



REPORT OF FIRST NOTICE OF DEATH

NOTE - This form must be filled out in ink or on a computer as it becomes a permanent record in the veteran's folder.	1. VA OFFICE	2. IDENTIFICATION NUMBERS (<i>C, XC, SS, XSS, V, K, etc.</i>)
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>)
		<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;">DAY</td> <td style="width: 50%; border: none;">EVENING</td> </tr> </table>
DAY	EVENING	
7. NAME OF PERSON CONTACTED		8. TYPE OF CONTACT (<i>If applicable</i>)
9. ADDRESS OF PERSON CONTACTED		10. TELEPHONE NUMBER OF PERSON CONTACTED (<i>Include Area Code</i>)

I certify that I properly identified my caller using the ID Protocol

11. FNOD INFORMATION

A. NAME OF DECEASED (<i>First, middle, last</i>)	B. DATE OF BIRTH OF DECEASED (<i>MM/DD/YYYY</i>)
C. CALLER'S RELATIONSHIP TO DECEASED	
<input type="checkbox"/> SURVIVING SPOUSE <input type="checkbox"/> SURVIVING CHILD <input type="checkbox"/> OTHER (<i>Explain</i>)	
D. DATE OF DEATH (<i>Month, Day, Year</i>)	E. STATE WHERE DEATH OCCURRED
F. IF THE DECEASED IS THE VETERAN, DID HE/SHE DIE AT OR EN ROUTE TO A VA OR CONTRACTED MEDICAL FACILITY/NURSING HOME?	
<input type="checkbox"/> YES <input type="checkbox"/> NO (<i>If, "Yes," provide the name, city and state:</i>) _____	
G. NAME OF VETERAN'S SURVIVING DEPENDENT(S) (<i>If any</i>)	H. SURVIVING DEPENDENT(S) ADDRESS & PHONE NUMBER (<i>If needed</i>)

12. DEATH OF VETERAN - FNOD ACTION

- I CERTIFY THAT I ADVISED THE CALLER THE BENEFITS WILL BE STOPPED THE FIRST OF THE MONTH OF DEATH (*If applicable*)
- I CERTIFY I LOOKED UP VETERAN'S RECORD (*BINQ, VID, M11, or corporate equivalents*)
- I CERTIFY I ANSWERED QUESTIONS CONCERNING POSSIBLE BENEFIT ENTITLEMENTS REFERRING TO "DEATH RELATED INFORMATION CHECKLIST" WORK AID
- I CERTIFY I PROCESSED THE VETERAN'S FNOD IN THE SYSTEM OF RECORDS
 - YES (*If, "No," explain:*) _____
- I CERTIFY I SENT THE FOLLOWING:
 - PMC NOK LETTER 21P-530 21P-534 40-1330 and/or OTHER (*Please specify*) _____

13. DEATH OF A NON-VETERAN BENEFICIARY - FOR STOP PAYMENT ACTION

Claims file location in BIRLS:

- I CERTIFY I ADVISED THE CALLER THE BENEFITS WILL BE STOPPED THE FIRST OF THE MONTH OF DEATH AND THAT ANY PAYMENT ISSUED FOLLOWING THAT DATE MUST BE RETURNED
- I CERTIFY I ADVISED THE CALLER OF POSSIBLE BURIAL OF SPOUSE/CHILD IN A NATIONAL CEMETERY
- I CERTIFY THAT I WILL ROUTE THIS REPORT OF DEATH TO THE REGIONAL OFFICE OF JURISDICTION OR PMC VIA APPROVED METHOD FOR STOP PAYMENT PROCESSING

14. FOR ALL CALLS

I certify that I read the following statement to the caller:

"I am a VA employee who is authorized to receive or request evidentiary information or statements that may result in a change in your VA benefits. The primary purpose for gathering this information or statement is to make an eligibility determination. It is subject to verification through computer matching programs with other agencies."

cc: POA (*If applicable*)

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, 58VA/21/22/28 Compensation, Pension, Education and Veteran Readiness 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: An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control Number. The OMB control number for this project is 2900-0734, and it expires XX/XX/20XX. Public reporting burden for this collection of information is estimated to average 5 minutes per respondent, per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate and any other aspect of this collection of information, including suggestions for reducing the burden to VA Reports Clearance Officer at VACOPaperworkReduAct@VA.gov. Please refer to OMB Control No. 2900-0734 in any correspondence. Do not send your completed VA Form 27-0820a to this email address.