OMB Control No. 2900-0075
Respondent Burden: 15 minutes
Expiration Date: 12/31/2020

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

STATEMENT IN SUPPORT OF CLAIM

INSTRUCTIONS: Read the Privacy Act and Respondent Burden on Page 2 before completing the form. Complete as much of Section I as possible. The information requested will help process your claim for benefits. If you need any additional room, use the second page.

SECTION I: VETERAN/BENEFICIARY'S IDENTIFICATION INFORMATION

NOTE: You will either complete the form online or by hand. Please print the information requested clearly, neatly, and legibly to help process the form.

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

2 VETERAN'S SOCIAL SECURITY NUMBER

3 VA FILE NUMBER (If applicable)

4 VETERAN'S DATE OF BIRTH (MM/DD/YYYY)
Month – Day – Year

5 VETERAN'S SERVICE NUMBER (If applicable)

6 TELEPHONE NUMBER (Include Area Code)

7 E-MAIL ADDRESS (Optional)

8 MAILING ADDRESS (Number and Street or Postal Route, P.O. Box, City, State, ZIP Code and Country)

No. & Street

Apt/Unit Number

City

State/Province

Country

ZIP Code/Postal Code –

SECTION II: REMARKS

(The following statement is made in connection with a claim for benefits in the case of the above-named veteran/beneficiary.)