OMB Approved No. 2900-0404
Respondent Burden: 45 minutes
Expiration Date:10/31/2020

Department of Veterans Affairs

(DO NOT WRITE IN THIS SPACE)
(VA DATE STAMP)

VETERAN'S APPLICATION FOR INCREASED COMPENSATION BASED ON UNEMPLOYABILITY

NOTE: This is a claim for compensation benefits based on unemployability. When you complete this form you are claiming total disability because of a service-connected disability(ies) which has/have prevented you from securing or following any substantially gainful occupation. Answer all questions fully and accurately. See mail/fax information on page 3 of this form.

Social Security Benefits: Individuals who have a disability and meet medical criteria may qualify for Social Security of Supplemental Security Income disability benefits. If you would like more information about Social Security benefits, contact your nearest Social Security Administration (SSA) office. You can locate the address of the nearest SSA office in your telephone book blue pages under "United States Government, Social Security Administration" or call 1-800-772-1213 (Hearing Impaired TDD line 1-800-325-0778.). You may also contact SSA by Internet at **http://www.ssa.gov/**.

SECTION I - VETERAN IDENTIFICATION INFORMATION

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 the form.

1. NAME OF VETERAN *(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. MAILING ADDRESS OF VETERAN *(No. and street or rural route, city or P.O., State, ZIP Code and Country)*

No. & Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code –

6. EMAIL ADDRESS *(If applicable)*

7. TELEPHONE NUMBER *(Include Area Code)*

SECTION II - DISABILITY AND MEDICAL TREATMENT

8. WHAT SERVICE-CONNECTED DISABILITY PREVENTS YOU FROM SECURING OR FOLLOWING ANY SUBSTANTIALLY GAINFUL OCCUPATION?

9. HAVE YOU BEEN UNDER A DOCTOR'S CARE AND/OR HOSPITALIZED WITHIN THE PAST 12 MONTHS?

☐ YES ☐ NO

10. DATE(S) OF TREATMENT BY DOCTOR(S)

FROM	TO

11. NAME AND ADDRESS OF DOCTOR(S)

12. NAME AND ADDRESS OF HOSPITAL

13. DATE(S) OF HOSPITALIZATION

FROM	TO

SECTION III - EMPLOYMENT STATEMENT

14. DATE YOUR DISABILITY AFFECTED FULL-TIME EMPLOYMENT — Month – Day – Year

15. DATE YOU LAST WORKED FULL-TIME — Month – Day – Year

16. DATE YOU BECAME TOO DISABLED TO WORK — Month – Day – Year

17A. WHAT IS THE MOST YOU EVER EARNED IN ONE YEAR?

$

17B. WHAT YEAR?

Year

17C. OCCUPATION DURING THAT YEAR

VETERAN'S SOCIAL SECURITY NO. ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION III - EMPLOYMENT STATEMENT *(Continued)*

18. LIST ALL YOUR EMPLOYMENT INCLUDING SELF-EMPLOYMENT FOR THE LAST FIVE YEARS YOU WORKED
(Include any military duty including inactive duty for training)

A. NAME AND ADDRESS OF EMPLOYER (OR UNIT)	B. TYPE OF WORK	C. HOURS PER WEEK	D. DATES OF EMPLOYMENT		E. TIME LOST FROM ILLNESS	F. HIGHEST GROSS EARNINGS PER MONTH
			FROM	TO		

18G. IF YOU ARE CURRENTLY SERVING IN THE RESERVE OR NATIONAL GUARD, DOES YOUR SERVICE CONNECTED DISABILITY PREVENT YOU FROM PERFORMING YOUR MILITARY DUTIES?

☐ YES ☐ NO

18H. INDICATE YOUR TOTAL EARNED INCOME FOR THE PAST 12 MONTHS	18I. IF PRESENTLY EMPLOYED, INDICATE YOUR CURRENT MONTHLY EARNED INCOME
$	$

19. DID YOU LEAVE YOUR LAST JOB/SELF-EMPLOYMENT BECAUSE OF YOUR DISABILITY?	20. DO YOU RECEIVE/EXPECT TO RECEIVE DISABILITY RETIREMENT BENEFITS?	21. DO YOU RECEIVE/EXPECT TO RECEIVE WORKERS COMPENSATION BENEFITS?
☐ YES ☐ NO *(If "Yes," give the facts in Item 26, "Remarks")*	☐ YES ☐ NO	☐ YES ☐ NO

22. HAVE YOU TRIED TO OBTAIN EMPLOYMENT SINCE YOU BECAME TOO DISABLED TO WORK?

☐ YES ☐ NO *(If "Yes," complete Items 22A, 22B, and 22C)*

A. NAME AND ADDRESS OF EMPLOYER	B. TYPE OF WORK	C. DATE APPLIED

SECTION IV - SCHOOLING AND OTHER TRAINING

23. EDUCATION *(Check highest year completed)*

GRADE SCHOOL ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 HIGH SCHOOL ☐ 1 ☐ 2 ☐ 3 ☐ 4 COLLEGE ☐ 1 ☐ 2 ☐ 3 ☐ 4

24A. DID YOU HAVE ANY OTHER EDUCATION AND TRAINING BEFORE YOU WERE TOO DISABLED TO WORK?

☐ YES ☐ NO *(If "Yes," complete Items 24B, and 24C)*

24B. TYPE OF EDUCATION OR TRAINING	24C. DATES OF TRAINING	
	BEGINNING	COMPLETION

25A. HAVE YOU HAD ANY EDUCATION AND TRAINING SINCE YOU BECAME TOO DISABLED TO WORK?

☐ YES ☐ NO *(If "Yes," complete Items 25B, and 25C)*

25B. TYPE OF EDUCATION OR TRAINING	25C. DATES OF TRAINING	
	BEGINNING	COMPLETION

VETERAN'S SOCIAL SECURITY NO. ☐☐☐ – ☐☐ – ☐☐☐☐

26. REMARKS *(If any)*

SECTION IV - AUTHORIZATION, CERTIFICATION, AND SIGNATURE

AUTHORIZATION FOR RELEASE OF INFORMATION: I authorize the 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.

CERTIFICATION OF STATEMENTS: I CERTIFY THAT as a result of my service-connected disabilities, I am unable to secure or follow *any* substantially gainful occupation and that the statements in this application are true and complete to the best of my knowledge and belief. I understand that these statements will be considered in determining my eligibility for VA benefits based on unemployability because of service-connected disability.

I UNDERSTAND THAT IF I AM GRANTED SERVICE-CONNECTED TOTAL DISABILITY BENEFITS BASED ON MY UNEMPLOYABILITY, I MUST IMMEDIATELY INFORM VA IF I RETURN TO WORK. I ALSO UNDERSTAND THAT TOTAL DISABILITY BENEFITS PAID TO ME AFTER I BEGIN WORK MAY BE CONSIDERED AN OVERPAYMENT REQUIRING REPAYMENT TO VA.

27. SIGNATURE OF CLAIMANT *(Do Not Print) (Sign in ink)*	28. DATE SIGNED

WITNESS TO SIGNATURE OF CLAIMANT IF MADE "X" MARK. NOTE: Signature made by mark must be witnessed by two persons to whom the person making the statement is personally know and the signature and address of such witnesses must be shown below.

29A. SIGNATURE OF WITNESS *(Sign in ink)*	29B. ADDRESS OF WITNESS
30A. SIGNATURE OF WITNESS *(Sign in ink)*	**30B. ADDRESS OF WITNESS**

SECTION V - WHERE TO SEND CORRESPONDENCE

MAIL TO:	FAX TO:
Department of Veterans Affairs **Evidence Intake Center** **PO Box 4444** **Janesville, WI 53547-4444**	**844-531-7818 (Toll Free) *OR*** **Local: 248-524-4260**

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: 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 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, U.S.C. 5101(c)(1). VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a 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 provided under the law. 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 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 45 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.