Department of Veterans Affairs

In Reply Refer To:

Ins. File No.

Name:

Soc. Sec. No.:

The above-named veteran has filed a claim for disability insurance benefits.

Before a claim can be processed, the employment information requested on the reverse of this letter must be obtained. Your cooperation in completing this form will permit us to expedite the veteran's claim.

We have the veteran's permission to request this report.

Sincerely yours,

Enclosure:

(Over)

OMB Approved No. 2900-0066
Respondent Burden: 10 minutes

Department of Veterans Affairs

REQUEST FOR EMPLOYMENT INFORMATION IN CONNECTION WITH A CLAIM FOR DISABILITY BENEFITS

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 5 Code of Federal Regulations 1.526 for routime uses indentified in the VA system of records, 36VA00, Veterans and Armed Forces Personnel U.S. Government Life Insurance Records - VA, published in the Federal Register. Your obligation to respond is voluntary, but your failure to provide us the information could impede processing.

RESPONDENT BURDEN - We need this information to help us make a decision on the claim for disability insurance benefits under consideration (38 U.S.C. 1912, 1915, 1942 and 1948). We estimate that you will need an average of 10 minutes per response 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.VA.EPA.html#VA. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

1. DATES OF EMPLOYMENT		2. INSURED WORKED	3. AVERAGE NO. OF HOURS WORKED		4. AVERAGE WAGES
FROM	TO	☐ FULL-TIME ☐ PART-TIME	DAILEY	WEEKLY	
5. LAST DAY INSURED WORKED		6. REASON			

7. TYPE OF DUTIES PERFORMED

8. DATES INSURED DID NOT WORK BECAUSE OF ILLNESS

9. NATURE OF ILLNESS

10. REMARKS

11A. SIGNATURE AND TITLE	11B. DATE SIGNED

FL 29-459
AUG 2007(R)