



REPORT OF DEFENSE FINANCE & ACCOUNTING SERVICE (DFAS)

NOTE - This form must be filled out in ink or on a typewriter or computer, as it becomes a permanent record in the veteran's folder.	1. VA OFFICE	2. IDENTIFICATION NUMBERS (C, XC, SS, XSS, V, K, etc.)
3. LAST NAME - FIRST NAME - MIDDLE NAME OF VETERAN (<i>Type or print</i>)		4. DATE OF CONTACT (<i>Month, day, year</i>)
5. ADDRESS OF VETERAN (<i>Include number and street or rural route, city or P.O., State and ZIP Code</i>)		6A. TELEPHONE NUMBER OF VETERAN (<i>Include Area Code</i>)
		DAY EVENING
		6B. E-MAIL ADDRESS (<i>If applicable</i>)
7. NAME OF PERSON CONTACTED		8. TYPE OF CONTACT <input type="checkbox"/> PERSONAL <input type="checkbox"/> TELEPHONE
9. ADDRESS OF PERSON CONTACTED		10. TELEPHONE NUMBER OF PERSON CONTACTED (<i>Include Area Code</i>)

11. BRIEF STATEMENT OF INFORMATION REQUESTED AND GIVEN (*If needed, continue on a separate sheet*)

The following is information received from DFAS regarding the above-named veteran's military retired pay or survivor's SBP and will be used to offset any compensation award as provided by 38 CFR 3.750 and M21-1MR, Part III, Subpart V, Chapter 5 or DIC as provided by 10 U.S.C. § 1450 (c) (1) and M21-1, Part IV, Subpart iii, Chapter 3, Section F.

The veteran's record was properly identified by confirming the following information (*check all that apply*)

- | | | |
|---|--|------------------------------------|
| <input type="checkbox"/> FULL NAME | <input type="checkbox"/> DATE OF DEATH | <input type="checkbox"/> PAY GRADE |
| <input type="checkbox"/> SOCIAL SECURITY NUMBER | <input type="checkbox"/> BRANCH OF SERVICE | |
| <input type="checkbox"/> DATE OF BIRTH | <input type="checkbox"/> DATES OF SERVICE | |

12. SUMMARY OF INFORMATION RECEIVED:

In receipt? YES NO PERMANENT TDRL SBP

13. RETIRED PAY/SBP/SEPARATION OR SEVERANCE PAY

A. Verified retired pay amount(s): DATE _____ GROSS PAY _____ DATE _____ GROSS PAY _____ DATE _____ GROSS PAY _____ DATE _____ GROSS PAY _____ DATE _____ GROSS PAY _____	B. Verified SBP: DATE _____ AMOUNT _____ SBP OVERPAYMENT _____ NAME OF SBP RECIPIENT _____ SSN OF SBP RECIPIENT _____	C. Verified Separation/Severance Pay <input type="checkbox"/> SEPARATION <input type="checkbox"/> SEVERANCE DATE _____ GROSS _____ NET _____
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A copy of this form was sent to Power of Attorney of record (*If applicable*)

cc:

DIVISION OR SECTION	EXECUTED BY (<i>Signature and title</i>)
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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 1.576 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. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN: We need this information to obtain evidence in support of your claim for benefits (38 U.S.C. 501(a) and (b)). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 5 minutes to respond to the questions on this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is 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 the information on where to send comments or suggestions about this form.