Department of Veterans Affairs

General Instructions
For Application for Dependency and Indemnity Compensation by Parent(s) (Including Accrued Benefits and Death Compensation when Applicable)
VA Form 21P-535

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 any questions about this form, how to fill it out, or about VA benefits, 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 711). You may also contact VA by Internet at https://iris.va.gov.

B. What is the purpose of VA Form 21P-535?

Use VA Form 21P-535 to apply for:

- VA benefits you may be entitled to receive as the surviving parent(s) of a deceased veteran
- Any money VA owes the veteran but did not pay prior to his/her death (accrued benefits).

If you apply for one of these benefits, the law requires that we also consider your entitlement for the other.

C. What is the purpose of the attached SSA-24 form?

You can apply for Social Security benefits by using the SSA-24 form attached to this VA form. You don't have to apply if you don't want to or have already done so. If you do want to apply, fill it out and leave it attached. We will send it to the Social Security Administration for you. They will then contact you.

D. What is dependency and indemnity compensation (DIC), and how does VA decide what I will or will not receive?

DIC may be payable to parent(s) when:

- a veteran's death occurred in service, or
- a veteran dies of a service-connected disability,

AND

- your income is limited.

VA pays Parents' DIC based on the amount of the claimant's countable income and whether the claimant is the sole surviving parent of the veteran or one of two parents. This is based on law. If the claimant is married and lives with his/her spouse, the claimant's and the spouse's income are counted. VA must include as income payments received from all sources that Federal law specifies.

Benefit rates and income limits are frequently changed, so it is not possible to keep this information current in these instructions. You can find out what the current income limitations and rates of benefits are by contacting your nearest VA regional office. You can locate your local VA regional at the following web site www.va.gov/directory.

Note: Unless a claim for DIC is filed within one year from the date of the veteran's death, that benefit is not payable from a date earlier than the date VA receives the claim.

E. How do I apply for the aid and attendance allowance?

VA may pay a higher rate of DIC to a surviving parent who is blind, a patient in a nursing home, or otherwise needs regular aid and attendance. If you wish to apply for this benefit, check "Yes" for Item 19.

F. How do I complete my application?

Print or type all answers clearly. If an answer is "none" or "0," write that. Your answer to every question is important to help us complete your claim. If you do not know the answer, write "unknown." For additional space, use Item 34, "Remarks, " or attach a separate sheet, indicating the item number to which the answers apply. Make sure you sign and date this application (Items 30a through 31b).

Note: If the claim is being made on behalf of an incompetent person, the application form should be completed and filed by the legal guardian. If no legal guardian has been appointed, it may be completed and filed by some person acting on behalf of the incompetent person.

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

When you have completed this application, mail **or** fax to the appropriate Pension Center listed on page 8. Be sure to attach any materials that support and explain your claim. Also, make a photocopy of your application and everything that you submit to VA before mailing or faxing it.

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

A representative can be an accredited member of an accredited organization or other service organization that the Secretary of Veterans Affairs recognizes, an agent recognized by VA, or a licensed lawyer. If you appeal the decision, agents and attorneys can charge you for services that you receive from them only after the Board of Veterans' Appeals (BVA) gives you its final decision about your application. That means you can use an attorney during any stage of your application for benefits; however, the agent or attorney cannot charge 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 Claimant's Representative*.

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

I. What if I believe that VA has made an error in processing or deciding my benefits?

You can ask for a personal hearing at any time during the processing of your claim. That means you can 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 the local VA regional 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 witnesses say during the hearing and include it in the official record. VA will furnish the hearing room and officials, 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.

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/.

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 5, Code of Federal Regulations 1.526 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. 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 determine eligibility for death benefits and accrued benefits under 38 U.S.C. 1121, 1310, 1315, and 5121. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 1 hour and 12 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.

OMB Control No. 2900-0005
Respondent Burden: 1 hour and 12 minutes
Expiration Date: XX/XX/XXXX

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

APPLICATION FOR DEPENDENCY AND INDEMNITY COMPENSATION BY PARENT(S)
(Including Accrued Benefits and Death Compensation when Applicable)

INSTRUCTIONS: Please read the attached "General Instructions" and the Privacy Act and Respondent Burden information before completing this form.

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

NOTE: You can ***either*** complete the form online or by hand. Please print your information using blue or black ink, neatly and legibly to help process the form.

1. VETERAN'S NAME *(First, Middle Initial, Last)*

2. VETERAN'S SOCIAL SECURITY NUMBER — – –

3. VA FILE NUMBER *(If applicable)*

4. VETERAN'S DATE OF BIRTH
Month – Day – Year

5. VETERAN'S DATE OF DEATH? (Month, Day, Year)
Month – Day – Year

6. VETERAN'S SERVICE NUMBER *(If applicable)*

7. NAME OF PERSON FILING CLAIM? *(First, Middle Initial, Last)*

8. WHAT IS YOUR RELATIONSHIP TO THE VETERAN?

9. HAVE YOU EVER FILED A CLAIM WITH VA?
☐ Yes ☐ No *(If "Yes," answer Item 10)*

10. WHAT IS YOUR VA FILE NUMBER?

11. EMAIL ADDRESS *(If applicable)*

12. TELEPHONE NUMBER *(Include Area Code)*

13A. DID THE VETERAN SERVE UNDER ANOTHER NAME?
☐ Yes ☐ No *(If "Yes," answer Item 13B)*

13B. LIST THE OTHER NAME(S) THE VETERAN SERVED UNDER:

NOTE: Attach a copy of the death certificate unless the veteran died while serving in the Army, Navy, Air Force, Marine Corps, or Coast Guard, or as a commissioned officer in the National Oceanic and Atmospheric Administration, Coast and Geodetic Survey, Environmental Science Services Administration, or Public Health Service, or in a hospital or institution under the control of the U.S. government.

SECTION II: VETERAN'S ACTIVE DUTY SERVICE

NOTE: SKIP TO SECTION III IF THE VETERAN WAS RECEIVING VA COMPENSATION OR PENSION AT THE TIME OF HIS/HER DEATH. If the veteran never filed a claim with VA, attach the original DD214 or a certified copy for each period of service listed. We will return original documents to you.
If more space is needed use Item 34, "Remarks,".

14A. VETERAN ENTERED ACTIVE SERVICE (Month, Day, Year)	14B. PLACE ENTERED ACTIVE SERVICE	14C. SERVICE NUMBER	
14D. VETERAN LEFT ACTIVE SERVICE (Month, Day, Year)	14E. PLACE LEFT ACTIVE SERVICE	14F. BRANCH OF SERVICE	14G. GRADE, RANK OR RATING

SECTION III: VETERAN'S PARENT(S) INFORMATION

NOTE*:* Parent means a biological or adoptive parent, or a foster parent. A foster parent is a person who stood in the relationship of a parent to a veteran for at least one year before the veteran's last entry into active service. The foster relationship must have begun prior to the veteran's 21st birthday. If you are claiming benefits as the foster parent of the veteran, you will also need to complete VA Form 21P-524, *Statement Of Person Claiming To Have Stood In Relation of Parent*. If you need a copy of this form, you may download the form at www.va.gov/vaforms. ***Note*: *Only one parent can be recognized for benefit payment purposes.***

- The age of majority is determined by State law and is age 18 in most States. Contact your State government for more information.
- Provide a copy of the veteran's public record of birth or a copy of the court record of adoption if the veteran was adopted.
- Parental control is considered to have been given up if the parent has ceased to provide for the child and the normal parent/child relationship has been broken.

Veteran's Social Security No. ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION III: VETERAN'S PARENT(S) INFORMATION *(Continued)*

15A. PARENT'S NAME? (First, Middle, Last)	15B. PARENT'S ADDRESS (Street address, rural route, or P.O. box, Apt. No., City, State, ZIP Code and Country)	
15C. PARENT'S DATE OF BIRTH (MM,DD,YYYY) *(If deceased, complete Item 15D)*	15D. PARENT'S DATE OF DEATH (MM,DD,YYYY)	15E. PARENT'S SOCIAL SECURITY NUMBER
15F. PARENT'S TELEPHONE NUMBER(S) (Include Area Code) *Daytime:* _____ *Evening:* _____	15G. PARENT'S EMAIL ADDRESS (If applicable)	

16A. PARENT'S NAME? (First, Middle, Last)	16B. PARENT'S ADDRESS (Street address, rural route, or P.O. box, Apt. No., City, State, ZIP Code and Country)	
16C. PARENT'S DATE OF BIRTH (MM,DD,YYYY) *(If deceased, complete Item 16D)*	16D. PARENT'S DATE OF DEATH (MM,DD,YYYY)	16E. PARENT'S SOCIAL SECURITY NUMBER
16F. PARENT'S TELEPHONE NUMBER(S) (Include Area Code) *Daytime:* _____ *Evening:* _____	16G. PARENT'S EMAIL ADDRESS (If applicable)	

17A. WAS THE VETERAN A MEMBER OF YOUR HOUSEHOLD OR UNDER YOUR PARENTAL CONTROL AT ALL TIMES BEFORE HE/SHE REACHED THE AGE OF MAJORITY?

☐ YES ☐ NO *(If "NO," answer Items 17B through 17D)*

17B. DATE(S) OF PARENTAL CONTROL (MM,DD,YYYY)

From: _____ To: _____

From: _____ To: _____

17C. WHY WASN'T THE VETERAN A MEMBER OF YOUR HOUSEHOLD OR UNDER YOUR PARENTAL CONTROL AT ALL TIMES BEFORE HE/SHE REACHED THE AGE OF MAJORITY? *(Explain fully)*

17D. NAME AND ADDRESS OF EACH PERSON WHO ASSUMED PARENTAL CONTROL OVER THE VETERAN OUTSIDE THE DATE(S) SHOWN IN ITEM 17B.

SECTION IV: VETERAN'S PARENT(S) MARITAL HISTORY

18A. WHAT IS YOUR MARITAL STATUS? (Check one)

☐ MARRIED AND LIVE WITH OTHER PARENT OF VETERAN

☐ MARRIED AND LIVE WITH SPOUSE WHO IS NOT THE OTHER PARENT OF VETERAN

☐ SEPARATED, MARRIED BUT NOT LIVING WITH SPOUSE, IF CHECKED PROVIDE DATE OF SEPARATION: _____

What was the cause of the separation? Give the reason, date(s), and duration of the separation. If the separation was by court order, attach a copy of the order.

☐ DIVORCED, IF CHECKED PROVIDE DATE OF DIVORCE: _____

☐ WIDOWED, IF CHECKED PROVIDE DATE OF DEATH OF YOUR SPOUSE: _____

☐ NEVER MARRIED, IF CHECKED SKIP TO SECTION V

18B. WHAT IS YOUR SPOUSE'S NAME (First, Middle, Last)	18C. SPOUSE'S DATE OF BIRTH (MM,DD,YYYY)	18D. SPOUSE'S SOCIAL SECURITY NUMBER
18E. IS YOUR SPOUSE ALSO A VETERAN? ☐ YES ☐ NO *(If "Yes," answer Item 18F)*	18F. WHAT IS YOUR SPOUSE'S VA FILE NUMBER (If any)	

Veteran's Social Security No. ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION V: INFORMATION REGARDING PARENT'S NEED FOR NURSING HOME CARE OR AID AND ATTENDANCE

19. ARE YOU CLAIMING THE AID AND ATTENDANCE ALLOWANCE BECAUSE YOU NEED THE REGULAR ASSISTANCE OF ANOTHER PERSON OR HAVE SEVERE VISUAL PROBLEMS?

☐ YES ☐ NO *(If "No," skip to Section VI)*

NOTE: If you answered "Yes," to Item 19 and are not in a nursing home, submit a statement from your doctor showing the extent of your disabilities. If you are in a nursing home, attach a statement signed by an official of the nursing home showing the date you were admitted to the nursing home, the level of care you receive, and the amount you pay-out-of-pocket for your care.

20A. ARE YOU NOW IN A NURSING HOME?	20B. PROVIDE THE NAME AND COMPLETE MAILING ADDRESS OF THE NURSING HOME
☐ YES ☐ NO *(If "Yes," answer Item 20B also)*	

SECTION VI: INFORMATION REGARDING PARENT'S INCOME

IMPORTANT - Payments from any source will be counted, unless the law indicates that they don't need to be counted. Report **all** income in the boxes below, and VA will determine any amount that does not count.

21. HAVE YOU CLAIMED OR ARE YOU RECEIVING BENEFITS FROM THE SOCIAL SECURITY ADMINISTRATION?	22. HAVE YOU FILED A CLAIM FOR COMPENSATION FROM THE OFFICE OF WORKER'S COMPENSATION PROGRAMS BASED ON THE DEATH OF THE VETERAN?	23. HAS A COURT AWARDED DAMAGES BASED ON THE DEATH OF THE VETERAN OR IS A CLAIM OR LEGAL ACTION FOR DAMAGES PENDING?
☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

Report the total amounts before you take out deductions for taxes, insurance, etc.
Do not report the same income in both tables.
If you expect to receive a payment, but you don't know how much it will be, write "Unknown" in the space.
If you do not receive any payments from one of the sources that we list, write "0" or "None" in the space.
VA will interpret a blank space to mean "0" or "None".
If you are receiving monthly benefits, give us a copy of your most recent award letter. This will help us determine the amount of benefits you should be paid.

Monthly Income - Report The Income You And Your Spouse Receive Monthly

Note: If you are filing this application as the guardian or custodian of the veteran's parent, ***do not*** report your own income.

Sources of recurring monthly income	Parent	Spouse *(If living together)*
24a. Social Security	$	$
24b. U.S. Civil Service		
24c. U.S. Railroad Retirement		
24d. Military Retirement		
24e. Black Lung Benefits		
24f. Other income received monthly *(Please write source below)*		
24g. Other income received monthly *(Please write source below)*		

Annual Income By Calendar Year - Tell Us About Annual Income For You And Your Spouse

NOTE: Report income received from January 1 to the date of the veteran's death. If the claim is filed more than one year after the veteran died, report the income you received from January 1 to the date you sign this application.

Sources of recurring monthly income	Parent	Spouse *(If living together)*
25a. Gross wages and salary	$	$
25b. Total dividends and interest		
25c. Life insurance		
25d. Other income expected *(Please write source below)*		

SECTION VII: INFORMATION REGARDING MEDICAL, LAST ILLNESS AND BURIAL OR OTHER REIMBURSED EXPENSES

Family medical expenses and certain other expenses actually paid by you may be deductible from your income. Show the amount of any continuing family medical expenses such as the monthly Medicare deduction or nursing home fees you pay. Also, show unreimbursed last illness and burial expenses you paid. Last illness and burial expenses are unreimbursed amounts paid by you for the last illness and burial of the veteran or your spouse at any time prior to the end of the year following the year of death. Show medical, legal or other expenses you paid because of a claim for compensation for injury or death for which civilian disability or death benefits have been awarded. When determining your countable income, we may be able to deduct these expenses from the disability benefits for the year in which the expenses are paid. **Do not** include any expenses for which you were reimbursed. If you receive reimbursement after you have filed this claim, promptly advise the VA office handling your claim. If more space is needed,use Remarks, Item 34, or attach a separate sheet.

26a. Amount paid by you	26b. Date Paid (MM,DD,YYYY)	26c. Purpose (Medicare deduction, doctor's fees, burial expenses, etc.)	26d. Paid To (Name of Doctor, hospital, pharmacy, etc.)	26e. Relationship of person for whom expenses were paid

SECTION VIII: DIRECT DEPOSIT INFORMATION

The Department of Treasury requires all Federal 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 27, 28, and 29 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.

NOTE: You can either attach a voided check, or answer Items 27, 28 and 29.

27. ACCOUNT NUMBER *(Please check the appropriate box and provide that account number, if applicable)*

☐ Checking

☐ Savings

☐ I certify that I **do not** have an account with a financial institution or certified payment agent

Account number _____

28. NAME OF FINANCIAL INSTITUTION

29. ROUTING OR TRANSIT NUMBER

SECTION IX: 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 except protected health information, and I waive any privilege which makes the information confidential.

30a. SIGNATURE OF PARENT, FOSTER PARENT, GUARDIAN OR CUSTODIAN *(Sign in ink)*	30b. DATE SIGNED
31a. SIGNATURE OF PARENT, FOSTER PARENT, GUARDIAN OR CUSTODIAN *(Sign in ink)*	31b. DATE SIGNED

NOTE: If you sign with an "X,"then you must have two people you know witness you as you sign. They must then sign the form and print their names and addresses also.

32a. SIGNATURE OF WITNESS *(If claimant signed above using an "X") (Sign in ink)*	32b. PRINTED NAME AND ADDRESS OF WITNESS
33a. SIGNATURE OF WITNESS *(If claimant signed above using an "X") (Sign in ink)*	33b. PRINTED NAME AND ADDRESS OF WITNESS

SECTION X: REMARKS

34. 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)*

NOTE - Use this space for any additional statements that you would like to make concerning your application.

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.

Mail your form to:
Department of Veterans Affairs
Claims Intake Center
Attn: Milwaukee Pension Center
P.O. Box 5192
Janesville, WI 53547-5192
Or fax your form to:
Toll Free: (844) 655-1604

This Pension Center Serves The Following:			
Alabama	Arkansas	Illinois	Indiana
Kentucky	Louisiana	Michigan	Mississippi
Missouri	Ohio	Tennessee	Wisconsin

Mail your form to:
Department of Veterans Affairs
Claims Intake Center
Attn: Philadelphia Pension Center
P.O. Box 5206
Janesville, WI 53547-5206
Or fax your form to:
Toll Free: (844) 655-1604

This Pension Center Serves The Following:			
Connecticut	Delaware	Florida	Georgia
Maine	Maryland	Massachusetts	New Hampshire
New Jersey	New York	North Carolina	Pennsylvania
Rhode Island	South Carolina	Vermont	Virginia
West Virginia	District of Columbia	Puerto Rico	Canada
Countries outside of North, Central or South America			

Mail your form to:
Department of Veterans Affairs
Claims Intake Center
Attn: St. Paul Pension Center
P.O. Box 5365
Janesville, WI 53547-5365
Or fax your form to:
Toll Free: (844) 655-1604

This Pension Center Serves The Following:			
Alaska	Arizona	California	Colorado
Hawaii	Idaho	Iowa	Kansas
Minnesota	Montana	Nebraska	Nevada
New Mexico	North Dakota	Oklahoma	Oregon
South Dakota	Texas	Utah	Washington
Wyoming	Mexico	Central America	South America
Caribbean			

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB Control No. 0960-0062

APPLICATION FOR SURVIVORS BENEFITS
(PAYABLE UNDER TITLE II OF THE SOCIAL SECURITY ACT)

(DO NOT WRITE IN THIS SPACE)
VA DATE STAMP

IMPORTANT-- Read instructions before completing form. Detach and retain ONLY the instruction sheet

1. FIRST NAME - MIDDLE NAME - LAST NAME OF VETERAN *(Type or print)*	2. DATE OF DEATH

NOTE: If the veteran's Social Security No. is unknown, complete Items 4, 5, 6 and 7 about veteran.

3. SOCIAL SECURITY NO. OF VETERAN	4. DATE OF BIRTH	5. PLACE OF BIRTH

6. NAME OF PARENT	7. MAIDEN NAME OF PARENT	8. DID THE VETERAN WORK IN THE RAILROAD INDUSTRY AT ANY TIME AFTER 1936?
		☐ YES ☐ NO

NOTE: The following information should be furnished for each period of the veteran's active service (regular or reserves) after September 7, 1939, in the military service of the United States or service as a commissioned officer in the Public Health Service or the National Oceanic and Atmospheric Administration or during WWII, Philippine or Filipino or Allied country military service. If additional space is needed, attach a separate sheet.

9A. DATE ENTERED ACTIVE SERVICE	9B. SERVICE NO.	9C. DATE SEPARATED FROM ACTIVE SERVICE	9D. GRADE, RANK, OR RATING, ORGANIZATION AND BRANCH OF SERVICE

10. RELATIONSHIP OF APPLICANT TO VETERAN	11. DATE OF BIRTH OF APPLICANT	12. VA FILE NO.
☐ SURVIVING SPOUSE OR SURVIVING DIVORCED SPOUSE ☐ CHILD ☐ PARENT		

CHILDREN: Show names of surviving children (including natural children, adopted children and stepchildren) or dependent grandchildren (including stepgrandchildren) who at any time since the veteran died, were unmarried and (a) under age 18; (b) age 18 to 19 and attending secondary school; (c) disabled or handicapped (18 or over and disability began before age 22).

13A.	13B.
13C.	13D.

I know that anyone who makes or causes to be made a false statement or representation of a material fact in an application or for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law by fine, imprisonment, or both. I affirm that all information I have given in this document is true.

14. DATE *(Month, day, year)*	15. SIGNATURE OF APPLICANT *(First name, middle initial, last name) (Sign in ink)*
	SIGN HERE

16. MAILING ADDRESS OF APPLICANT *(No. and street or rural route, city or P.O., State and ZIP Code)*	17. TELEPHONE NO. *(Include Area Code)*

WITNESSES REQUIRED ONLY IF SIGNATURE OF APPLICANT IS MADE BY "X" MARK ABOVE

18A. SIGNATURE OF WITNESS *(Sign in ink)*	18B. ADDRESS OF WITNESS *(No. and street, city, State and ZIP Code)*
19A. SIGNATURE OF WITNESS *(Sign in ink)*	19B. ADDRESS OF WITNESS *(No. and street, city, State and ZIP Code)*

ITEMS BELOW TO BE COMPLETED BY THE DEPARTMENT OF VETERANS AFFAIRS Use reverse for "Remarks"

20. PROOFS RECEIVED

☐ DEATH ☐ MARRIAGE

☐ AGE _____ *(NAME)*

☐ OTHER *(Specify)* _____ *(NAME)*

_____ *(NAME)*

21. PROOFS REQUESTED FROM CLAIMANT OR OTHER *(Specify)*

☐ DEATH ☐ MARRIAGE

☐ AGE _____ *(NAME)*

☐ OTHER *(Specify)* _____ *(NAME)*

_____ *(NAME)*

22. DATE	23. NAME AND ADDRESS OF TRANSMITTING VA OFFICE

IMPORTANT: PLEASE READ THE FOLLOWING BEFORE YOU COMPLETE THE SSA-24.
INSTRUCTIONS FOR COMPLETING FORM SSA-24, APPLICATION FOR SURVIVORS BENEFITS
(Payable Under Title II of the Social Security Act)

This application form, SSA-24, is an Application for Survivors Benefits Payable under Title II of the Social Security Act, as amended. Under authority of section 202(o) of the Social Security Act, the application requests information in order to determine eligibility to social security benefits.
You do not have to complete this application; there are no penalties under the law if you do not complete part or all of the SSA-24. However, it is usually to your advantage to provide the information because not providing it could prevent and accurate and timely decision on your claim or could result in the loss of some benefits or insurance coverage.

If you **do** wish to supply the information requested on the SSA-24, this information will be forwarded to the Social Security Administration and used by them to determine whether social security benefits may be payable to surviving dependent(s) of the veteran. Social Security will then contact you regarding any social security benefits payable based on information given on this form.

If you should have any question about entitlement to social security benefits or the information you have provided on this form, please contact your local social security office.
Complete each item of the attached application, Form SSA-24, (except Items 20 through 23). When signed and dated the form SHOULD BE LEFT ATTACHED to your completed

- **VA FORM 21-534, Application for Dependency and Indemnity Compensation, Death Pension and Accrued Benefits by a Surviving Spouse or Child (Including Death Compensation if Applicable) or**
- **VA FORM 21-535, Application for Dependency and Indemnity Compensation by Parent(s) (Including Accrued Benefits and Death Compensation When Applicable).**

Privacy Act Statement
Collection and Use of Personal Information

Section 202(o) of the Social Security Act, as amended, authorizes us to collect this information. We will use the information you provide to determine whether social security benefits may be payable to survivors of a veteran.

The information you furnish on this form is voluntary. However, failure to provide the requested information could prevent an accurate and timely decision on your claim or could result in the loss of some benefits or insurance coverage.

We generally use the information you supply to determine whether social security benefits may be payable to survivors of a veteran. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;

2. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veterans' Affairs);

3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and

4. To facilitate statistical research, audit or investigative activities necessary to assure the integrity of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Additional information about this form, and any other information regarding our systems and programs, is available on-line at www.socialsecurity.gov or at your local Social Security office.

PAPERWORK REDUCTION ACT: This information collection meets the clearance requirements of 44 U.S.C. §3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 15 minutes to read the instructions, gather the necessary facts, and answer the questions. ***Send only comments relating to our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.***