

 Department of Veterans Affairs		VA DATE STAMP (DO NOT WRITE IN THIS SPACE)
APPLICATION FOR DISABILITY COMPENSATION AND RELATED COMPENSATION BENEFITS		
IMPORTANT: Please read the Privacy Act and Respondent Burden on Page 14 before completing the form. Use this form to determine your eligibility for compensation. 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 1-800-827-1000 (TTY: 711). If you prefer you may complete and submit the form online at www.va.gov . VA forms are available at www.va.gov/vaforms .		
<p>1. SELECT THE TYPE OF CLAIM PROGRAM/PROCESS THAT APPLIES TO YOU. NOTE: Your claim will be processed as described on pages 1 through 8 unless one of the following special programs is selected. See Instruction pages 1 through 3 for definitions of the Fully Developed Claim (FDC) Program (Optional Expedited Process) or the Standard Claim Process.</p> <p><input type="checkbox"/> FDC PROGRAM <input type="checkbox"/> STANDARD CLAIM PROCESS</p> <p><input type="checkbox"/> IDES (Select this option only if you have been referred to the IDES Program by your Military Service Department)</p> <p><input type="checkbox"/> BDD Program Claim (Select this option only if you meet the criteria for the BDD Program specified on Instruction Page 5)</p>		
SECTION I: VETERAN'S IDENTIFICATION INFORMATION (If claim is not an original claim, only Section I, IV (if applicable), V and a signature are required)		
NOTE: You may <i>either</i> 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 check box to help expedite processing of the form.		
2. VETERAN/SERVICEMEMBER'S NAME (First, Middle Initial, Last) <div style="border: 1px solid black; height: 20px; width: 100%;"></div>		
3. SOCIAL SECURITY NUMBER (SSN) <div style="border: 1px solid black; width: 100%;"></div>	4. HAVE YOU EVER FILED A CLAIM WITH VA? (If "Yes," provide your file number in Item 5) <input type="checkbox"/> YES <input type="checkbox"/> NO	5. VA FILE NUMBER <div style="border: 1px solid black; width: 100%;"></div>
6. DATE OF BIRTH (MM-DD-YYYY) <div style="border: 1px solid black; width: 100%;"></div>	7. SERVICE NUMBER (If applicable) <div style="border: 1px solid black; width: 100%;"></div>	
8. BDD CLAIMS ONLY: PROVIDE THE DATE OR ANTICIPATED DATE OF RELEASE FROM ACTIVE DUTY (MM-DD-YYYY) <div style="border: 1px solid black; width: 100%;"></div>	9. TELEPHONE NUMBER (Optional) (Include Area Code) <div style="border: 1px solid black; width: 100%;"></div> Enter International Phone Number (If applicable) <div style="border: 1px solid black; width: 100%;"></div>	
10. CURRENT MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country) No. & Street <div style="border: 1px solid black; width: 100%;"></div> Apt./Unit Number <div style="border: 1px solid black; width: 100px;"></div> City <div style="border: 1px solid black; width: 200px;"></div> State/Province <div style="border: 1px solid black; width: 50px;"></div> Country <div style="border: 1px solid black; width: 50px;"></div> ZIP Code/Postal Code <div style="border: 1px solid black; width: 100px;"></div> - <div style="border: 1px solid black; width: 50px;"></div>		
11. EMAIL ADDRESS (Optional) <input type="checkbox"/> I agree to receive electronic correspondence from VA in regards to my claim. <div style="border: 1px solid black; width: 100%;"></div> <div style="border: 1px solid black; width: 100%;"></div>		
<input type="checkbox"/> 12. IF YOU ARE CURRENTLY A VA EMPLOYEE, CHECK THE BOX (Includes Work Study/Internship) (If you are not a VA employee skip to Section II, if applicable)		
SECTION II: CHANGE OF ADDRESS		
NOTE: If you are temporarily or permanently changing your address, complete Items 13A through 13C.		
13A. TYPE OF ADDRESS CHANGE (Complete if applicable) (Check only one box) <input type="checkbox"/> TEMPORARY <input type="checkbox"/> PERMANENT		
13B. NEW ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country) No. & Street <div style="border: 1px solid black; width: 100%;"></div> Apt./Unit Number <div style="border: 1px solid black; width: 100px;"></div> City <div style="border: 1px solid black; width: 200px;"></div> State/Province <div style="border: 1px solid black; width: 50px;"></div> Country <div style="border: 1px solid black; width: 50px;"></div> ZIP Code/Postal Code <div style="border: 1px solid black; width: 100px;"></div> - <div style="border: 1px solid black; width: 50px;"></div>		
13C. EFFECTIVE DATE(S) OF NEW ADDRESS (If your change of address is temporary , complete both the beginning and ending date of your temporary address) (If your change of address is permanent , please enter your effective date in the beginning date only)		
<div style="display: flex; justify-content: space-between;"><div>BEGINNING DATE: <div style="display: flex; align-items: center;"><div style="border: 1px solid black; width: 40px; height: 20px; margin-right: 5px;"></div>Month<div style="border: 1px solid black; width: 40px; height: 20px; margin-right: 5px;"></div>Day<div style="border: 1px solid black; width: 40px; height: 20px; margin-right: 5px;"></div>Year</div></div><div>ENDING DATE: <div style="display: flex; align-items: center;"><div style="border: 1px solid black; width: 40px; height: 20px; margin-right: 5px;"></div>Month<div style="border: 1px solid black; width: 40px; height: 20px; margin-right: 5px;"></div>Day<div style="border: 1px solid black; width: 40px; height: 20px; margin-right: 5px;"></div>Year</div></div></div>		