



VA DATE STAMP
DO NOT WRITE IN THIS SPACE

VETERAN'S SUPPLEMENTAL CLAIM FOR COMPENSATION

IMPORTANT: PLEASE READ THE PRIVACY ACT NOTICE AND RESPONDENT BURDEN INFORMATION ON PAGE 2 BEFORE COMPLETING THIS FORM.

PART I - VETERAN'S IDENTIFYING INFORMATION

1. NAME OF VETERAN (First, Middle, Last)	
<input type="text"/>	
2. VETERAN'S SOCIAL SECURITY NUMBER	3. VA FILE NUMBER
<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/>
4. VETERAN'S ADDRESS (Number, street or rural route, City or P.O., State and ZIP Code)	
<input type="text"/>	
5. TELEPHONE NUMBER(S)	
A. DAYTIME (Include Area Code)	B. EVENING (Include Area Code)
<input type="text"/>	<input type="text"/>
6. E-MAIL ADDRESS (If applicable)	
<input type="text"/>	

PART II - INFORMATION ABOUT CLAIM

7. DISABILITY (IES) INFORMATION

<p>A. LIST THE DISABILITIES YOU ARE CLAIMING FOR INCREASED EVALUATION (The disability(ies) for which you are already service connected)</p>	<p>B. LIST NEW DISABILITY(IES) YOU ARE CLAIMING FOR SERVICE CONNECTION (List only <i>new</i> disability(ies))</p>				
1.	1.				
2.	2.				
3.	3.				
4.	4.				
5.	5.				
<p>C. DISABILITY(IES) SECONDARY TO MY EXISTING SERVICE CONNECTED DISABILITY(IES) (Provide the name of the disability(ies) and your service connected condition(s))</p>	<p>D. REOPENING OF PREVIOUSLY DENIED DISABILITY(IES) (List your previously denied disability(ies))</p>				
1.	1.				
2.	2.				
3.	3.				
4.	4.				
5.	5.				
8A. NAME AND LOCATION OF VA MEDICAL CENTER THAT HAS MY RELEVANT TREATMENT RECORDS	8B. NAME AND ADDRESS OF MILITARY FACILITY THAT HAS MY RELEVANT TREATMENT RECORDS				
<input type="text"/>	<input type="text"/>				
8C. DO YOU HAVE PRIVATE TREATMENT RECORDS? (If "Yes," please attach the treatment records to this form. If you would like to have VA request your private treatment records, please attach a VA Form 21-4142, Authorization and Consent to Release Information to the Department of Veterans Affairs, for each private treatment provider. The form is available at www.va.gov/vaforms/ .)					
<input type="checkbox"/> YES <input type="checkbox"/> NO					
9. I WOULD LIKE TO FILE A CLAIM FOR OTHER VA BENEFITS (Check appropriate box)					
<input type="checkbox"/> AID AND ATTENDANCE <input type="checkbox"/> AUTOMOBILE ALLOWANCE <input type="checkbox"/> OTHER (Specify benefit) _____					
<p>IMPORTANT - If you are certifying that you are married for the purpose of VA benefits, your marriage must be recognized by the place where you and/or your spouse resided at the time of marriage, or where you and/or your spouse resided when you filed your claim (or a later date when you became eligible for benefits) (38 U.S.C. § 103 (c)). Additional guidance on when VA recognizes marriages is available at http://www.va.gov/opa/marriage/.</p>					
10. I WOULD LIKE TO FILE A CLAIM FOR ADDITIONAL BENEFITS BECAUSE MY SPOUSE IS SERIOUSLY DISABLED (Please provide spouse's name and social security number in Items 10A & 10B)	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%;">A. SPOUSE'S NAME</td> <td style="width:50%;">B. SPOUSE'S SOCIAL SECURITY NO.</td> </tr> <tr> <td> <input type="text"/> </td> <td> <input type="text"/> </td> </tr> </table>	A. SPOUSE'S NAME	B. SPOUSE'S SOCIAL SECURITY NO.	<input type="text"/>	<input type="text"/>
A. SPOUSE'S NAME	B. SPOUSE'S SOCIAL SECURITY NO.				
<input type="text"/>	<input type="text"/>				
11A. VETERAN'S SIGNATURE (Do NOT print)	11B. DATE SIGNED				
<input type="text"/>	<input type="text"/>				

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 Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. Giving us your SSN account information is mandatory. Applicants are required to provide their SSN 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 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 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.

RESPONDENT BURDEN: We need this information to make an eligibility determination for veterans' filing supplemental compensation claims (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 15 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.