VA Individual Unemployability

If you can't work because of a disability related to your service in the military (a service-connected disability), you may qualify for what's called "Individual Unemployability." This means you may be able to get disability compensation or benefits at the same level as a Veteran who has a 100% disability rating.

Am I eligible for disability benefits from VA?

You may be eligible for disability benefits if you meet both of these requirements.

Both of these must be true:

- You have at least 1 service-connected disability rated at 60% or more disabling, or 2 or more service-connected disabilities—with at least 1 rated at 40% or more disabling and a combined rating of 70% or more—**and**
- You can't hold down a steady job that supports you financially (known as substantially gainful employment) because of your service-connected disability. Odd jobs (marginal employment) don't count.

Note: In certain cases—for example, if you need to be in the hospital often—you may qualify at a lower disability rating.

Who's covered?

Veterans

What kind of benefits can I get?

- Health care
- Compensation (payments)

How do I get these benefits?

You'll need to file a claim for disability compensation. When you file, you'll have to provide evidence (supporting documents like a doctor's report or medical test results) showing that

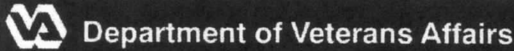
your disability prevents you from holding down a steady job. We'll also review your work and education history.

Example: A Veteran has a service-connected heart condition and a 60% disability rating. She was still able to work until last year when she began to get chest pain when doing anything physical, like walking or lifting boxes. Her doctor told her to retire as soon as possible. She filed a claim for more disability compensation. We reviewed her work and education history and agreed that she was individually unemployable because of her service-connected disability. So we increased her disability compensation to the same rate as a 100% disabled Veteran.

When you file a disability claim, you'll also need to fill out the enclosed additional forms for Individual Unemployability benefits:

- A Veteran's Application for Increased Compensation Based on Unemployability (VA Form 21-8940)
  and
- A Request for Employment Information in Connection with Claim for Disability Benefits (VA Form 21-4192)

OMB Approved No. 2900-0404
Respondent Burden: 45 minutes
Expiration Date: 06/30/2024



VA DATE STAMP (DO NOT WRITE IN THIS SPACE)

VETERAN'S APPLICATION FOR INCREASED COMPENSATION BASED ON UNEMPLOYABILITY

IMPORTANT: 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 mailing information on page 4 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 may complete the form online or by hand. If completed by hand print the information requested in ink, neatly, and legibly, insert one letter per box, and completely fill each applicable circle to help expedite processing of the form.

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

2. SOCIAL SECURITY NUMBER

3. VA FILE NUMBER

4. DATE OF BIRTH
Month – Day – Year

5. MAILING ADDRESS *(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)*

◯ I agree to receive electronic correspondence from VA in regards to my claim.

7. TELEPHONE NUMBER *(Include Area Code)*

Enter International Phone Number *(If applicable)*

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) (Go to Item 26 - Remarks - for additional dates)

FROM

TO

11. NAME AND ADDRESS OF DOCTOR(S)

12. NAME AND ADDRESS OF HOSPITAL

13. DATE(S) OF HOSPITALIZATION (Go to Item 26 - Remarks - for additional dates)

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?

17C. OCCUPATION DURING THAT YEAR?

VETERAN'S SOCIAL SECURITY NUMBER [ ] - [ ] - [ ]

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) (Note: For additional employment information use Section V, Remarks)

NAME AND ADDRESS OF EMPLOYER (OR UNIT)		TYPE OF WORK	HOURS PER WEEK
D. DATES OF EMPLOYMENT		TIME LOST FROM ILLNESS	HIGHEST GROSS EARNINGS PER MONTH
FROM	TO		
- -	- -		$,

NAME AND ADDRESS OF EMPLOYER (OR UNIT)		TYPE OF WORK	HOURS PER WEEK
DATES OF EMPLOYMENT		TIME LOST FROM ILLNESS	HIGHEST GROSS EARNINGS PER MONTH
FROM	TO		
- -	- -		$,

NAME AND ADDRESS OF EMPLOYER (OR UNIT)		TYPE OF WORK	HOURS PER WEEK
DATES OF EMPLOYMENT		TIME LOST FROM ILLNESS	HIGHEST GROSS EARNINGS PER MONTH
FROM	TO		
- -	- -		$,

NAME AND ADDRESS OF EMPLOYER (OR UNIT)		TYPE OF WORK	HOURS PER WEEK
DATES OF EMPLOYMENT		TIME LOST FROM ILLNESS	HIGHEST GROSS EARNINGS PER MONTH
FROM	TO		
- -	- -		$,

NAME AND ADDRESS OF EMPLOYER (OR UNIT)		TYPE OF WORK	HOURS PER WEEK
DATES OF EMPLOYMENT		TIME LOST FROM ILLNESS	HIGHEST GROSS EARNINGS PER MONTH
FROM	TO		
- -	- -		$,

VETERAN'S SOCIAL SECURITY NUMBER [ ] - [ ] - [ ]

SECTION III - EMPLOYMENT STATEMENT *(Continued)*

19. 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

20A. INDICATE YOUR TOTAL EARNED INCOME FOR THE PAST 12 MONTHS	20B. IF PRESENTLY EMPLOYED, INDICATE YOUR CURRENT MONTHLY EARNED INCOME
$,	$,

21A. DID YOU LEAVE YOUR LAST JOB/SELF-EMPLOYMENT BECAUSE OF YOUR DISABILITY?	21B. DO YOU RECEIVE/EXPECT TO RECEIVE DISABILITY RETIREMENT BENEFITS?	21C. DO YOU RECEIVE/EXPECT TO RECEIVE WORKERS COMPENSATION BENEFITS?
◯ YES ◯ NO *(If "Yes," explain 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)*

22A. NAME AND ADDRESS OF EMPLOYER	22B. TYPE OF WORK	22C. DATE APPLIED (MM/DD/YYYY)
		- -
NAME AND ADDRESS OF EMPLOYER	TYPE OF WORK	DATE APPLIED (MM/DD/YYYY)
		- -
NAME AND ADDRESS OF EMPLOYER	TYPE OF WORK	DATE APPLIED (MM/DD/YYYY)
		- -

SECTION IV - SCHOOLING AND OTHER TRAINING

23. EDUCATION *(Check highest year completed)*

GRADE SCHOOL ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 HIGH SCHOOL ◯ 9 ◯ 10 ◯ 11 ◯ 12 COLLEGE ◯ Fresh ◯ Soph ◯ Jr ◯ Sr

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 (MM/DD/YYYY)	COMPLETION (MM/DD/YYYY)
	- -	- -

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 (MM/DD/YYYY)	COMPLETION (MM/DD/YYYY)
	- -	- -

VETERAN'S SOCIAL SECURITY NUMBER [ ][ ][ ] – [ ][ ] – [ ][ ][ ][ ]

SECTION V - REMARKS

NOTE: This section can be used for any additional information, if needed.

26. REMARKS

SECTION VI - 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 *(Required)*	28. DATE SIGNED (MM/DD/YYYY)
	[ ][ ] – [ ][ ] – [ ][ ][ ][ ]

WITNESSES NEEDED IF "X" MARK IS MADE (Signature made by mark must be witnessed by two persons to whom the person making the statement is personally known and the signature and address of such witnesses must be shown in Items 29A & 29B and 30A & 30B.

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

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.

SECTION VII - WHERE TO SEND CORRESPONDENCE

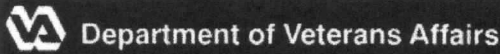
MAIL TO:

Department of Veterans Affairs
Evidence Intake Center
PO Box 4444
Janesville, WI 53547-4444

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.

OMB Control No. 2900-0065
Respondent Burden: 15 minutes
Expiration Date: 7/31/2024



VA DATE STAMP
DO NOT WRITE IN THIS SPACE

REQUEST FOR EMPLOYMENT INFORMATION IN CONNECTION WITH CLAIM FOR DISABILITY BENEFITS

1. NAME AND ADDRESS OF EMPLOYER OF VETERAN *(Complete)*

RETURN TO

2. ADDRESS *(Complete)*

INSTRUCTIONS: The veteran named in Item 3 has filed a claim for veterans disability benefits and has stated that he/she was recently employed by you. In order to arrive at a fair decision in this case, we need the information requested below. Please complete Sections II, III and IV and return to this office at the address below. Please be sure to sign and date this form in Items 23A and 23B. For free help in completing this form, call VA toll-free at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the Federal number is 711.

Where to Send Correspondence - After completing the form, mail to:
Department of Veterans Affairs
Evidence Intake Center
P.O. Box 4444
Janesville, WI 53547-4444

SECTION I - IDENTIFICATION INFORMATION

NOTE: You may complete the form online or by hand. If completed by hand, print the information requested in ink, neatly and legibly, insert one letter per box, and completely fill in each applicable circle to help expedite processing of the form.

3. VETERAN/BENEFICIARY'S NAME (First, Middle Initial, Last)

4. SOCIAL SECURITY NUMBER

5. VA FILE NUMBER (If applicable)

6. DATE OF BIRTH
Month — Day — Year

SECTION II - EMPLOYMENT INFORMATION *(To be completed by employer)*

7. BEGINNING DATE OF EMPLOYMENT
Month — Day — Year

8. ENDING DATE OF EMPLOYMENT
Month — Day — Year

9. TYPE OF WORK PERFORMED

10. AMOUNT EARNED DURING 12 MONTHS PRECEDING LAST DATE OF EMPLOYMENT (BEFORE DEDUCTIONS)
$, .

11. TIME LOST DURING 12 MONTHS PRECEDING LAST DATE OF EMPLOYMENT (DUE TO DISABILITY)

12A. NUMBER OF HOURS WORKED (Daily)

12B. NUMBER OF HOURS WORKED (Weekly)

13. CONCESSIONS (if any) MADE TO EMPLOYEE BY REASON OF AGE OR DISABILITY

14A. IF VETERAN IS NOT WORKING, STATE THE REASON FOR TERMINATION OF EMPLOYMENT: (IF RETIRED ON DISABILITY, PLEASE SPECIFY)

14B. DATE LAST WORKED
Month — Day — Year

15A. DATE OF LAST PAYMENT
Month — Day — Year

15B. GROSS AMOUNT OF LAST PAYMENT
$

16A. WAS LUMP SUM PAYMENT MADE?
◯ YES ◯ NO
GROSS AMOUNT PAID
$

16B. DATE PAID
Month — Day — Year

SECTION III - RESERVE OR NATIONAL GUARD DUTY STATUS

(Only complete if claimant is currently serving in the Reserve or National Guard)

17A. WHAT IS THE VETERAN'S CURRENT DUTY STATUS?

17B. DOES THE VETERAN HAVE ANY DISABILITIES THAT PREVENT THEM FROM PERFORMING THEIR MILITARY DUTIES?
◯ YES ◯ NO

VETERAN'S SOCIAL SECURITY NO. [ ][ ][ ] – [ ][ ] – [ ][ ][ ][ ]

SECTION IV - INFORMATION ON BENEFIT ENTITLEMENT AND/OR PAYMENTS *(To be completed by employer)*

18. IS VETERAN RECEIVING OR ENTITLED TO RECEIVE, AS A RESULT OF HIS/HER EMPLOYMENT WITH YOU, SICK, RETIREMENT OR OTHER BENEFITS?

◯ YES ◯ NO *(If "Yes," complete Items 19 through 21C)*

19. TYPE OF BENEFIT

20. GROSS MONTHLY AMOUNT OF BENEFIT

$ [ ][ ][ ] , [ ][ ][ ] . [ ][ ]

21A. DATE BENEFIT BEGAN	21B. DATE FIRST PAYMENT ISSUED	21C. DATE BENEFIT WILL STOP *(If known)*
Month – Day – Year	Month – Day – Year	Month – Day – Year

22. REMARKS

I CERTIFY THAT the statements made in this form are true and complete to the best of my knowledge and belief.

23A. SIGNATURE OF EMPLOYER OR SUPERVISOR ***(Required)***	23B. DATE SIGNED *(MM/DD/YYYY)*

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a meterial fact, knowing it to be false, or for 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 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 voluntary. 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 submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN: We need this information to determine eligibility for disability benefits based on unemployability (38 U.S.C. 1521). 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.