U.S. Department of Veterans Affairs

INFORMATION ON FILING A CLAIM FOR DISABILITY COMPENSATION BENEFITS

When to Use This Form:

Use this form, **VA Form 21-526EZ**, *Application for Disability Compensation Benefits,* to submit a **new, original, or increased** claim for VA compensation. You may also complete and submit the form online at: **https://www.va.gov/disability/file-disability-claim-form-21-526ez/introduction**.

Note: If you disagree with a prior decision, **do not use this form.** Review the decision notice for available options. For additional information, visit **https://www.va.gov/decision-reviews/**.

Where to Send Your Application:

You may send your application and any evidence in support of your claim by using the following methods shown in the table below.

MAIL TO	SUBMIT ONLINE
Department of Veterans Affairs **Evidence Intake Center** **PO Box 4444** **Janesville, WI 53547-4444**	**VA.gov: www.va.gov**

Common Benefit Forms:

If claiming...	Submit a completed...
Individual Unemployability…	**VA Form 21-8940**, *Veteran's Application for Increased Compensation Based on Unemployability*, and **VA Form 21-4192**, *Request for Employment Information in Connection with Claim for Disability Benefits*.
any mental health condition(s) based on a traumatic event(s)…	**VA Form 21-0781**, *Statement in Support of Claimed Mental Health Disorder(s) Due to an In-Service Traumatic Event(s),* (recommended, not required).
Specially Adapted Housing or Special Home Adaptation…	**VA Form 26-4555**, *Application in Acquiring Specially Adapted Housing or Special Home Adaptation Grant*.
Auto Allowance…	**VA Form 21-4502**, *Application for Automobile or Other Conveyance and Adaptive Equipment*.
Aid and Attendance for you or your spouse…	**VA Form 21-2680**, *Examination for Housebound Status or Permanent Need for Regular Aid and Attendance;* or if claiming Aid and Attendance based on nursing home status, a **VA Form 21-0779**, *Request for Nursing Home Information in Connection with Claim for Aid and Attendance*.
dependents…	**VA Form 21-686c**, *Application Request to Add and/or Remove Dependents*. If claiming a child in school between the ages of 18 and 23; also submit a completed **VA Form 21-674**, *Request for Approval of School Attendance*. If claiming dependency for parents, submit a completed **VA Form 21-509**, *Statement of Dependency of Parent(s).*
veterans non-service-connected pension benefits…	**VA Form 21P-527EZ,** *Application for Veterans Pension*.
survivor benefits…	**VA Form 21P-534EZ,** *Application for D.I.C., Survivors Pension, and/or Accrued Benefits*.
Note: All the forms listed above in this table and more are available at **https://www.va.gov/forms/.**	

General Information:

For information on **how to file a claim**, and **where to send** your information or evidence, visit **https://www.va.gov/disability/how-to-file-claim/** or call 1-800-698-2411 (TTY:711).

You may contact an accredited representative (attorney, claims agent, or Veterans Service Organization (VSO) representative) to assist you in completing this form. If you have not already appointed a representative or if you want to change your representative, a searchable database of VA accredited VSOs, attorneys, and claims agents is available at **https://www.va.gov/get-help-from-accredited-representative/find-rep/**. You may also contact your State Department(s) of Veterans Affairs at **www.va.gov/statedva**.

Regarding Fees for Claims: Generally, a VA-accredited attorney or agent may charge you a fee for assisting in seeking further review of a claim for VA benefits only after VA has issued an initial decision and the attorney or agent has complied with the applicable power-of-attorney and fee agreement requirements. Section 5904, Title 38, United States Code (U.S.C.) (codified in 14.636, Title 38, Code of Federal Regulations (C.F.R.)) contains provisions regarding fees that may be charged, allowed, or paid for services provided by a VA-accredited attorney or agent in connection with a proceeding before VA with respect to a claim for benefits under laws administered by the Department. Generally, an accredited attorney or claims agent can **ONLY** charge claimants a fee after VA has issued a decision.

For information on **VHA health care services**, visit **www.va.gov/health-care/about-va-health-benefits**. To learn more about VHA health care services **related to military sexual trauma (MST)**, you can contact a VHA MST Coordinator. A list is available at www.mentalhealth.va.gov/msthome/vha-mst-coordinators.asp or you can contact your local VA medical facility and ask to speak to the MST Coordinator.

You are entitled to a hearing at any time in the claims process. If you wish to have a hearing, you can contact us in writing, online through **AccessVA** (**https://eauth.va.gov/accessva/**), or call us toll-free at 1-800-698-2411 (TTY:711).

OMB Control No. 2900-0747
Respondent Burden: 15 minutes
Expiration Date: X/XX/20XX

VA | U.S. Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

APPLICATION FOR DISABILITY COMPENSATION BENEFITS

IMPORTANT: Please read the Privacy Act and Respondent Burden on page 4 before completing the form. Use this form to apply for VA compensation benefits. For more information, you can contact us online through Ask VA: **https://ask.va.gov/**. Ask us a question online or call us toll-free at 1-800-698-2411 (TTY:711).

SECTION I: VETERAN/SERVICE MEMBER'S IDENTIFICATION INFORMATION

1. VETERAN/SERVICE MEMBER'S NAME (First, Middle Initial, Last)

Note: You only need to complete **ONE** of the following, either 2A, 2B, or 2C.

2A. SOCIAL SECURITY NUMBER (SSN) ☐☐☐ – ☐☐ – ☐☐☐☐

2B. ELECTRONIC DATA INTERCHANGE PERSONAL IDENTIFIER (EDIPI)

2C. INTEGRATION CONTROL NUMBER (ICN)

3. DATE OF BIRTH (MM/DD/YYYY) ☐☐ – ☐☐ – ☐☐☐☐

4. **BDD CLAIMS ONLY:** PROVIDE THE ANTICIPATED DATE OF RELEASE FROM ACTIVE DUTY (MM/DD/YYYY) ☐☐ – ☐☐ – ☐☐☐☐

5. CURRENT MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code, and Country) (**Note**: If your address changes or is set to change in the future, complete and submit VA Form 20-572, *Request for Change of Address/Cancellation of Direct Deposit*, to inform VA as soon as possible.)

☐ I AM EXPERIENCING HOMELESSNESS OR AT RISK OF HOMELESSNESS (If checked, complete VA Form 20-10207, *Priority Processing Request*, and submit with this form. VA forms are available at **https://www.va.gov/forms/**.)

6A. TELEPHONE NUMBER (Include Area Code)

6B. EMAIL ADDRESS

SECTION II: CLAIM INFORMATION

7. FOR EACH **CONDITION(S)** IDENTIFY THE **CLAIM TYPE** AND PROVIDE AN **EXPLANATION** AND THE APPROXIMATE **DATE**
(If you need additional space, use SECTION XI: CLAIM INFORMATION (ADDENDUM))

CONDITION(S): What issue(s) or disability(ies) are you claiming? (**Note**: List **one** per line)	**CLAIM TYPE:** **NEW:** I've never claimed this issue before. **INCREASE:** I'm already service-connected for this issue but I'm seeking a higher rating because it has worsened.	**EXPLANATION:** - The specific event, injury, other service-related disability, or exposure that caused the condition, and - The specific date(s) and location(s) the event, injury or potential exposure occurred.	**DATE:** Provide the approximate date (MM/YYYY) the condition(s) started or worsened
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SECTION III: 5103 NOTICE OF ACKNOWLEDGMENT

8. **IMPORTANT**: For specific evidence you need to provide with your claim, visit **https://www.va.gov/disability/how-to-file-claim/evidence-needed/**.

☐ **I CERTIFY THAT** I HAVE REVIEWED THE NOTICE OF EVIDENCE THAT RELATES TO MY CLAIM

☐ **I HAVE NOT** REVIEWED THE NOTICE (**Note**: If you check this box, VA will send you the 5103 notice through the mail. This will delay the decision on your claim.)

SECTION IV: EVIDENCE

IMPORTANT: You may submit evidence to VA or tell us about any evidence that VA can assist you with gathering in support of your claim. If you have records in your possession, attach the records to this form, and list your name and SSN on each page. If you know of evidence not in your possession and want VA to try to get it for you, complete and sign **VA Form 21-4142,** *Authorization to Disclose Information to the Department of Veterans Affairs (VA)*, and **VA Form 21-4142a**, *General Release for Medical Provider Information to the Department of Veterans Affairs (VA)*, identifying any private medical records you wish VA to request for you. **Note**: VA has access to VA Medical Centers (VAMC), Community-Based Outpatient Clinics (CBOC), and Military Treatment Facility(ies) (MTF) records. A consent form is not needed.

9. IDENTIFY WHERE YOU HAVE RECEIVED TREATMENT (Check **all** that apply)

☐ PRIVATE HEALTHCARE PROVIDER ☐ VET CENTER(S) ☐ COMMUNITY CARE (Paid for by VA) ☐ VAMC AND CBOC

☐ DEPARTMENT OF DEFENSE (DOD) MTF ☐ OTHER (Specify):

A. ENTER THE NAME AND LOCATION OF THE TREATMENT FACILITY AND CONDITION TREATED	B. APPROXIMATE DATE(S) OF TREATMENT (MM/YYYY)	C. CHECK THE BOX IF YOU DO NOT HAVE DATE(S) OF TREATMENT
	☐☐ / ☐☐☐☐	☐ Don't have date
	☐☐ / ☐☐☐☐	☐ Don't have date
	☐☐ / ☐☐☐☐	☐ Don't have date
	☐☐ / ☐☐☐☐	☐ Don't have date

SECTION V: SERVICE INFORMATION

10A. BRANCH OF SERVICE (Check **ALL** that apply)

☐ ARMY ☐ NAVY ☐ MARINE CORPS
☐ AIR FORCE ☐ COAST GUARD ☐ SPACE FORCE
☐ NOAA ☐ USPHS

10B. COMPONENT (Check **ALL** that apply)

☐ ACTIVE ☐ RESERVES ☐ NATIONAL GUARD

11A. MOST RECENT ACTIVE SERVICE DATES

	Month	Day	Year
ENTRY DATE:	☐☐ –	☐☐ –	☐☐☐☐
EXIT DATE:	☐☐ –	☐☐ –	☐☐☐☐

11B. ARE YOU OR WILL YOU BE RECEIVING SERVICE PAY? (i.e., retired, inactive, or active training pay)

☐ YES (If "Yes," complete Section VI)
☐ NO

12A. **RESERVES OR NATIONAL GUARD**: ARE YOU CURRENTLY SERVING, HAVE YOU EVER SERVED, OR ARE YOU ACTIVATED

☐ YES (If "Yes," complete Items 12B and 12C) ☐ NO (If "No," skip to Item 13, if applicable)

☐ CURRENTLY ACTIVATED (If checked, include your anticipated separation date (MM/DD/YYYY) ☐☐ – ☐☐ – ☐☐☐☐

12B. **RESERVES OR NATIONAL GUARD** COMPONENT

☐ RESERVES ☐ NATIONAL GUARD

12C. OBLIGATION TERM OF SERVICE FOR **RESERVES OR NATIONAL GUARD**

	Month	Day	Year
FROM:	☐☐ –	☐☐ –	☐☐☐☐
TO:	☐☐ –	☐☐ –	☐☐☐☐

13. HAVE YOU EVER BEEN A PRISONER OF WAR? (Check **ALL** that apply, otherwise skip to Section VI)

☐ YES (If "Yes," input dates and select era/campaign)(MM/DD/YYYY): FROM: ☐☐ – ☐☐ – ☐☐☐☐ TO: ☐☐ – ☐☐ – ☐☐☐☐

ERA/CAMPAIGN: ☐ WWII ☐ KOREA ☐ VIETNAM ☐ GULF WAR IRAQ ☐ OIF ☐ OEF

SECTION VI: SERVICE PAY

IMPORTANT INFORMATION ON MILITARY RETIRED PAY (Includes all Uniformed Services Retired Pay)

Submission of this application constitutes a waiver of military retired pay in an amount equal to VA compensation awarded, if you are entitled to both benefits. Your retired pay may be reduced by the amount of VA compensation awarded. Receipt of the full amount of military retired pay and VA compensation at the same time may result in an overpayment, which may be subject to collection. In addition, the gross amount of any lump sum retirement payments made under the Blended Retirement System (BRS) must be recouped from VA compensation. If you qualify for full concurrent receipt of VA compensation and military retired pay, the waiver of retired pay or recoupment of any lump sum retirement payments will not apply.

If you check Item 14, you will not receive VA compensation if granted. If you currently receive VA compensation and you check Item 14, your VA compensation will be terminated if you are also eligible for military retired pay. Note: VA compensation is non-taxable. Therefore, VA compensation may be the greater benefit.

☐ **14. I CHOOSE NOT TO RECEIVE VA COMPENSATION IF I CANNOT RECEIVE BOTH RETIRED PAY AND VA COMPENSATION. I DO NOT WANT TO RECEIVE VA COMPENSATION INSTEAD OF MY RETIRED PAY.**

IMPORTANT INFORMATION ON ACTIVE OR INACTIVE DUTY TRAINING PAY

By law, inactive duty or annual active duty training pay cannot be paid at the same time you are receiving VA compensation or pension payments. Inactive duty training pay may include, but is not limited to, drills, schooling, conferences, preparation for inspections, additional flight training, muster duty, or funeral honors duty. Annual active duty training is typically performed 15 days each year by reservists and members of the National Guard. You may decide to keep the training pay you received from your military branch. However, to keep your training pay, you must waive your VA benefits for the same number of days as the number of days you received pay for inactive duty or annual active duty training. Usually, it is to your advantage to waive benefits and keep your training pay.

If you waive VA payments to receive training pay by checking Item 15, VA will adjust your payments by withholding payment equal ONLY to the number of TOTAL training days waived and at the monthly rate in effect for the fiscal year period for which you received training pay. This action may result in an overpayment of VA compensation, which may be subject to collection. In addition, an election to waive VA payments will result in automatic adjustments of any future training pay. Note: VA compensation is non-taxable. However, in most instances, training pay is the greater benefit.

☐ **15. I CHOOSE TO KEEP THE MILITARY TRAINING PAY I RECEIVED. VA WILL WITHHOLD COMPENSATION FOR ONLY THE NUMBER OF DAYS I RECEIVED TRAINING PAY. I WILL CONTINUE TO RECEIVE VA COMPENSATION FOR ALL DAYS THAT I DO NOT RECEIVE TRAINING PAY.**

SECTION VII: DIRECT DEPOSIT
(Note: If you have already signed up for direct deposit, skip to Section VIII)

IMPORTANT: The Department of the Treasury **requires** all Federal benefit payments to be made by electronic funds transfer (EFT), also called **direct deposit**. To enroll in direct deposit, provide the information requested below, or visit **https://www.va.gov/change-direct-deposit/** to enroll or change your direct deposit account information online. If you do not have a bank account, visit **https://www.benefits.va.gov/benefits/banking.asp**. If you elect not to enroll, you must contact the Department of Treasury at 1-888-224-2950.

☐ 16. I CERTIFY THAT I DO NOT HAVE AN ACCOUNT WITH A FINANCIAL INSTITUTION OR CERTIFIED PAYMENT AGENT. (If you check this box skip to Section VIII)

17. ACCOUNT NUMBER (Check only **one** box below and provide the account number)

Account No.: | | | | | | | | | | | | | | | | ☐ CHECKING ☐ SAVINGS

18. NAME OF FINANCIAL INSTITUTION (Provide the name of the bank where you want your direct deposit)

19. ROUTING OR TRANSIT NUMBER (The first nine numbers located at the bottom left of your check)

| | | | | | | | | |

SECTION VIII: CLAIM CERTIFICATION AND SIGNATURE

VETERAN/SERVICE MEMBER 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. For the limited purpose of providing VA with this information as it may relate to my claim, I waive any privilege that may apply and would otherwise make the information confidential and not disclosable.

I CERTIFY THAT I have enclosed all the information or evidence that will support my claim, including an identification of relevant records available at a Federal facility such as a VA medical center; **OR,** I have no information or evidence to give VA to support my claim.

20A. VETERAN/SERVICE MEMBER SIGNATURE (**REQUIRED**)

20B. DATE SIGNED (MM/DD/YYYY)

| | | – | | | – | | | | |

SECTION IX: WITNESSES TO SIGNATURE

21A. SIGNATURE OF WITNESS 1 (**Note**: Only sign if veteran signed in Item 20A using an "X")

21B. PRINTED NAME

21C. ADDRESS OF WITNESS

22A. SIGNATURE OF WITNESS 2 (**Note**: Only sign if veteran signed in Item 20A using an "X")

22B. PRINTED NAME

22C. ADDRESS OF WITNESS

SECTION X: AUTHORIZED REPRESENTATIVE/ALTERNATE SIGNER'S CERTIFICATION AND SIGNATURE
(Note: Required only if Item 20A is blank. A first claim cannot be signed by anyone other than the veteran/Service member)

I CERTIFY THAT the claimant has authorized the undersigned representative to file this claim on behalf of the claimant and that the claimant is aware and accepts the information provided in this document. I certify that the claimant has authorized the undersigned representative to state that the claimant certifies the truth and completion of the information contained in this document to the best of claimant's knowledge.

Note: If you are signing on behalf of the Veteran/Service member as an alternate signer or an authorized representative, VA **will not** accept your signature unless a valid VA Form 21-0972, *Alternate Signer Certification*, 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,* is of record or attached with this form.

23A. AUTHORIZED REPRESENTATIVE/ALTERNATE SIGNER'S SIGNATURE (**REQUIRED**)

23B. DATE SIGNED (MM/DD/YYYY)

| | | – | | | – | | | | |

23C. ACCREDITATION NUMBER

23D. POA CODE

| | | |

23E. DATE LAST VA FORMS 21-22 OR 21-22A WAS SUBMITTED (If known)

| | | – | | | – | | | | |

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 to which you are not entitled.

PRIVACY ACT NOTICE: The form will be used to determine allowance to VA compensation benefits (38 U.S.C. 5101). The responses you submit are considered confidential (38 U.S.C. 5701). VA may disclose the information that you provide, including Social Security numbers, outside VA if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Veterans Readiness and Employment Records - VA, published in the Federal Register. The requested information is considered relevant and necessary to determine maximum benefits under the law. Information submitted is subject to verification through computer matching programs with other agencies. VA may make a "routine use" disclosure for: 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. Your obligation to respond is required to obtain or retain benefits. 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. Social Security information: You are required to provide the Social Security number requested under 38 U.S.C. 5101(c)(1). VA may disclose Social Security numbers as authorized under the Privacy Act and specifically may disclose them for purposes stated above.

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 2900-0747, and it expires X/XX/XXXX Public reporting burden for this collection of information is estimated to average 15 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 **VAPRA@va.gov**. Please refer to OMB Control No. 2900-0747 in any correspondence. Do not send your completed VA Form 21-526EZ to this email address.

SECTION XI: CLAIM INFORMATION (ADDENDUM)

(Submit this page with the completed application if you have additional disabilities to add to your claim. If more space is needed, make additional copies of this page to submit with your application.)

FOR EACH **CONDITION(S)** IDENTIFY THE **CLAIM TYPE** AND PROVIDE AN **EXPLANATION** AND THE APPROXIMATE **DATE**

CONDITION(S): What issue(s) or disability(ies) are you claiming? (**Note**: List **one** per line)	**CLAIM TYPE:** **NEW**: I've never claimed this issue before. **INCREASE**: I'm already service-connected for this issue but I'm seeking a higher rating because it has worsened.	**EXPLANATION:** - The specific event, injury, other service-related disability, or exposure that caused the condition, and - The specific date(s) and location(s) the event, injury or potential exposure occurred.	**DATE:** Provide the approximate date (MM/YYYY) the condition(s) started or worsened
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