Department of Veterans Affairs

APPLICATION FOR DISABILITY COMPENSATION AND RELATED COMPENSATION BENEFITS

VA DATE STAMP (DO NOT WRITE IN THIS SPACE)

IMPORTANT: Please read the Privacy Act and Respondent Burden on page 8 before completing the form.

SECTION I: IDENTIFICATION AND CLAIM INFORMATION

1. VETERAN/SERVICE MEMBER NAME (Last, first, middle)
2. SOCIAL SECURITY NUMBER
3. DATE OF BIRTH (MM,DD,YYYY)
4. SEX ☐ MALE ☐ FEMALE
5. HAVE YOU EVER FILED A CLAIM WITH VA? ☐ YES ☐ NO (If "Yes," provide your file number in Item 6)
6. VA FILE NUMBER

7A. CURRENT MAILING ADDRESS
Street address, rural route, or P.O. Box Apt. number
City State ZIP Code Country

7B. FORWARDING ADDRESS
Street address, rural route, or P.O. Box Apt. number
City State ZIP Code Country

7C. TELEPHONE NUMBERS (Include Area Code)
DAYTIME
EVENING
CELL PHONE

8A. PREFERRED E-MAIL ADDRESS (If applicable)

8B. ALTERNATE E-MAIL ADDRESS (If applicable)

9. LIST THE DISABILITY(IES) YOU ARE CLAIMING (If applicable, identify whether a disability is due to a service-connected disability, is due to confinement as a Prisoner of War, is due to exposure to Agent Orange, Asbestos, Mustard Gas, Ionizing Radiation, or Gulf War Environmental Hazards, or is related to benefits under 38 U.S.C. 1151).
Please list your contentions below. See the following examples, for more information:

- Example 1: Hearing loss
- Example 2: Diabetes-Agent Orange (exposed 12/72, Da Nang)
- Example 3: Left knee - secondary to right knee

DISABILITIES		
1.	11.	21.
2.	12.	22.
3.	13.	23.
4.	14.	24.
5.	15.	25.
6.	16.	26.
7.	17.	27.
8.	18.	28.
9.	19.	29.
10.	20.	30.

10. LIST VA MEDICAL CENTER(S) WHERE YOU RECEIVED TREATMENT FOR YOUR CLAIMED DISABILITY(IES) AND PROVIDE TREATMENT DATES:

A. NAME AND LOCATION OF VA MEDICAL CENTER	B. DATE(S) OF TREATMENT

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

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

SECTION II: SERVICE INFORMATION

11A. DID YOU SERVE UNDER ANOTHER NAME? ☐ YES (If "Yes," complete Item 11B) ☐ NO (If "No," skip to Item 12A)

11B. PLEASE LIST THE OTHER NAME(S) YOU SERVED UNDER

12A. I ENTERED ACTIVE SERVICE ON (MM,DD,YYYY)

12B. BRANCH OF SERVICE

12C. RELEASE DATE OR ANTICIPATED DATE OF RELEASE FROM ACTIVE SERVICE

12D. DID YOU SERVE IN A COMBAT ZONE SINCE 9-11-2001? ☐ YES ☐ NO

12E. PLACE OF LAST OR ANTICIPATED SEPARATION

13A. ARE YOU CURRENTLY ACTIVATED TO FEDERAL ACTIVE DUTY UNDER THE AUTHORITY OF TITLE 10, U.S.C. (National Guard)? ☐ YES ☐ NO (If "Yes," provide date of activation in Item 13B)

13B. DATE OF ACTIVATION (MM,DD,YYYY)

14A. WHAT IS THE NAME AND ADDRESS OF YOUR RESERVE/NATIONAL GUARD UNIT?	14B. WHAT IS THE TELEPHONE NUMBER OF YOUR CURRENT UNIT? (Include Area Code)
15A. HAVE YOU EVER BEEN A PRISONER OF WAR? ☐ YES (If "Yes," complete Item 15B) ☐ NO (If "No," skip to Item 16A)	15B. DATES OF CONFINEMENT From: To:

SECTION III: SERVICE PAY

16A. DID/DO YOU RECEIVE ANY TYPE OF SEPARATION/SEVERANCE/RETIRED PAY?	16B. LIST AMOUNT (If known)	16C. LIST TYPE (If known)
☐ YES ☐ NO (If "Yes," complete Items 16B and 16C)	$	

IMPORTANT: Submission of this application constitutes an election of VA compensation in lieu of military retired pay if it is determined you are entitled to both benefits. If you are entitled to receive military retired pay, your retired pay may be reduced by the amount of any VA compensation that you are awarded. VA will notify the Military Retired Pay Center of all identified changes. Receipt of military retired pay or Voluntary Separation Incentive (VSI) and VA compensation at the same time may result in an overpayment, which may be subject to collection. However, if you do not want to receive VA compensation in lieu of military retired pay, you should check the box in Item 17. Please note that if you check the box in Item 17, you ***will not*** receive VA compensation, if granted.

17. ☐ **I want military retired pay instead of VA compensation.**

SECTION IV: DIRECT DEPOSIT INFORMATION

The Department of Treasury requires all Federal benefit payments 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 18, 19 and 20 to enroll in direct deposit. If you do not have a bank account, you must receive your payment through Direct Express Debit MasterCard. To request a Direct Express Debit MasterCard you must apply at www.usdirectexpress.com or by telephone at 1-800-333-1795. If you elect not to enroll, you must contact representatives handling waiver requests for the Department of Treasury at 1-888-224-2950. They will encourage your participation in EFT and address any questions or concerns you may have.

18. ACCOUNT NUMBER (Check the appropriate box and provide the account number, or simply write "Established" if you have a direct deposit with VA)

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

Account No.:_____ Account No.:_____

19. NAME OF FINANCIAL INSTITUTION (Please provide the name of the bank where you want your direct deposit)	20. ROUTING OR TRANSIT NUMBER (The first nine numbers located at the bottom left of your check)

SECTION V: CLAIM CERTIFICATION AND SIGNATURE

I certify and authorize the release of information. I certify that the statements in this document are true and complete to the best of my knowledge. I authorize any person or entity, including but not limited to any organization, service provider, employer, or government agency, to give the Department of Veterans Affairs any information about me, and I waive any privilege which makes the information confidential.

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

I certify I have enclosed all the information or evidence that will support my claim, to include an identification of relevant records that will locate a Federal facility, such as a VA medical center; **OR,** I have no information or evidence to give VA to support my claim; **OR,** I have checked the box in Item 21, indicating that I do not want my claim considered for rapid processing in the Fully Developed Claim (FDC) Program because I plan to submit further evidence in support of my claim.

21. The FDC Program is designed to rapidly process compensation or pension claims received with the evidence necessary to decide the claim. VA will automatically consider a claim submitted on this form for rapid processing under the FDC Program. Check the box below **ONLY if you DO NOT want your claim considered for rapid processing** under the FDC Program because you plan on submitting further evidence in support of your claim.

☐ **I DO NOT want my claim considered for rapid processing** under the FDC Program because I plan to submit further evidence in support of my claim.

22A. VETERAN/SERVICE MEMBER SIGNATURE (**REQUIRED**)	22B. DATE SIGNED

SECTION VI: WITNESSES TO SIGNATURE

23A. SIGNATURE OF WITNESS (If veteran signed above using an "X")	23B. PRINTED NAME AND ADDRESS OF WITNESS
24A. SIGNATURE OF WITNESS (If veteran signed above using an "X")	24B. PRINTED NAME AND ADDRESS OF WITNESS

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

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