OMB Control No. 2900-0001
Respondent Burden: 15 minutes
Expiration Date: X/XX/XXXX

Department of Veterans Affairs

VA DATE STAMP
DO NOT WRITE IN THIS SPACE

VETERAN'S SUPPLEMENTAL CLAIM FOR COMPENSATION

INSTRUCTIONS: Please read the Privacy Act Notice and Respondent Burden information on Page 2 before completing this form. If you have any questions about this form, call VA toll-free at 1-800-827-1000 (Hearing Impaired TDD federal relay number is 711). Also, see mail/fax information and information about completing the form online on Page 2.

NOTE: You can *either* complete the form online or by hand. If completed by hand, print the information requested in ink, neatly, and legibly to expedite processing of the form.

SECTION I - VETERAN'S IDENTIFICATION INFORMATION

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

2. VETERAN'S SOCIAL SECURITY NUMBER – –

3. VA FILE NUMBER

4. DATE OF BIRTH *(MM/DD/YYYY)*
Month – Day – Year

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

6. MAILING ADDRESS (*Number and street or rural route, P. O. Box, City, State, ZIP Code and Country*)

No. & Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code –

7. TELEPHONE NUMBER *(Include Area Code)*

8. EMAIL ADDRESS *(Optional)*

SECTION II: CLAIM INFORMATION

9A. LIST THE CURRENT DISABILITY(IES) OR SYMPTOMS THAT YOU CLAIM ARE RELATED TO YOUR MILITARY SERVICE AND/OR SERVICE-CONNECTED DISABILITY *(If applicable, identify whether a disability is due to a service-connected disability; confinement as a prisoner of war; exposure to Agent Orange, asbestos, mustard gas, ionizing radiation, or Gulf War environmental hazards; or a disability for which compensation is payable under 38 U.S.C. 1151)*

NOTE: List your claimed conditions below. **See the following three examples for guidance on how to complete Section II**.

EXAMPLES OF DISABILITY(IES)	EXAMPLES OF EXPOSURE TYPE	EXAMPLES OF HOW THE DISABILITY(IES) RELATE TO SERVICE	EXAMPLES OF DATES
Example 1. HEARING LOSS	NOISE	HEAVY EQUIPMENT OPERATOR IN SERVICE	JULY 1968
Example 2. DIABETES	AGENT ORANGE	SERVICE IN VIETNAM WAR	DECEMBER 1972
Example 3. LEFT KNEE, SECONDARY TO RIGHT KNEE		INJURED LEFT KNEE WHEN BRACE ON RIGHT KNEE FAILED	6/11/2008

	CURRENT DISABILITY(IES)	IF DUE TO EXPOSURE, EVENT, OR INJURY, PLEASE SPECIFY (e.g., Agent Orange, radiation)	EXPLAIN HOW THE DISABILITY(IES) RELATES TO THE IN-SERVICE EVENT/EXPOSURE/INJURY	APPROXIMATE DATE DISABILITY(IES) BEGAN OR WORSENED
1.				
2.				
3.				
4.				
5.				
6.				

VETERAN'S SOCIAL SECURITY NO. ___ – ___ – ____

SECTION II: CLAIM INFORMATION *(Continued)*

CURRENT DISABILITY(IES)	IF DUE TO EXPOSURE, EVENT, OR INJURY, PLEASE SPECIFY (e.g., Agent Orange, radiation)	EXPLAIN HOW THE DISABILITY(IES) RELATES TO THE IN-SERVICE EVENT/EXPOSURE/INJURY	APPROXIMATE DATE DISABILITY(IES) BEGAN OR WORSENED
7.			
8.			
9.			
10.			

9B. LIST VA MEDICAL CENTER(S) (VAMC) AND DEPARTMENT OF DEFENSE (DOD) MILITARY TREATMENT FACILITIES (MTF) WHERE YOU RECEIVED TREATMENT AFTER DISCHARGE FOR YOUR CLAIMED DISABILITY(IES) AND PROVIDE TREATMENT DATES:

A. NAME AND LOCATION	B. DATE(S) OF TREATMENT	

9C. DO YOU HAVE PRIVATE TREATMENT RECORDS?

☐ YES ☐ NO *(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.)*

10. I WOULD LIKE TO FILE A CLAIM FOR OTHER VA BENEFITS *(Check appropriate box)*

☐ AID AND ATTENDANCE ☐ OTHER *(Specify benefit)* _____

☐ AUTOMOBILE ALLOWANCE

11A. IF YOU WOULD LIKE TO FILE A CLAIM FOR ADDITIONAL BENEFITS BECAUSE YOUR SPOUSE IS SERIOUSLY DISABLED *(Please check the box and provide your spouse's name and social security number in Items 12B & 12C)* ☐

11B. SPOUSE'S SOCIAL SECURITY NUMBER ___ – ___ – ____

11C. SPOUSE'S NAME (*First, Middle Initial, Last*)

SECTION III - CERTIFICATION AND SIGNATURE

I CERTIFY THAT the statements in this document are true and correct to the best of my knowledge and belief.

12A. VETERAN'S SIGNATURE *(Do NOT print) (Sign in ink)*	12B. DATE SIGNED (*MM/DD/YYYY*)

MAIL TO:	FAX TO:	ONLINE:
Department of Veterans Affairs Evidence Intake Center PO Box 4444 Janesville, WI 53547-4444	**844-531-7818 (Toll Free) *OR* For Foreign Claims 248-524-4260**	**www.ebenefits.gov**

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 determine your eligibility for compensation. 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.

PENALTY: The law provides severe penalties which include a fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false.