

**GENERAL INSTRUCTIONS
FOR VETERAN'S APPLICATION FOR COMPENSATION
VA FORM 21-526**

NOTE: Read very carefully, detach, and keep these instructions for your reference.

A. How can I contact VA if I have questions?

If you have questions about VA benefits, this form or how to fill it out, contact your nearest VA regional office. You can locate the address of the nearest regional office in your telephone book blue pages under "United States Government Veterans" or call 1-800-827-1000 (Hearing Impaired TDD line 1-800-829-4833). You may also contact VA by Internet at <http://www.vba.va.gov/benefits/address.htm>.

B. How can I get information about Social Security Benefits?

Individuals with a disability who meet certain medical criteria may qualify for benefits under the Social Security or Supplemental Security Income disability programs. These programs are administered by the Social Security Administration (SSA). For more information, contact SSA. You can locate the address of the nearest SSA office in the blue pages of your telephone book under "United States Government, Social Security Administration" or call 1-800-772-1213 (Hearing Impaired TTY line 1-800-325-0778). You can also contact SSA by Internet at www.ssa.gov.

C. What is the purpose of VA Form 21-526?

Use VA Form 21-526 to apply for compensation for service-connected disabilities.

D. What is disability compensation and how does VA decide what I will or will not receive?

VA pays veterans disability compensation for disability(ies) that are a result of their military service. If VA determines that your disability(ies) are 30% or more disabling, VA can pay additional compensation for your spouse, children, and dependent parents. VA will pay a higher amount of compensation for a spouse when the spouse is a patient in a nursing home or is disabled and requires regular aid and attendance of another person.

If any of the following are true, use VA Form 21-526 to apply for compensation:

- You were injured or seriously ill during service
- You believe you have continuing problems as a result of a service-related condition
- You developed a mental or physical disorder that may be related to your service

E. What evidence should I submit?

If you have records that support your claim you should attach them to this application. Refer to the checklist on page 2 of these instructions for a list of records you should submit. If you know of other records that will support your claim, VA will help you by requesting them from the person, company, or agency that has them.

If you want help obtaining existing non-VA medical records, you must complete the attached VA Form 21-4142, Authorization and Consent to Release Information to the Department of Veterans Affairs (VA). By signing VA Form 21-4142, you authorize any doctors, hospitals or caregivers that have treated you to release information about your treatment to VA. You do not need to complete this form for any treatment you received at a VA facility. Complete a separate VA Form 21-4142 for each medical provider. If you need additional copies of this form, you may contact VA as shown in paragraph A, download the form from our website at <http://www.va.gov/vaforms/>, or photocopy the attached form.

Note : You may complete and submit this application electronically at <http://vabenefits.vba.va.gov/vonapp/main.asp>.

F. How do I complete my application?

You will find instructions for completing each section of VA Form 21-526 in the checklist below. Your answer to every question is important in assisting us to decide your claim. Print all answers clearly. If an answer is "none" or "0," write that. If you do not know the answer, write "unknown." For additional space, use Item 52 "remarks" or attach a separate sheet of paper to your form, identifying the item number to which your answer applies.

CHECKLIST: THINGS YOU'LL NEED TO PREPARE FOR FILLING OUT YOUR APPLICATION		
<i>When you fill out this VA Form. . .</i>	<i>You'll need this information ready to answer questions. . .</i>	<i>You should attach these documents. . .</i>
Sections II through IV	<input type="checkbox"/> Dates and places you entered and left active duty <input type="checkbox"/> Date and place your Reserve and/or National Guard service began and ended (If applicable) <input type="checkbox"/> Mailing addresses of the Reserve or National Guard units in which you served	<input type="checkbox"/> Original or certified copies of your DD214 or other separation documents for all periods of service Note: To obtain a certified copy, you can take the original to your local courthouse and have it copied and signed by an official of the court. A VA employee can also certify a copy of the original for you
Section V	<input type="checkbox"/> Date(s) and place(s) of your injury while on travel	
Section VI	<input type="checkbox"/> Type and amount of military benefits you receive	
Section VII	<input type="checkbox"/> Information about the disabilities you are claiming, including <ul style="list-style-type: none"> • treatment dates during service • name and address of the medical facilities where you have been treated since service ended <input type="checkbox"/> Information about any exposure to toxins or events that caused disabilities you are claiming, including dates and places where the exposure(s) occurred	<input type="checkbox"/> Original or copies of service medical records in your possession <input type="checkbox"/> Medical records you possess showing your disabilities still exist <input type="checkbox"/> Medical records you possess indicating that the disabilities were caused by or happened during active duty <input type="checkbox"/> Completed VA Form 21-4142 for each non-VA medical care provider whose records you would like us to help you obtain
Section VIII and IX	<input type="checkbox"/> Information about your current spouse, including: <ul style="list-style-type: none"> • social security number • date of birth • VA file number if he/she is a veteran <input type="checkbox"/> Information about you and your spouse's previous marriages, including: <ul style="list-style-type: none"> • dates and places of those marriages • dates and places those marriages 	<input type="checkbox"/> A copy of your marriage certificate and all divorce decrees may be required upon request by VA
Section X	<input type="checkbox"/> Information about your children, including: <ul style="list-style-type: none"> • social security number • dates and places of birth <input type="checkbox"/> Additional information about your children who are not living with you, including: <ul style="list-style-type: none"> • addresses • amounts that you contribute in child support for them 	<input type="checkbox"/> Copies of the public birth records for each child you claim as a dependent may be required in some cases <input type="checkbox"/> Copies of the court records of adoption for each adopted child
Section X	<input type="checkbox"/> Direct Deposit Information	<input type="checkbox"/> Voided Check
Section XII	<input type="checkbox"/> Sign and date your application	<input type="checkbox"/> If you sign with an "X," two persons must witness it, and you must provide their names and addresses
Section XIII	<input type="checkbox"/> Any additional information you would like to provide VA as it relates to your claim	

G. What do I do when I have completed my application?

1. Make sure you sign and date this application (Items 48 and 49)
2. Attach any materials that support and explain your claim. Review the checklist on pages 2 and 3 of these instructions to make sure you have attached all supporting material.
3. Make a photocopy of your application and everything that you submit to VA for your records.
4. Mail or take your original application and supporting materials to your nearest VA regional office.

Note : If you find you need to change or add information to your application, contact the VA office where you submitted your application immediately.

H. How can I assign someone to act as my representative?

A representative may be an accredited member of an accredited organization that the Secretary of Veterans Affairs recognizes, an agent recognized by VA, or a licensed lawyer. Agents and attorneys may charge you for service they provide only after the Board of Veterans' Appeals (BVA) gives you its final decision about your claim. That means you can use an attorney during any stage of your application for benefits. However, the agent or attorney is prohibited by law from charging you for services unless you are trying to resolve a dispute with VA after BVA has made a decision about your claim.

If you want to use a representative to help you with your application, contact the nearest VA regional office. Depending on the type of representative you want to designate, we will send you one of the following forms:

- VA Form 21-22, Appointment of Veterans Service Organization as Claimant's Representative, or
- VA Form 21-22a, Appointment of Individual as Claimants Representative.

You may also download these forms at <http://www.va.gov/vaforms/>. If you have already designated a representative, no further action is required on your part.

I. What if I believe VA made an error in processing or deciding my claim?

You may ask for a personal hearing at any time. That means you may ask for the hearing while VA is processing your claim or after VA has made a decision. You should contact the nearest VA regional office and tell them that you want a personal hearing on your case. Someone in that office will arrange a time and a place for your hearing. At this hearing, you may bring witnesses. VA will record whatever you and your witness say during the hearing and include it in the official record. VA will furnish the hearing room and official, and prepare a transcript of the hearing. VA cannot pay your expenses or the expenses of anyone you want to bring with you to the hearing.

Privacy Act Notice: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed 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 voluntary; however, no allowance of compensation may be granted unless this form is completed fully as required by law. Giving us your and your dependents' Social Security number 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 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 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. Income 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.

Respondent Burden: We need this information to determine eligibility for compensation (38 U.S.C. 5101). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 1 hour and 30 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.whitehouse.gov/omb/library/OMBINV.html#VA. If



Department of Veterans Affairs

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

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

VETERAN'S APPLICATION FOR COMPENSATION
VA Form 21-526

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

SECTION I Tell us about you

1. What is your name?
2. What is your social security number?
3. What is your sex?
4a. Have you ever filed a claim with VA?
4b. I filed a claim with VA for
5a. Did you serve under another name?
5b. Please list the other name(s) you served under
6. What is your address?
7. What are your telephone numbers?
8. What is your e-mail address?
9. What is your date of birth?
10. Where were you born?
11a. Are you receiving disability benefits from the Office of Workers' Compensation (OWCP)?
11b. When was the claim filed?
11c. For what disability are you receiving benefits?
12a. What is the name of your nearest relative or other person we could contact if necessary?
12b. What is his/her telephone number?
12c. What is this person's address?
12d. How is this person related to you?

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 Item 52, "Remarks." Also in Item 52, give us the date you think you will be at the new address.

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

<p>SECTION II</p> <p>Tell us about your active duty</p> <p>1. Enter complete information for all periods of service. If more space is needed, use Item 52 "Remarks".</p> <p>2. Attach your original DD214 (discharge papers) or a certified copy to this form (We will return original documents to you.)</p> <p>The VA has a registry of veterans who served in the Gulf War theater of operations. 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 15b. VA will only share the information in this registry with the Department of Defense and others as permitted by law (such as the National Academy of Sciences). We will keep you informed of significant developments in research on health consequences found to be related to military service in the Gulf War. You may request a VA health examination that will include consultation and counseling covering the results of the examination. You should contact our nearest VA medical facility to request an examination.</p>	<p>13a. I entered active service the first time. . .</p> <p> / / mo day yr</p>	<p>13b. Place:</p>	<p>13c. My service number was . . .</p>		
	<p>13d. I left this active service. . .</p> <p> / / mo day yr</p>	<p>13e. Place:</p>	<p>13f. Branch of Service</p>	<p>13g. Grade, rank, or rating</p>	
	<p>13h. I entered my second period of active service. . .</p> <p> / / mo day yr</p>	<p>13i. Place:</p>	<p>13j. My service number was . . .</p>		
	<p>13k. I left this active service. . .</p> <p> / / mo day yr</p>	<p>13l. Place:</p>	<p>13m. Branch of Service</p>	<p>13n. Grade, rank, or rating</p>	
	<p>14a. Did you serve in Vietnam?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(If "Yes," answer Item 15b also)</p>		<p>14b. When were you in Vietnam?</p> <p>from to</p> <p> / / / / mo day yr mo day yr</p>		
	<p>15a. Were you stationed in the Gulf after August 1, 1990?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(If "Yes," answer Item 15b also)</p>		<p>15b. Do you want to have medical and other information about you included in the "Gulf War Veterans' Health Registry?"</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>		
	<p>16a. Have you ever been a prisoner of war?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(If "Yes," answer Items 16b, 16c, and 16d also)</p>		<p>16b. What country or government imprisoned you?</p>		
<p>16c. When were you confined?</p> <p>from to</p> <p> / / / / mo day yr mo day yr</p>		<p>16d. What was the name of the camp or sector, and what are the names of the city and country near its location?</p>			
<p>SECTION III</p> <p>Tell us about your reserve duty</p>	<p>17a. Are you currently assigned to an active reserve unit?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(If "Yes," answer Item 17b also)</p>		<p>17b. What is the name, mailing address, and telephone number of your current unit?</p>		
	<p>17c. Were you previously assigned to an active reserve unit within the last 2 years?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(If "Yes," answer Item 17d also)</p>		<p>17d. What is the name, mailing address, and telephone number of that unit?</p>		

SECTION III (Continued) Tell us about your reserve duty	17e. Do you have an inactive reserve obligation? (You perform no active duty, but you could be activated if there was a national emergency) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know (If "Yes," answer Item 17f also)	17f. What is your reserve obligation termination date? <div style="text-align: center;"> / / mo day yr </div>	
Instructions 17g-17k If you are currently or have ever been a full time reservist for operational or support duty, 1. Complete 17g-17k for that service only. 2. Attach proof of reserve service	17g. I entered reserve service. . . <div style="display: flex; align-items: center;"> <div style="flex: 1;"> <div style="text-align: center;"> / / mo day yr </div> </div> <div style="flex: 1; border-left: 1px solid black; padding-left: 5px;"> Place: _____ </div> </div>	17h. My service number was . . . _____	
Instructions 17l-17p If your disability occurred or was aggravated during any period of reserve duty, 1. Complete 17l-17p for the period when your disability occurred. 2. Attach proof that your disability occurred during reserve service.	17i. I left reserve service. . . <div style="display: flex; align-items: center;"> <div style="flex: 1;"> <div style="text-align: center;"> / / mo day yr </div> </div> <div style="flex: 1; border-left: 1px solid black; padding-left: 5px;"> Place: _____ </div> </div>	17j. Branch of service	17k. Grade, rank, or rating
SECTION IV Tell us about your National Guard duty	17l. I entered reserve service. . . <div style="display: flex; align-items: center;"> <div style="flex: 1;"> <div style="text-align: center;"> / / mo day yr </div> </div> <div style="flex: 1; border-left: 1px solid black; padding-left: 5px;"> Place: _____ </div> </div>	17m. My service number was . . . _____	
Instructions 17l-17p If your disability occurred or was aggravated during any period of reserve duty, 1. Complete 17l-17p for the period when your disability occurred. 2. Attach proof that your disability occurred during reserve service.	17n. I left reserve service. . . <div style="display: flex; align-items: center;"> <div style="flex: 1;"> <div style="text-align: center;"> / / mo day yr </div> </div> <div style="flex: 1; border-left: 1px solid black; padding-left: 5px;"> Place: _____ </div> </div>	17o. Branch of service	17p. Grade, rank, or rating
SECTION IV Tell us about your National Guard duty	18a. Are you currently a member of the National Guard? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not assigned yet (If "Yes," answer Item 18b also)	18b. What is the name, mailing address, and telephone number of your current unit?	
Instructions 18e-18i If you were activated to Federal active duty under the Authority of Title 10, United States Code, 1. Complete 18e-18i for that service only 2. Attach proof of this Federal Active Duty.	18c. Were you previously assigned to a guard unit within the last 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," answer Item 18d also)	18d. What is the name, mailing address, and telephone number of that unit?	
Instructions 18j-18n If your disability occurred or was aggravated during any period of Guard duty, 1. Complete 18j-18n for the period when your disability occurred 2. Attach proof that your disability occurred during National Guard service.	18e. I entered Federal Active Duty. . . <div style="display: flex; align-items: center;"> <div style="flex: 1;"> <div style="text-align: center;"> / / mo day yr </div> </div> <div style="flex: 1; border-left: 1px solid black; padding-left: 5px;"> Place: _____ </div> </div>	18f. My service number was . . . _____	
Instructions 18j-18n If your disability occurred or was aggravated during any period of Guard duty, 1. Complete 18j-18n for the period when your disability occurred 2. Attach proof that your disability occurred during National Guard service.	18g. I left Federal Active Duty. . . <div style="display: flex; align-items: center;"> <div style="flex: 1;"> <div style="text-align: center;"> / / mo day yr </div> </div> <div style="flex: 1; border-left: 1px solid black; padding-left: 5px;"> Place: _____ </div> </div>	18h. Branch of service	18i. Grade, rank, or rating
	18j. I entered the National Guard. . . <div style="display: flex; align-items: center;"> <div style="flex: 1;"> <div style="text-align: center;"> / / mo day yr </div> </div> <div style="flex: 1; border-left: 1px solid black; padding-left: 5px;"> Place: _____ </div> </div>	18k. My service number was . . . _____	
	18l. I left National Guard. . . <div style="display: flex; align-items: center;"> <div style="flex: 1;"> <div style="text-align: center;"> / / mo day yr </div> </div> <div style="flex: 1; border-left: 1px solid black; padding-left: 5px;"> Place: _____ </div> </div>	18m. Branch of service	18n. Grade, rank, or rating

SECTION V Tell us about your travel status	19a. Were you injured while traveling to or from your military assignment? <input type="checkbox"/> Yes <input type="checkbox"/> No <small>(If "Yes," answer Items 19b thru 19e)</small>	19b. When did your injury happen? _____ / _____ / _____ mo day yr	19c. Where did your injury happen? (City, State, Country)
	19d. Where were you treated? (Provide name and address of Doctor's office, hospital, etc.)	19e. With what agency did you file an accident report?	

SECTION VI Tell us about your military benefits <small>Note: If you are receiving or are entitled to receive military retired pay, your military retired pay may be reduced by the amount of any compensation that VA may award you. However, this is to your advantage, because VA compensation is not taxable and most retired pay is taxable. Your signature on this application indicates to us, without separate notice, that you want to get VA compensation instead of military retired pay. Military retired pay in excess of VA compensation will still be awarded to you if VA compensation is granted. In some cases you may be entitled to both VA compensation and military retired pay or Combat Related Special Compensation. VA notifies the Military Retired Pay Center of awards of VA benefits and all VA benefit changes. The Department of Defense determines if you are eligible for payments from your service branch.</small> <small>If you received any of these military benefits and VA benefits are awarded, the amount you received may be recouped by VA, or in the case of VSI, by the Department of Defense.</small>	20a. Are you receiving or will you receive retired pay or retainer pay that is based on your military service? <input type="checkbox"/> Yes <small>(If "Yes," answer Items 20b thru 20d)</small> <input type="checkbox"/> No <small>(If "No," skip to Item 21)</small>													
	20b. What branch of service is paying or will pay your retired pay?													
	20c. What is the monthly amount? \$ _____ Monthly Amount													
	20d. What is your retirement based on? <input type="checkbox"/> Length of service <input type="checkbox"/> Disability <input type="checkbox"/> TDRL (Temporary Disability Retired List)													
	20e. Have you received or will you receive any of the following military benefits? (Please check the appropriate boxes and tell us the amount)													
	<table border="1"> <thead> <tr> <th><i>Benefit</i></th> <th><i>Amount</i></th> </tr> </thead> <tbody> <tr> <td>(1) <input type="checkbox"/> Lump Sum Readjustment Pay</td> <td>\$ _____</td> </tr> <tr> <td>(2) <input type="checkbox"/> Separation pay under 10 USC 1174</td> <td>\$ _____</td> </tr> <tr> <td>(3) <input type="checkbox"/> Special Separation Benefit (SSB)</td> <td>\$ _____</td> </tr> <tr> <td>(4) <input type="checkbox"/> Voluntary Separation Incentive (VSI)</td> <td>\$ _____</td> </tr> <tr> <td>(5) <input type="checkbox"/> Disability Severance Pay (name of disability _____)</td> <td>\$ _____</td> </tr> <tr> <td>(6) <input type="checkbox"/> Other (tell us the type of benefit _____)</td> <td>\$ _____</td> </tr> </tbody> </table>	<i>Benefit</i>	<i>Amount</i>	(1) <input type="checkbox"/> Lump Sum Readjustment Pay	\$ _____	(2) <input type="checkbox"/> Separation pay under 10 USC 1174	\$ _____	(3) <input type="checkbox"/> Special Separation Benefit (SSB)	\$ _____	(4) <input type="checkbox"/> Voluntary Separation Incentive (VSI)	\$ _____	(5) <input type="checkbox"/> Disability Severance Pay (name of disability _____)	\$ _____	(6) <input type="checkbox"/> Other (tell us the type of benefit _____)
<i>Benefit</i>	<i>Amount</i>													
(1) <input type="checkbox"/> Lump Sum Readjustment Pay	\$ _____													
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(5) <input type="checkbox"/> Disability Severance Pay (name of disability _____)	\$ _____													
(6) <input type="checkbox"/> Other (tell us the type of benefit _____)	\$ _____													

SECTION VII 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. Try to list the actual disease and medical condition that a doctor has diagnosed.
- 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 physicians before, during, and after your service.

21a. What disability are you claiming?	21b. When did your disability begin?	21c. When were you treated?	21d. What medical facility or doctor treated you?	21e. What is the address of that medical facility or doctor?
	____/____/____ mo day yr	from to ____/____/____ ____/____/____ mo day yr mo day yr		
	____/____/____ mo day yr	from to ____/____/____ ____/____/____ mo day yr mo day yr		
	____/____/____ mo day yr	from to ____/____/____ ____/____/____ mo day yr mo day yr		
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	____/____/____ mo day yr	from to ____/____/____ ____/____/____ mo day yr mo day yr		

SECTION VII

Tell us about your disability
(Continued)

<p>22a. Did you have a separation or retirement physical examination?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(If "Yes," answer Items 22b and 22c also)</p>	<p>22b. When was the exam?</p> <p>____/____/____</p> <p>mo day yr</p>	<p>22c. Where did the exam occur?</p>
<p>23. Do you have a medical condition (pregnancy, recent surgery, allergy to contrast media, etc.) that may prevent you from undergoing a VA physical examination?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>		
<p>24a. Did exposure to Agent Orange or other herbicides cause your disability?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(If "Yes," answer Item 24b and 24c also)</p>	<p>24b. What is your disability?</p>	<p>24c. In what country were you exposed?</p>
<p>25a. Did exposure to Asbestos cause your disability?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(If "Yes," answer Items 25b and 25c also)</p>	<p>25b. What is the disability?</p> <hr/> <p>25c. When and how were you exposed?</p>	
<p>26a. Did exposure to mustard gas cause your disability?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(If "Yes," answer Items 26b and 26c also)</p>	<p>26b. What is the disability?</p> <hr/> <p>26c. When and how were you exposed?</p>	
<p>27a. Did exposure to ionizing radiation cause your disability?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(If "Yes," answer Items 27b through 27d)</p>	<p>27b. What is the disability?</p> <hr/> <p>27c. What are the dates and places of exposure, OR what is the operation or test-shot code name?</p>	
<p>27d. How were you exposed to radiation?</p> <p><input type="checkbox"/> Atmospheric or oceanic testing</p> <p><input type="checkbox"/> American occupation of Nagasaki or Hiroshima</p> <p><input type="checkbox"/> Military duties (occupational exposure) (Describe circumstances below in Item 29)</p>		
<p>28a. Did exposure to an environmental hazard in the Gulf War cause your disability?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(If "Yes," answer Items 28b through 28c)</p>	<p>28b. What is the disability?</p> <hr/> <p>28c. What was the hazard?</p>	
<p>29. How are the disabilities listed in Item 21a related to your military service?</p>		

SECTION X	Tell us about any previous marriages	<p>You must furnish complete information about <i>all</i> of your and your present spouse's previous marriages. If you need additional space, please use Item 52 "Remarks" or attach a separate sheet of paper.</p> <p>NOTE: You should provide copies of divorce decrees or death certificates.</p>
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Your previous marriages

39a. How many times have you been married before? _____

39b. When were you married?	39c. Where were you married? (city/state or country)	39d. Who were you married to? (first, middle initial, last)	39e. When did your marriage end? mo day yr	39f. Why did your marriage end? (death, divorce)	39g. 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

40a. How many times has your current spouse been married before? _____

40b. When was your spouse married?	40c. Where was your spouse married? (city/state or country)	40d. To whom was your spouse married? (first, middle initial, last)	40e. When did your spouse's marriage end? mo day yr	40f. Why did your spouse's marriage end? (death, divorce)	40g. Where did your spouse's marriage end? (city/state or country)
/ / mo day yr			/ / mo day yr		
/ / mo day yr			/ / mo day yr		

SECTION X

Tell us about your other dependents

Note: 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.

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

- under the age of 18, **or**
- at least 18 but under 23 and pursuing an approved course of education, **or**
- of any age if they became permanently unable to support themselves before reaching age 18.

"Seriously disabled" (Item 43h) means that the child became permanently unable to support himself/herself 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. If you need additional space, please use Item 52 "Remarks" or attach a separate sheet of paper.

41. Are your parents financially dependent on you?

Yes No (If "Yes," we may request additional information from you later.)

42. Do you have dependent children?

Yes No (If "No," Skip to Section XI)

SECTION XII 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 two people witness it. 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 that makes the information confidential.

48. Your signature	49. Today's date <div style="text-align: center;"> ____ / ____ / ____ mo day yr </div>
50a. Signature of witness (If claimant signed above using an "X")	50b. Printed name and address of witness
51a. Signature of witness (If claimant signed above using an "X")	51b. Printed name and address of witness

SECTION XIII

Remarks—Use this space for any additional statements that you would like to make concerning your application for compensation.

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.

52. 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 section and item number)*

SECTION III CONSENT TO RELEASE INFORMATION

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

9A. PRIVACY ACT NOTICE: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28 Compensation, Pension, Education, and Rehabilitation Records - VA, and published in the Federal Register. Your obligation to respond is voluntary. However, if the information including your Social Security Number (SSN) is not furnished completely or accurately, the health care provider to which this authorization is addressed may not be able to identify and locate your records, and provide a copy to VA. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. The VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by Federal Statute of law in effect prior to January 1, 1975, and still in effect.

9B. I, the undersigned, hereby authorize the hospital, physician or other health care provider or health plan shown in Item 7A, to release any information that may have been obtained in connection with a 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. I understand that the health care provider or health plan identified in Item 7A who is being asked to provide the Veterans Benefits Administration with records under this authorization may not require me to execute this authorization before it will, or will continue to, provide me with treatment, payment for health care, enrollment in a health plan, or eligibility for benefits provided by it. I understand that once my health care provider sends this information to VA under this authorization, the information will no longer be protected by the HIPPA Privacy Rule, but will be protected by the Federal Privacy Act, 5 USC 552a, and VA may disclose this information as authorized by law. I also understand that I may revoke this authorization, at anytime (except to the extent that the health care provider has already released information to VA under this authorization) by notifying the health care provider shown in Item 7A. Please contact the VA Regional Office handling your claim or the Board of Veterans' Appeals, if an appeal is pending, regarding such action. If I do not revoke this authorization, it will automatically end 180 days from the date you sign and date the form (Item 10C).

9C. I (AUTHORIZE) (DO NOT AUTHORIZE) the source shown in Item 7A 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), sickle cell anemia or psychotherapy notes. 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, please provide full name, title, organization, city, State and ZIP Code. All court appointments must include docket number, county and State)	10C. DATE
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10D. MAILING ADDRESS (Number and Street or rural route, city, or P.O. State and ZIP Code)	10E. TELEPHONE NUMBER (Include Area Code)
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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.

11A. SIGNATURE OF WITNESS	11B. DATE
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11C. MAILING ADDRESS OF WITNESS