OMB Control No. 2900-0826
Respondent Burden: 5 minutes
Expiration Date: 05/31/2029

VA | U.S. Department of Veterans Affairs

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

# INTENT TO FILE A CLAIM FOR COMPENSATION AND/OR PENSION, OR SURVIVORS PENSION AND/OR DIC

**INSTRUCTIONS**: Before completing this form, read the Privacy Act and Respondent Burden on page 2. This form is used to notify VA of your intent to file for the general benefit(s). For more information, 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). VA forms are available at **www.va.gov/vaforms**.

## SECTION I: VETERAN'S 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 check box to expedite processing of the form.

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

2. SOCIAL SECURITY NUMBER

3. HAVE YOU EVER FILED A VA CLAIM?
☐ YES (If "YES," complete Item 4)
☐ NO

4. VA FILE NUMBER (If applicable)

5. DATE OF BIRTH (MM/DD/YYYY)

6. VETERAN'S SERVICE NUMBER (If applicable)

7. MAILING ADDRESS (If applicable) (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)

8. TELEPHONE NUMBER (Include Area Code)

Enter International Phone Number (If applicable)

9. EMAIL ADDRESS (If applicable) ☐ I agree to receive electronic correspondence from VA in regards to my claim.

## SECTION II: CLAIMANT'S IDENTIFICATION INFORMATION
**(Complete this section ONLY if the claimant is NOT the veteran)**

10. CLAIMANT'S NAME (First, Middle Initial, Last)

11. SOCIAL SECURITY NUMBER

12. HAVE YOU EVER FILED A VA CLAIM?
☐ YES (If "YES," complete Item 13)
☐ NO

13. VA FILE NUMBER (If applicable)

14. RELATIONSHIP TO VETERAN (Check one)

☐ SPOUSE ☐ CHILD ☐ FIDUCIARY ☐ VETERAN SERVICE OFFICER ☐ ALTERNATE SIGNER

☐ THIRD-PARTY ☐ OTHER (Specify)

15. CLAIMANT'S DATE OF BIRTH (MM/DD/YYYY)

16. MAILING ADDRESS (If applicable) (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)

17. TELEPHONE NUMBER (Include Area Code)

Enter International Phone Number (If applicable)

18. EMAIL ADDRESS (If applicable) ☐ I agree to receive electronic correspondence from VA in regards to my claim.

## SECTION III: GENERAL BENEFIT ELECTION

**IMPORTANT:** VA may not be able to use this form to establish an effective date for benefits if you **do not** select one or more of the general benefits listed below.

19. I INTEND TO FILE FOR THE GENERAL BENEFIT(S) CHECKED BELOW: (Check all that apply)

☐ COMPENSATION ☐ PENSION

**NOTE: ONLY CHECK THE BOX BELOW IF YOU ARE A SURVIVING DEPENDENT OF THE VETERAN.**

☐ SURVIVORS PENSION AND/OR DEPENDENCY AND INDEMNITY COMPENSATION (DIC)

**IMPORTANT:** After receiving this form, VA will give you the appropriate application to file for the general benefit you select above. You can also apply for VA disability compensation online at **www.va.gov**. If you give VA a completed application for the selected general benefit within *one* year of filing this form, your completed application will be considered filed as of the date of receipt of this form. Only the *first* completed application for each selected general benefit that is received after you file this form will be considered filed as of the date of receipt of this form. You may indicate your intent to file for more than one general benefit on this form or you may submit a separate intent to file (VA Form 21-0966) for each general benefit. Please complete as much of this form as possible, as VA cannot process this form if we cannot identify the claimant and/or veteran.

## SECTION IV: DECLARATION OF INTENT AND SIGNATURE

By filing this form, **I HEREBY INDICATE MY INTENT** to apply for one or more general benefits under the laws administered by VA.

I acknowledge that:

(1) this is **not a claim for benefits**,
(2) I must file a complete application for each general benefit with VA before VA will process my claim; and
(3) a complete application for the same general benefit(s) as indicated on this form must be received within one year of the date VA receives this form for my application to be considered filed as of the date of this form.

20. SIGNATURE OF VETERAN/CLAIMANT/AUTHORIZED SIGNATURE **(REQUIRED)**

21. DATE SIGNED (MM/DD/YYYY)

__ __ – __ __ – __ __ __ __

22. NAME OF ATTORNEY, AGENT, OR VETERANS SERVICE ORGANIZATION (VSO) (Please Print)

**NOTE**: This form may only be completed by a VSO, attorney, or agent if a valid power of attorney has been completed.

**Where to Send Your Correspondence** - After completing this form, mail to:

Department of Veterans Affairs
Evidence Intake Center
P.O. Box 4444
Janesville, WI 53547- 4444

**PENALTY**: The law provides severe penalties (including fine and/or imprisonment) for willfully submitting any statement or evidence of a material fact you know to be false, or for fraudulent receipt of any document you are not entitled to.

**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 benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Veteran Readiness and Employment Records - VA, published in the Federal Register. Your obligation to respond is required only to preserve a date of claim for an application that is received within one year of receipt of this form. VA uses your Social Security number to identify if you have a claim file and to ensure that your records are properly associated with your claim file. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by 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 the appropriate application and provide it to the claimant.

**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 2900-0826, and it expires 05/31/2029. 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 **vapra@va.gov**. Please refer to OMB Control No. 2900-0826 in any correspondence. Do not send your completed VA Form 21-0966 to this email address.