFORMATION. Complete and return the attached VA Form 21-4142 to authorize release of information from any doctors and/or hospitals providing any treatment you received. Please complete every item, and give the complete name(s) and address(es) of hospitals/doctors. You do not need to complete this form for the treatment received at a VA facility. Be sure to sign and date the form. If you wish, you may contact the doctors or hospitals yourself and authorize the release of this information to us. This may reduce the amount of time required to process your claim.

C. REPRESENTATION. You may be represented, without charge, by an accredited representative of a veterans organization or other service organization, recognized by the Secretary of Veterans Affairs, or you may employ an attorney to assist you with your claim. Typical examples of counsel who may be available include attorneys in private practice or legal aid services. If you desire representation, let us know and we will send you the necessary forms. If you have already designated a representative, no further action is required on your part.

D. HEARINGS. You have the right to a personal hearing at any stage of claims processing, either before or after a decision is made. This right may be exercised with regard to an original claim, supplemental claim or with regard to any subsequent action affecting your entitlement. All you need do is inform the nearest VA office as to your desires, and we will arrange a time and place for the hearing. You may bring witnesses if you desire and their testimony will be entered in the record. VA will furnish the hearing room, provide hearing officials, and prepare the transcript of the proceedings. VA cannot pay any of your expenses in connection with the hearing.

E. EVIDENCE - GENERAL. If you have not previously filed a claim, furnish the separation forms you received from the armed forces. A statement from your doctor showing the extent of your disabilities should be furnished with your application. If you are a nursing home patient, you should furnish a statement signed by an official of the nursing home showing the date of your admission and patient status. Indicate nursing/Medicaid status in Item 41F. If you are a patient in a nursing home, give the name and address in Item 41G.

F. REPORTING NET WORTH FOR PENSION FOR DISABILITY NOT RESULTING FROM SERVICE. Pension cannot be paid if net worth is sizable. Net worth is the market value of all interest or rights in any kind of property except ordinary personal effects necessary for daily living such as automobile, clothing or furniture and the dwelling (single family unit) used as your principal residence. Therefore, all other assets must be reported so that we may determine whether net worth prevents you from receiving pension benefits. "Market Value" is the price an item would get if it were sold in an open market.

G. INCOME LIMITS AND RATES OF PENSION. The rate of pension paid to a veteran depends upon the amount of family income and the number of dependents, according to a formula provided by law. All payments from all sources are countable unless excluded by law. Because benefit rates and income limits are frequently changed, such information cannot be kept current in these instructions. Information regarding current income limitations and rates of benefits may be obtained by contacting your nearest VA office.

(1) A higher rate of pension is payable to a veteran who is a patient in a nursing home or otherwise determined to be in need of regular aid and attendance or who is permanently housebound due to disability.

(2) Pension rates are also increased for a veteran who served during the Mexican Border Period or World War I.

IMPORTANT

YOU MUST SHOW ALL TYPES of PAYMENTS FROM ALL SOURCES FOR YOURSELF, SPOUSE AND DEPENDENT CHILDREN BEFORE ANY DEDUCTIONS OR WITHHOLDINGS. UNDER 38 CFR 3.271(a) PAYMENTS OF ANY KIND FROM ANY SOURCE SHALL BE COUNTED AS INCOME UNLESS SPECIFICALLY EXCLUDED BY LAW. VA WILL DETERMINE ANY AMOUNT WHICH DOES NOT COUNT. INCLUDE ALL SEVERANCE PAY OR OTHER ACCRUED PAYMENTS OF ANY KIND OR FROM ANY SOURCE. WHEN NO INCOME IS RECEIVED OR EXPECTED FROM A SPECIFIED SOURCE, WRITE "NONE" IN THE APPROPRIATE BLOCK (ITEMS 36A THROUGH 39A). IF INCOME FROM ANY SOURCE IS ANTICIPATED BUT THE AMOUNT IS NOT YET DETERMINED, WRITE "UNKNOWN" IN THE APPROPRIATE BLOCK. ATTACH SEPARATE SHEETS IF ADDITIONAL SPACE IS NEEDED.

H. FAMILY MEDICAL EXPENSES are amounts actually paid by you for which you are not reimbursed by insurance or otherwise. We can reduce your income for VA purposes (and increase your rate of pension) if your medical expenses qualify for exclusion under the formula provided by law. If you are awarded pension, a VA Form 21-8416, Medical Expense Report will be mailed to you approximately a year after the effective date of your award. You should keep a record of all medical expenses you pay after you become entitled to pension and report them on the form. Normally, an adjustment for medical expenses is made at the end of the income reporting year and results in a retroactive payment to you. However, if your income is static and you have a consistently high level of medical expenses (such as nursing home fees), it may be possible to increase your rate without waiting until the end of the year. Show unreimbursed medical expenses in Items 41A through 41G.

I. LAST ILLNESS AND BURIAL EXPENSES. Your countable income may be reduced by the amount of expenses of the last illness and burial of a spouse or child paid by you. Use Item 40, "Remarks," to report such expenses.

J. EDUCATIONAL OR VOCATIONAL REHABILITATION EXPENSES are amounts paid for courses of education, including tuition, fees, and materials and may be deducted from the respective incomes of a veteran and the earned income of a child if the child is pursuing a course of postsecondary education or vocational rehabilitation or training. If you or your child(ren) paid these expenses, keep a record of the payments and report them to VA at the end of the calendar year.

K. GULF WAR VETERANS HEALTH REGISTRY. VA has a registry of veterans who served in the Gulf War theater of operations. If you served there during the war, we will include your name in the registry. If you want us to include medical and other information about you, you must check the "YES" block above your signature on page 11. The information in this registry will be shared only with the Department of Defense, the National Academy of Sciences and others as permitted by law, (for example: research purposes). We will keep you informed of significant developments in research on the health consequences of military service in the Gulf theater of operations. You may request a VA health examination that will include a consultation and counseling covering the results of that examination. Contact your nearest VA medical facility to request an examination or call the toll-free VA Gulf War Information Helpline at 1-800-PGW-VETS (1-800-749-8387).

SPECIFIC INSTRUCTIONS

IMPORTANT: These instructions are numbered to correspond with the items on the application. If additional space is required, attach a separate sheet and identify your statements by their item numbers.

ITEMS 3A and 3B - The number entered in Item 3A, Veteran's Social Security Number, should be your own Social Security Number. In Item 3B enter your spouse's Social Security Number. Disclosure of these Social Security Numbers is mandatory under Title 38 U.S.C. 5101(c).

SPECIFIC INSTRUCTIONS (Continued)

ITEMS 14A and 14D inclusive - Retired Pay - A veteran may not receive full service retired pay and VA compensation at the same time. In the absence of a request to the contrary, filing of this application will constitute an election to receive VA compensation in lieu of the total amount of retired pay, or a waiver of that portion of retired pay equal in amount to the VA compensation. If you do NOT want to receive VA compensation in lieu of military retired pay, make a statement to that effect in Item 40, "Remarks." If you are found entitled to VA compensation, we will notify the retired pay division that you have waived your retired pay (unless you specifically negate the waiver of military retired pay by making a statement in Item 40). If you think that you have a service-connected disability, you should file for VA compensation (even if you don't plan to waive your retired pay) in order to establish your survivors' entitlement to VA benefits in the event you should die from a service-connected condition.

ITEMS 15A and 15B - **Disability Severance Pay** - The full amount of disability Severance pay received for the disability or disabilities for which VA compensation is payable will be recouped from that benefit.

ITEMS 16A and 16B - Lump Sum Readjustment Pay or Separation Pay - If entitlement to VA compensation was established on or after September 15, 1981, the full amount of readjustment pay you received will be recouped from any VA compensation payable. If entitlement was established before that date, 75 percent will be recouped.

Items 19, 20 and 21 should not be completed if you are NOT claiming compensation for a service-connected disability.

ITEM 19A to 19D inclusive - Complete information concerning beginning and ending dates of treatment for claimed conditions. If you were treated as an inpatient of a military hospital, the ending date of treatment for the hospitalized condition would be the final date of inpatient or outpatient follow-up treatment. ATTACH TO THIS APPLICATION COPIES OF ANY SERVICE MEDICAL RECORDS YOU HAVE.

Items 24C and 25C - Months Worked - The time actually worked should be stated. For example If you worked full time for 2, 4, 6, 8, or 10 months, you should so state. If you did not work full time each month you should state the months or parts of months you actually worked. For example 2 months, 1 week, 2 days.

ITEMS 26A to 30D inclusive - Marital Information - Complete information concerning all marriages entered into by both you and your spouse and the termination of such marriages must be furnished. Specific details as to the date, place, and manner of dissolution of marriage must be included. If your spouse is also a veteran, include his/her VA file number (if known) in Item 26F.

ITEM 33A - Include market value of stocks, checking accounts, bank deposits, savings accounts, and cash. If such assets are held jointly by you and your spouse, one-half of the total value of these holding should be reported for each of you.

ITEM 33B - Do not include the value of the single dwelling unit or that portion of real property used solely as your principal residence. On all other real estate reduce the market value by amount of the indebtedness thereon such as mortgages, liens, etc.

ITEM 33C - Report the total market value of your rights and interest in all other property not included in Items 33A and 33B. Do not include value of ordinary personal effects necessary for your daily living such as an automobile, clothing, and furniture. Include gifts, bequests, and inheritances of all property other than cash.

ITEM 33D - Report the total of Items 33A through 33C. This should be your **NET WORTH.**

ITEM 34A TO 35E - If you or your spouse have applied for Social Security, unemployment or workmen's compensation, or any disability benefit, show the expected payment in the appropriate column. If the amount or date of payment is not yet determined, enter the word "unknown."

SPECIFIC INSTRUCTIONS (Continued)

IMPORTANT: These instructions are numbered to correspond with the items on the application. If additional space is required, attach a separate sheet and identify your statements by their item numbers.

ITEMS 36, 37 and 38 inclusive - You should report under these items your expected total income for the periods covered. You must report total income from all sources for yourself and your dependent. When reporting income, report the total amount to which you are entitled before any deductions, not the amount you actually receive. Include as income all amounts received or expected as severance pay or accrued payments of any kind or from any source. If you and your spouse receive income from dividends, interest, rents, investments or operation of a business, profession or farm, which you own jointly, report one-half of the income as yours and one-half as your spouse's. Report Social Security benefits in Item 36A, and Supplemental Security Income (SSI) benefits in Item 36F. If you report income in foreign currency, we will convert it into dollars based on the average exchange rate for the preceding four quarters (as provided by the Department of the Treasury). We can exclude all or part of a dependent child's income if it is not reasonably available to you, or if it would cause hardship to consider this income in determining your rate of pension. If you feel that your child's income should be excluded, make a statement to that effect in Item 40, "Remarks."

ITEMS 39A and 39B - You should report under these items the total amount of your final pay at termination of employment, not the amount you actually received, and the date you received this pay.

NOTE: If you furnish a copy of your latest award letter from Social Security stating the type and gross amount of your benefit, it will help us in our initial determination of the amount of VA benefits to be paid.

PRIVACY ACT INFORMATION: No allowance of compensation or pension may be granted unless this form is completed fully as required by existing law (38 U.S.C. Chapters 11 and 15, Subchapter III). The responses you submit are considered confidential (38 U.S.C. 5701). They may be disclosed outside 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.

Income information and employment information furnished by you will be compared with information obtained by VA from the Secretary of Health and Human Services or the Secretary of the Treasury under clause (viii) of section 6103 (1)(7)(D) of the Internal Revenue Code of 1986. Any information provided by you including your Social Security Number, may be used in matching programs conducted in connection with any proceeding for the collection of an amount owed the United States by virtue of your participation in any benefit program administered by the Department of Veterans Affairs.

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 2 hours 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.

OMB Approved No. 2900-0001
Respondent Burden: 2 hours

Department of Veterans Affairs

VETERAN'S APPLICATION FOR COMPENSATION OR PENSION

IMPORTANT: Read attached General and Specific Instructions before completing this form. Type, print, or write plainly.

(DO NOT WRITE IN THIS SPACE) VA DATE STAMP

1A. FIRST, MIDDLE, LAST NAME OF VETERAN

1B. TELEPHONE NO. *(Include Area Code)*

1C. IF YOU SERVED UNDER ANOTHER NAME, GIVE NAME AND PERIOD DURING WHICH YOU SERVED AND SERVICE NUMBER

3A. VETERAN'S SOCIAL SECURITY NO.

2. MAILING ADDRESS OF VETERAN *(Number and street or rural route, city or P.O., and ZIP Code)*

3B. SPOUSE'S SOCIAL SECURITY NO.

4. DATE OF BIRTH	5. PLACE OF BIRTH	6. SEX ☐ MALE ☐ FEMALE	7. RAILROAD RETIREMENT NO.

8. HAVE YOU EVER FILED A CLAIM FOR COMPENSATION FROM THE OFFICE OF WORKERS' COMPENSATION PROGRAMS? *(Formerly the U.S. Bureau of Employee's Compensation)*

☐ YES ☐ NO

9A. VA FILE NUMBER

9B. HAVE YOU PREVIOUSLY FILED A CLAIM FOR ANY BENEFIT WITH VA

☐ NON ☐ VOCATIONAL REHABILITATION ☐ DENTAL OR OUTPATIENT
☐ HOSPITALIZATION OR MEDICAL CARE ☐ VETERANS EDUCATIONAL ASSISTANCE ☐ WAIVER OF NSLI
☐ DISABILITY COMPENSATION OR PENSION ☐ DEPENDENTS EDUCATIONAL ASSISTANCE ☐ OTHER *(Specify)*

9C. VA OFFICE HAVING YOUR RECORDS

SERVICE

NOTE Enter complete information for each period of active duty. Attach DD Form 214 or other separation papers for all periods of active duty to expedite processing of your claim. If you do NOT have your DD Form 214 or other separation papers check (X) here ☐

10A. ENTERED ACTIVE SERVICE DATE	10A. ENTERED ACTIVE SERVICE PLACE	10B. SERVICE NO.	10C. SEPARATED FROM ACTIVE SERVICE DATE	10C. SEPARATED FROM ACTIVE SERVICE PLACE	10D. GRADE, RANK OR RATING, ORGANIZATION OR BRANCH OF SERVICE

10E. HAVE YOU EVER BEEN A PRISONER OF WAR? ☐ YES ☐ NO *(If "YES," complete Items 10F and 10G)*	10F. NAME OF COUNTRY	10G. DATES OF CONFINEMENT

RESERVE AND NATIONAL GUARD

NOTE: Enter complete information for each period of Reserve and National Guard Service. Attach any separation papers you have.

11A. ENTERED SERVICE DATE	11A. ENTERED SERVICE PLACE	11B. SERVICE NO.	11C. SEPARATED FROM SERVICE DATE	11C. SEPARATED FROM SERVICE PLACE	11D. GRADE, RANK OR RATING ORGANIZATION OR BRANCH OF SERVICE

12. IF DISABILITY OCCURRED DURING ACTIVE OR INACTIVE DUTY FOR TRAINING, GIVE BRANCH OF SERVICE AND DATE OF OCCURRENCE

13A. IF YOU ARE NOW A MEMBER OF THE RESERVE FORCES OR NATIONAL GUARD GIVE THE BRANCH OF SERVICE	13B. RESERVE STATUS ☐ ACTIVE ☐ RESERVE OBLIGATION ☐ INACTIVE	13C. RESERVE OR NATIONAL GUARD UNIT ADDRESS

14A. ARE YOU NOW RECEIVING OR WILL YOU RECEIVE RETIREMENT OR RETAINER PAY FROM THE ARMED FORCES ? ☐ YES ☐ NO *(If "YES," complete Items 14B,14C and 14D)*	14B. BRANCH OF SERVICE	14C. MONTHLY AMOUNT $	14D. RETIRED STATUS ☐ PERMANENT ☐ TEMPORARY DISABILITY RETIRED LIST

15A. HAVE YOU EVER APPLIED FOR OR RECEIVED DISABILITY SEVERANCE PAY FROM THE ARMED FORCES? ☐ YES ☐ NO *(If "YES," complete Item 15B)*	15B. AMOUNT $	16A. HAVE YOU RECEIVED LUMP SUM READJUSTMENT OR SEPARATION PAY FROM THE ARMED FORCES? ☐ YES ☐ NO *(If "YES," complete Item 16B)*	16B. AMOUNT $

NATURE AND HISTORY OF DISABILITIES

17. NATURE OF SICKNESS,DISEASE OR INJURIES FOR WHICH THIS CLAIM IS MADE AND DATE EACH BEGAN

18A. ARE YOU NOW OR HAVE YOU BEEN HOSPITALIZED OR FURNISHED DOMICILIARY CARE WITHIN THE PAST 3 MONTHS? ☐ YES ☐ NO *(If "YES," complete Items 18B And 18C)*	18B. DATES OF HOSPITALIZATION OR DOMICILIARY CARE	18C. NAME AND ADDRESS OF INSTITUTION

YOU MUST SIGN AND DATE THIS FORM AT THE BOTTOM OF PAGE 11

SKIP ITEMS 19, 20 AND 21 IF YOU ARE NOT CLAIMING COMPENSATION FOR A SERVICE-CONNECTED DISABILITY.

NOTE: IF YOU RECEIVED ANY TREATMENT WHILE IN SERVICE, COMPLETE THE FOLLOWING INFORMATION (ATTACH TO THIS APPLICATION COPIES OF ANY SERVICE MEDICAL RECORDS YOU HAVE)

19A. NATURE OF SICKNESS, DISEASE, OR INJURY	19B. TREATMENT DATES		19C. NAME, NUMBER OR LOCATION OF HOSPITAL, FIRST-AID STATION, DRESSING STATION, OR INFIRMARY	19D. ORGANIZATION/UNIT AT TIME SICKNESS, DISEASE, OR INJURY WAS INCURRED
	BEGINNING DATE	ENDING DATE		

20. LIST CIVILIAN PHYSICIANS AND HOSPITALS WHERE YOU WERE TREATED FOR ANY SICKNESS, INJURY OR DISEASE FOR WHICH YOU ARE CLAIMING SERVICE CONNECTION BEFORE, DURING, OR SINCE YOUR SERVICE, AND ANY MILITARY HOSPITALS SINCE YOUR LAST DISCHARGE

A. NAME	B. PRESENT ADDRESS	C. DISABILITY	D. DATE

21. LIST PERSONS OTHER THAN PHYSICIANS WHO KNOW ANY FACTS ABOUT SICKNESS, DISEASE, OR INJURY SHOWN IN ITEM I9A, WHICH YOU HAD BEFORE, DURING, OR SINCE YOUR SERVICE

A. NAME	B. PRESENT ADDRESS	C. DISABILITY	D. DATE

IF YOU CLAIM TO BE TOTALLY DISABLED *(Complete Items 22A through 25E)*

22A. ARE YOU NOW EMPLOYED? ☐ YES ☐ NO	22B. IF YOU WERE SELF-EMPLOYED BEFORE BECOMING TOTALLY DISABLED, WHAT PART OF THE WORK DID YOU DO?
22C. DATE YOU LAST WORKED	22D. IF YOU ARE STILL SELF-EMPLOYED WHAT PART OF THE WORK DO YOU DO NOW?

23A. EDUCATION (*Circle highest year completed*) 1 2 3 4 5 6 7 8 (GRADE SCHOOL) 1 2 3 4 (HIGH SCHOOL) 1 2 3 4 (COLLEGE)	23B. NATURE OF AND TIME SPENT IN OTHER EDUCATION AND TRAINING

LIST ALL YOUR EMPLOYMENT, INCLUDING SELF-EMPLOYMENT, SINCE YOU BECAME TOTALLY DISABLED

24A. NAME AND ADDRESS OF EMPLOYER	24B. KIND OF WORK	24C. MONTHS WORKED	24D. TIME LOST FROM ILLNESS	24E. TOTAL EARNINGS

LIST ALL YOUR EMPLOYMENT, INCLUDING SELF-EMPLOYMENT, FOR ONE YEAR BEFORE YOU BECAME TOTALLY DISABLED

25A. NAME AND ADDRESS OF EMPLOYER	25B. KIND OF WORK	25C. MONTHS WORKED	25D. TIME LOST FROM ILLNESS	25E. TOTAL EARNINGS

MARITAL AND DEPENDENCY INFORMATION

26A. MARITAL STATUS *(If widowed or divorced, complete Items 26C and 29A through 29D only)* ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ NEVER MARRIED *(If so, do not complete Items 26B through 30D)*			26B. SPOUSE'S BIRTH DATE
26C. NUMBER OF TIMES YOU HAVE BEEN MARRIED	26D. NUMBER OF TIMES YOUR PRESENT SPOUSE HAS BEEN MARRIED	26E. IS YOUR SPOUSE ALSO A VETERAN?	26F. SPOUSE'S VA FILE NO. *(If any)* C-
27A. DO YOU LIVE TOGETHER? ☐ YES ☐ NO		27B. REASON FOR SEPARATION *(For example, marital problems, job requirements, health, etc.)*	27C. PRESENT ADDRESS OF SPOUSE
27D. AMOUNT YOU CONTRIBUTE TO YOUR SPOUSE'S SUPPORT MONTHLY $			

28. CHECK (X) WHETHER YOUR CURRENT MARRIAGE WAS PERFORMED BY:

☐ CLERGYMAN OR AUTHORIZED PUBLIC OFFICIAL ☐ OTHER *(Explain)*

YOU MUST SIGN AND DATE THIS FORM AT THE BOTTOM OF PAGE 11

MARITAL AND DEPENDENCY INFORMATION *(Continued)*

NOTE: Furnish the following information about each of your marriages. Where a date is requested, show month, day,

29A. DATE AND PLACE OF MARRIAGE	29B. TO WHOM MARRIED	29C. TERMINATED *(Death, Divorce)*	29D. DATE AND PLACE TERMINATED

FURNISH THE FOLLOWING INFORMATION ABOUT EACH PREVIOUS MARRIAGE OF YOUR PRESENT SPOUSE

30A. DATE AND PLACE OF MARRIAGE	30B. TO WHOM MARRIED	30C. TERMINATED *(Death, Divorce)*	30D. DATE AND PLACE TERMINATED

IDENTIFICATION OF CHILDREN AND INFORMATION RELATIVE TO CUSTODY

NOTE: Furnish the following information for each of your unmarried children (Complete Items 31A thru 31H)

31A. NAME OF CHILD *(First,middle initial, last)*	31B. DATE OF BIRTH *(Month, day, year)*	31C.PLACE OF BIRTH *(City,State)*	31D. SOCIAL SECURITY NUMBER OF CHILD	31E. CHECK EACH APPLICABLE CATEGORY				
				MARRIED PREVIOUSLY	STEPCHILD OR ADOPTED	ILLEGI-TIMATE	OVER 18 ATTENDING SCHOOL	SERIOUSLY DISABLED

31F. NAME(S) OF ANY CHILD(REN) NOT IN YOUR CUSTODY	31G. NAME AND ADDRESS OF PERSON HAVING CUSTODY	31H. MONTHLY AMOUNT YOU CONTRIBUTE TO CHILD'S SUPPORT
		$

INFORMATION RELATING TO DEPENDENT PARENT(S) AND NEAREST RELATIVE

32A. IS YOUR FATHER DEPENDENT UPON YOU FOR SUPPORT?	32B. NAME AND ADDRESS OF DEPENDENT FATHER	32C. IS YOUR MOTHER DEPENDENT UPON YOU FOR SUPPORT?
☐ YES ☐ NO *(If "Yes," complete Item 32B)*		☐ YES ☐ NO *(If "Yes," complete Item 32D)*

32D. NAME AND ADDRESS OF DEPENDENT MOTHER	32E. NAME AND ADDRESS OF NEAREST RELATIVE	32F. RELATIONSHIP OF NEAREST RELATIVE

NET WORTH OF VETERANS AND DEPENDENTS

NOTE: Items 33A through 33D should be completed ONLY if you are applying for nonservice-connected

ITEM NO.	SOURCE	AMOUNTS				
		VETERAN	SPOUSE	NAME OF CHILD(REN)		
33A.	STOCKS, BONDS, BANK DEPOSITS	$	$	$	$	$
33B.	REAL ESTATE					
33C.	OTHER PROPERTY					
33D.	TOTAL NET WORTH	$	$	$	$	$

INCOME RECEIVED AND EXPECTED FROM ALL SOURCES

34A. HAVE YOU OR YOUR SPOUSE APPLIED FOR OR ARE YOU RECEIVING OR ENTITLED TO RECEIVE ANY BENEFITS FROM THE SOCIAL SECURITY ADMINISTRATION (OTHER THAN SSI) OR RAILROAD RETIREMENT BOARD?	34B. MONTHLY AMOUNT *(Include Medicare Deduction)*	34C. BEGINNING DATE	34D. DATE YOU EXPECT BENEFITS TO BEGIN
	VETERAN $		
	SPOUSE $		

	34E. WILL YOU OR YOUR SPOUSE APPLY FOR EITHER BENEFIT DURING THE NEXT 12 MONTHS?	34F. DATE OF INTENTION TO APPLY	
☐ YES ☐ NO *(If "Yes," complete Items 34B through 34F)*	☐ YES ☐ NO	**VETERAN**	**SPOUSE**

35A. HAVE YOU OR YOUR SPOUSE APPLIED FOR OR ARE YOU RECEIVING OR ENTITLED TO RECEIVE ANNUITY OR RETIREMENT BENEFITS OR ENDOWMENT INSURANCE FROM ANY OTHER SOURCE?

☐ YES ☐ NO *(If "YES," complete Items 35B through 35E)*

YOU MUST SIGN AND DATE THIS FORM AT THE BOTTOM OF PAGE 11

INCOME RECEIVED AND EXPECTED FROM ALL SOURCES *(Continued)*

35B. MONTHLY AMOUNT	35C. BEGINNING DATE	35D. DATE OF INTENTION TO APPLY	35E. SOURCE OF BENEFITS
VETERAN $			
SPOUSE $			

VETERAN'S AND DEPENDENTS'MONTHLY INCOME

NOTE: For each source report gross monthly amount, including deductions, for each family member.

ITEM NO.	SOURCE OF MONTHLY INCOME	AMOUNTS *(If none, write "NONE" or "0")*				
		VETERAN	SPOUSE	NAME OF CHILD/REN		
36A.	SOCIAL SECURITY	$	$	$	$	$
36B.	U.S. CIVIL SERVICE					
36C.	U.S. RAILROAD RETIREMENT					
36D.	MILITARY RETIREMENT					
36E.	BLACK LUNG BENEFIT					
36F.	SUPPLEMENTAL SECURITY/PUBLIC ASSIST.					
36G.	ALL OTHER MONTHLY INCOME *(Specify Source)*					

VETERAN'S AND DEPENDENTS' OTHER INCOME *(If none, write "NONE" OR "0")*

NOTE: Please provide the amount of annual income or one-time nonrecurring income (specify source) for the 12 month period preceding the date the claim is filed with the Department of Veterans Affairs.

37A.	TOTAL WAGES					
37B.	TOTAL INTEREST AND DIVIDENDS					
37C.	ALL OTHER INCOME *(Specify Source)*					

NOTE: Please provide the amount of expected annual income or one-time nonrecurring income (specify source) for the 12 month period following the date the claim is filed with the Department of Veterans Affairs.

38A.	TOTAL WAGES					
38B.	TOTAL INTEREST AND DIVIDENDS					
38C.	ALL OTHER INCOME *(Specify Source)*					

39A. GROSS AMOUNT OF FINAL PAY RECEIVED

$

39B. DATE FINAL PAY WAS RECEIVED

40. REMARKS *(Identify your statements by their applicable item number. If additional space is required, attach a separate sheet and identify your statements by their item numbers)*

40. REMARKS *(Continued)*

NOTE: Items 41a through 41g should be completed only if you are applying for nonservice-connected pension.

INFORMATION CONCERNING, MEDICAL, LEGAL OR OTHER EXPENSES

NOTE: Family medical expenses actually paid by you may be deductible from your income. Show the amount of unreimbursed medical expenses you paid for yourself or relatives you are under an obligation to support. Also, show medical, legal or other expenses you paid because of a disability for which civilian disability benefits have been awarded. When determining your income, we may be able to deduct them from the disability benefits for the year in which the expenses are paid. Do not include any expenses for which you were reimbursed. Show the Medicare deduction in line 1.

41A. AMOUNT PAID BY YOU	41B. DATE PAID	41C. PURPOSE *(Doctor's fees, hospital charges, Attorney fees, etc.)*	41D. PAID TO *(Name of doctor, hospital, pharmacy, Attorney, etc.)*	41E. DISABILITY OR RELATIONSHIP OF PERSON FOR WHOM EXPENSES PAID

41F. ARE YOU NOW A PATIENT IN A NURSING HOME?

☐ YES *(If "Yes," please complete Item 41G)*

☐ NO

41G. DOES MEDICAID COVER ALL OR PART OF YOUR NURSING HOME COSTS?

☐ YES *(If "Yes," give the name and address of the nursing home below)*

☐ NO

NOTE: Filing of this application constitutes a waiver of military retired pay in the amount of any VA compensation to which you may be entitled. See instructions for Items 14A thru 14D inclusive, Retired Pay.

DIRECT DEPOSIT INFORMATION

All Federal payments made to a person who applied and became eligible for benefit payments after July 26, 1996, must be made by electronic funds transfer (EFT). This requirement cannot be waived by the VA unless you certify that you do not have an account with a financial institution or an authorized payment agent. VA payments to you will be made EFT unless you certify that you do not have an account with a financial institution or an authorized payment agent. Please attach a voided personal check or deposit slip or provide all of the following

42. ACCOUNT NUMBER - PLEASE CHECK THE APPROPRIATE BOX AND PROVIDE THAT ACCOUNT NUMBER, IF APPLICABLE

☐ CHECKING

☐ SAVINGS

ACCOUNT NUMBER _____

☐ I CERTIFY THAT I DO NOT HAVE AN ACCOUNT WITH A FINANCIAL INSTITUTION OR CERTIFIED PAYMENT AGENT

43. NAME OF FINANCIAL INSTITUTION

44. ROUTING OR TRANSIT NUMBER

CERTIFICATION AND AUTHORIZATION FOR RELEASE OF INFORMATION - I CERTIFY THAT the forgoing statements are true and complete to the best of my knowledge and belief. **I CONSENT THAT** any physician, surgeon, dentist, or hospital that has treated or examined me for any purpose, or that I have consulted professionally, may furnish to the **DEPARTMENT OF VETERANS AFFAIRS** any information about myself, and I waive any privilege which renders such information confidential. DO YOU WANT TO HAVE MEDICAL AND OTHER INFORMATION ABOUT YOU INCLUDED IN THE "GULF WAR VETERANS HEALTH REGISTRY?" (See "GENERAL INSTRUCTIONS," paragraph K.) YES ☐ NO ☐

45A. DAYTIME TELEPHONE NO. *(Include Area Code)*	45B. EVENING TELEPHONE NO. *(Include Area Code)*
46. SIGNATURE OF CLAIMANT	47. DATE SIGNED

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. The signature and printed names and addresses of the witnesses must be shown.

48A. SIGNATURE AND PRINTED NAME OF WITNESS	48B. ADDRESS OF WITNESS
49A. SIGNATURE AND PRINTED NAME OF WITNESS	49B. 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.

Department of Veterans Affairs

AUTHORIZATION AND CONSENT TO RELEASE INFORMATION TO THE DEPARTMENT OF VETERANS AFFAIRS (VA)

IF YOU HAVE ANY QUESTIONS ABOUT THIS FORM, CALL VA TOLL-FREE AT 1-800-827-1000
(TDD 1-800-829-4833 FOR THE HEARING IMPAIRED)

SECTION I - VETERAN/CLAIMANT IDENTIFICATION

1. LAST NAME - FIRST NAME - MIDDLE NAME OF VETERAN *(Type or print)*	2. VETERAN'S VA FILE NUMBER
3. CLAIMANT'S NAME (If other than Veteran) LAST NAME, FIRST, MIDDLE	4. VETERAN'S SOCIAL SECURITY NUMBER
5. RELATIONSHIP OF CLAIMANT TO VETERAN	6. CLAIMANT'S SOCIAL SECURITY NUMBER

SECTION II - SOURCE OF INFORMATION

7A. LIST THE NAME AND ADDRESS OF THE SOURCE SUCH AS A PHYSICIAN, HOSPITAL, ETC, *(Include ZIP Codes, and also a telephone number, if available.)*	7B. DATE(S) OF TREATMENT, HOSPITALIZATIONS, OFFICE VISITS, DISCHARGE FROM TREATMENT OR CARE, ETC. *(Include month and year)*	7C. CONDITION(S) (*Illness, injury, etc.)*

8. COMMENTS:

YOU MUST SIGN AND DATE THIS FORM ON THE REVERSE AND CHECK THE APPROPRIATE BOX IN ITEM 9B

SECTION III - CONSENT TO RELEASE INFORMATION

READ BOTH PARAGRAPHS CAREFULLY BEFORE SIGNING. YOU MUST CHECK THE APPROPRIATE STATEMENT UNDERLINED IN PARENTHESES IN PARAGRAPH 9B.

9A. I, the undersigned, hereby authorize the hospital, physician or other caregiver shown in Item 7 to disclose and release to the Department of Veterans Affairs (VA) any information that may have been obtained in connection with physical, psychological or psychiatric examination or treatment, with the understanding that VA will use this information in determining my eligibility to veterans benefits I have claimed. The responses which are submitted may be disclosed outside VA as permitted by law. I understand that this authorization, except for action already taken, may be voided by me at any time. If I do not void this authorization, it will automatically end 180 days from the date I sign this form in Item 10A.

9B. I ☐ (AUTHORIZE) ☐ (DO NOT AUTHORIZE) the above source to release or disclose any information or records relating to the diagnosis, treatment or other therapy for the condition(s) of drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia. Title 38 U.S.C. 7332. IF MY CONSENT TO THIS INFORMATION IS LIMITED, THE LIMITATION IS WRITTEN HERE:

10A. SIGNATURE OF VETERAN/CLAIMANT OR LEGAL REPRESENTATIVE	10B. RELATIONSHIP TO VETERAN/CLAIMANT *(If other than self)*	10C. DATE

10D. MAILING ADDRESS *(Number and Street or rural route, city, or P.O., State and ZIP Code)*	10E. TELEPHONE NUMBER (*Include Area Code)*

The signature and address of a person who either knows the person signing this form or is satisfied as to that person's identity is requested below. This is not required by VA but may be required by the source of the information, (physician, hospital etc.).

11A. SIGNATURE OF WITNESS	11B. DATE SIGNED

11C. MAILING ADDRESS OF WITNESS