DEPARTMENT OF VETERANS AFFAIRS
Regional Office and Insurance Center

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In Reply Refer To:

Name of Veteran:

File Number:

The information requested below is needed in connection with your claim for disability insurance benefits.

OMB Approved No. 2900-0129
Respondent Burden: 5 Mins.
Expiration Date: XX/XX/XXXX

SUPPLEMENTAL DISABILITY REPORT

PRIVACY ACT INFORMATION - No claim for disability benefits may be approved until proof of entitlement is received (38 U.S.C. 1912,1915, 1942 and 1948). The information provided on a voluntary basis will be used by VA employees and your authorized representatives in the maintenance of Government insurance programs. The responses which are furnished 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, 36VA00, Veterans and Armed Forces Personnel U.S. Government Life Insurance Records - VA, published in the Federal Register.

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 5 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.

1. ARE YOU WORKING NOW?

☐ YES ☐ NO

2. HAVE YOU WORKED SINCE ______________________________? ☐ YES ☐ NO

3. DATE EMPLOYMENT STARTED __________________________ NUMBER OF HOURS WORKED PER WEEK __________________

4. NAME AND ADDRESS OF EMPLOYER ____
____
____

5. WHERE HAVE YOU RECEIVED MEDICAL TREATMENT SINCE _____________________________?

a. Name and address of physician or hospital ____

b. Dates of treatment ____

6. DAYTIME TELEPHONE NUMBER	7. SOCIAL SECURITY NUMBER

8. SIGNATURE OF INSURED VETERAN OR FIDUCIARY	9. DATE SIGNED

SUPERSEDES VA FORM 29-30a, OCT 2004, WHICH WILL NOT BE USED.

FL 29-30a
JAN 2014(RS)