OMB Approved No. 2900-0404
Respondent Burden: 45 minutes

Department of Veterans Affairs

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.

1. VA FILE NUMBER	2. VETERAN'S SOCIAL SECURITY NUMBER	3. DATE OF BIRTH

4. NAME OF VETERAN *(First, Middle, Last) (Type or Print)*	5. ADDRESS OF CLAIMANT *(No. and street or rural route, city or P.O., State and ZIP Code)*

SECTION I - DISABILITY AND MEDICAL TREATMENT

6. WHAT SERVICE-CONNECTED DISABILITY PREVENTS YOU FROM SECURING OR FOLLOWING ANY SUBSTANTIALLY GAINFUL OCCUPATION?	7. HAVE YOU BEEN UNDER A DOCTOR'S CARE AND/OR HOSPITALIZED WITHIN THE PAST 12 MONTHS?	8. DATE(S) OF TREATMENT BY DOCTOR(S)
9. NAME AND ADDRESS OF DOCTOR(S)	10. NAME AND ADDRESS OF HOSPITAL	11. DATE(S) OF HOSPITALIZATION

SECTION II - EMPLOYMENT STATEMENT

12. DATE YOUR DISABILITY AFFECTED FULL TIME EMPLOYMENT	13. DATE YOU LAST WORKED FULL TIME	14. DATE YOU BECAME TOO DISABLED TO WORK
15A. WHAT IS THE MOST YOU EVER EARNED IN ONE YEAR? $	15B. WHAT YEAR?	15C. OCCUPATION DURING THAT YEAR

16. LIST ALL YOUR EMPLOYMENT INCLUDING SELF-EMPLOYMENT FOR THE LAST FIVE YEARS YOU WORKED

A. NAME AND ADDRESS OF EMPLOYER	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		

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

17. DID YOU LEAVE YOUR LAST JOB/SELF-EMPLOYMENT BECAUSE OF YOUR DISABILITY?	18. DO YOU RECEIVE/EXPECT TO RECEIVE DISABILITY RETIREMENT BENEFITS?	19. DO YOU RECEIVE/EXPECT TO RECEIVE WORKERS COMPENSATION BENEFITS?
☐ YES ☐ NO *(If "Yes," give the facts in Item 24)*	☐ YES ☐ NO	☐ YES ☐ NO

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

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

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

EXISTING STOCKS OF VA FORM 21-8940, DEC 1994, WILL BE USED.

SECTION III - SCHOOLING AND OTHER TRAINING

21. EDUCATION *(Circle highest year completed)*

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

22A. DID YOU HAVE ANY OTHER EDUCATION AND TRAINING BEFORE YOU WERE TOO DISABLED TO WORK?

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

22B. TYPE OF EDUCATION OR TRAINING	22C. DATES OF TRAINING	
	BEGINNING	COMPLETION

23A. HAVE YOU HAD ANY EDUCATION AND TRAINING SINCE YOU BECAME TOO DISABLED TO WORK?

☐ YES ☐ NO *(If "Yes," complete Items 23B and 23C)*

23B. TYPE OF EDUCATION OR TRAINING	23C. DATES OF TRAINING	
	BEGINNING	COMPLETION

24. REMARKS

SECTION IV - AUTHORIZATION, CERTIFICATION, AND SIGNATURE

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I consent that any physician, surgeon, dentist, or hospital that has treated or examined me for any purpose or that I have consulted professionally may furnish to VA any information about myself and I waive any privilege which makes this information confidential.

AUTHORIZATION FOR RELEASE OF EMPLOYMENT INFORMATION: I consent that any employer that has employed me for the past five years may furnish to VA any information about myself and I waive any privilege which makes this 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 and 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, THAT 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.

25. SIGNATURE OF CLAIMANT	26. DATE SIGNED	27. TELEPHONE NUMBER(S) *(Include Area Code)*	
		A. DAYTIME	B. NIGHTTIME

WITNESS TO SIGNATURE OF CLAIMANT IF MADE BY "X" MARK. NOTE: 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 below.

28A. SIGNATURE OF WITNESS	28B. ADDRESS OF WITNESS
29A. SIGNATURE OF WITNESS	**29B. 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.

PRIVACY ACT INFORMATION: The responses you submit are considered confidential (38 U.S.C. 5701). They may be disclosed outside VA only if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records, 58VA21/22, Compensation, Pension, Education and Rehabilitation Records - VA, published in the Federal Register. The requested information is considered relevant and necessary to determine maximum benefits provided under the law. Information submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN: VA may not conduct or sponsor, and respondent is not required to respond to this collection of information unless it displays a valid OMB Control Number. Public reporting burden for this collection of information is estimated to average 45 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have comments regarding this burden estimate or any other aspect of this collection of information, call 1-800-827-1000 for mailing information on where to send your comments.