OMB Control No. 2900-0002
Respondent Burden: 25 minutes
Expiration Date: 4/30/2019

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

APPLICATION FOR PENSION

IMPORTANT: Please read the Privacy Act and Respondent Burden on page 8 before completing the form.

SECTION I: VETERAN'S PERSONAL INFORMATION *(MUST COMPLETE)*

1. VETERAN'S NAME *(Last, first, middle)*	2. SOCIAL SECURITY NUMBER	3. DATE OF BIRTH *(MM,DD,YYYY)*
john middle smith Sr.	111223333	03/07/1985

4. SEX	5. HAVE YOU EVER FILED A CLAIM WITH VA?	6. VA FILE NUMBER
[X] MALE [ ] FEMALE	[X] YES [ ] NO *(If "Yes," provide your file number in Item 6)*	c12345678

7A. MAILING ADDRESS	7B. TELEPHONE NUMBERS *(Include Area Code)*
street, street2	DAYTIME (112) 3456789
Street address, rural route, or P.O. Box — Apt. number	EVENING (012) 3456789
Baltimore, MD, 21231, USA	CELL PHONE (212) 3456789
City — State — ZIP Code — Country	

8A. PREFERRED E-MAIL ADDRESS *(If applicable)*	8B. ALTERNATE E-MAIL ADDRESS *(If applicable)*
foo@foo.com	alt@foo.com

9. WHAT DISABILITY(IES) PREVENTS YOU FROM WORKING?

A. DISABILITY(IES)	B. DATE DISABILITY(IES) BEGAN
disability 1	12/01/2016

10. LIST ANY VA MEDICAL CENTERS WHERE YOU RECEIVED TREATMENT FOR YOUR CLAIMED DISABILITY(IES) AND PROVIDE TREATMENT DATES

A. NAME AND LOCATION OF VA MEDICAL CENTER	B. DATE(S) OF TREATMENT
hospital1, nyc	01/01/2016 01/02/2016
hospital2, dc	12/01/2016 12/02/2016 12/03/2016

SECTION II: VETERAN'S SERVICE INFORMATION (*MUST COMPLETE*)

11A. DID YOU SERVE UNDER ANOTHER NAME?	11B. PLEASE LIST THE OTHER NAME(S) YOU SERVED UNDER
[X] YES *(If "Yes," complete Item 11B)* [ ] NO *(If "No," skip to Item 12A)*	name1 last1, name2 last2

12A. I ENTERED ACTIVE SERVICE ON *(MM,DD,YYYY)*	12B. BRANCH OF SERVICE	12C. RELEASE DATE OR ANTICIPATED DATE OF RELEASE FROM ACTIVE SERVICE
06/26/2012	army	04/10/2013

12D. DID YOU SERVE IN A COMBAT ZONE SINCE 9-11-2001?	12E. PLACE OF LAST OR ANTICIPATED SEPARATION
[X] YES [ ] NO	city, state

13A. ARE YOU CURRENTLY ACTIVATED TO FEDERAL ACTIVE DUTY UNDER THE AUTHORITY OF TITLE 10, U.S.C. *(National Guard)*?	13B. DATE OF ACTIVATION *(MM,DD,YYYY)*
[X] YES [ ] NO *(If "Yes," provide date of activation in Item 13B)*	04/11/2013

14A. WHAT IS THE NAME AND ADDRESS OF YOUR RESERVE/NATIONAL GUARD UNIT?	14B. WHAT IS THE TELEPHONE NUMBER OF YOUR CURRENT UNIT? *(Include Area Code)*
foo, 111 Uni Drive, Baltimore, MD, 21231, USA	(212) 3456789

15A. HAVE YOU EVER BEEN A PRISONER OF WAR?	15B. DATES OF CONFINEMENT ON *(MM,DD,YYYY)*
[X] YES [ ] NO *(If "Yes," complete Item 15B) (If "No," skip to Item 16A)*	From: 04/10/2012 To: 05/10/2013

16A. DID YOU RECEIVE ANY TYPE OF SEPARATION/SEVERANCE RETIRED PAY?	16B. LIST AMOUNT *(If known)*	16C. LIST TYPE *(If known)*
[X] YES [ ] NO *(If "Yes," complete Items 16B and 16C)*	$ 1	Longevity

SECTION III: VETERAN'S WORK HISTORY *(MUST COMPLETE)*

***NOTE**: In the table below, tell us about all of your employment, including self-employment, for **one** year before you became disabled to the present.*

17A. WHAT WAS THE NAME AND ADDRESS OF YOUR EMPLOYER?	17B. WHAT WAS YOUR JOB TITLE?	17C. WHEN DID YOUR JOB BEGIN?	17D. WHEN DID YOUR JOB END?	17E. HOW MANY DAYS WERE LOST DUE TO DISABILITY?	17F. WHAT WERE YOUR TOTAL ANNUAL EARNINGS?
1, str1, 1, MD, 21231, USA	worker1	04/01/2012	05/01/2013	1	$ 10
2, str2, 2, MD, 21231, USA	worker2	04/02/2012	05/02/2013	2	$ 20

SECTION IV: MARITAL STATUS *(MUST COMPLETE)*

18A. WHAT IS YOUR MARITAL STATUS? *(Check one)*

☒ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ NEVER MARRIED *(Skip to Section VI if never married)*

TELL US ABOUT YOUR MARRIAGE/PREVIOUS MARRIAGES

18B. HOW MANY TIMES HAVE YOU BEEN MARRIED *(including current marriage)*?

2

19A. DATE *(month, day, year)* AND PLACE OF MARRIAGE *(city/state or country)*	19B. TO WHOM MARRIED *(first, middle, last name)*	19C. TYPE OF MARRIAGE *(ceremonial, common-law, proxy, tribal, or other)*	19D. HOW MARRIAGE TERMINATED *(death, divorce, marriage has not been terminated)*	19E. DATE *(month, day, year)* AND PLACE MARRIAGE TERMINATED *(city/state or country)*
03/01/1985 marriagelocation1	Mark1 Olson	type1	divorce1	04/01/1985 location1
03/02/1985 marriagelocation2	Mark2 Olson	type2	divorce2	04/02/1985 location2

19F. IF YOU INDICATED "OTHER" AS TYPE OF MARRIAGE IN ITEM 19C, PLEASE EXPLAIN:

other

SECTION V: CURRENT MARITAL INFORMATION (*COMPLETE ONLY IF YOU ARE CURRENTLY MARRIED)*

NOTE - Skip to Section VI if not currently married.

TELL US ABOUT YOUR SPOUSE'S MARRIAGE/PREVIOUS MARRIAGES

20. HOW MANY TIMES HAS YOUR SPOUSE BEEN MARRIED *(including current marriage)*?

2

21A. DATE *(month, day, year)* AND PLACE OF MARRIAGE *(city/state or country)*	21B. TO WHOM MARRIED *(first, middle, last name)*	21C. TYPE OF MARRIAGE *(ceremonial, common-law, proxy, tribal, or other)*	21D. HOW MARRIAGE TERMINATED *(death, divorce, marriage has not been terminated)*	21E. DATE *(month, day, year)* AND PLACE MARRIAGE TERMINATED *(city/state or country)*
03/01/1985 marriagelocation1	spouse1 Olson	type1	divorce1	04/01/1985 location1
03/02/1985 marriagelocation2	spouse2 Olson	type2	divorce2	04/02/1985 location2

21F. IF YOU INDICATED "OTHER" AS TYPE OF MARRIAGE IN ITEM 21C, PLEASE EXPLAIN:

spouse other

22A. WHAT IS YOUR SPOUSE'S DATE OF BIRTH? *(month, day, year)*	22B. WHAT IS YOUR SPOUSE'S SOCIAL SECURITY NUMBER?	22C. IS YOUR SPOUSE ALSO A VETERAN?	22D. WHAT IS YOUR SPOUSE'S VA FILE NUMBER *(if any)*?
06/26/2012	111223334	☒ YES ☐ NO	c22345678

22E. DO YOU LIVE WITH YOUR SPOUSE?

☒ YES ☐ NO *(If "Yes," skip to Section VI)*

(If "No," complete Items 22F - 22H)

22F. WHAT IS YOUR SPOUSE'S ADDRESS? *(Number and street or rural route, city or P.O., State, ZIP Code and country)*

str1, city1, MD, 21231, USA

22G. TELL US THE REASON WHY YOU ARE NOT LIVING WITH YOUR SPOUSE *(i.e.; illness, work, etc.)*

illness

22H. HOW MUCH DO YOU CONTRIBUTE MONTHLY TO YOUR SPOUSE'S SUPPORT?

$ 1

SECTION VI: DEPENDENT CHILDREN *(COMPLETE IF YOU HAVE DEPENDENT CHILDREN)*

NOTE - Skip to Section VII if you have no dependent children.

23A. NAME OF DEPENDENT CHILD *(First, middle initial, last)*	23B. DATE AND PLACE OF BIRTH *(city, state or country)*	23C. SOCIAL SECURITY NUMBER	*(Check all that apply)* 23D. BIOLOGICAL	23E. ADOPTED	23F. STEPCHILD	23G. 18-23 YEARS OLD *(in school)*	23H. SERIOUSLY DISABLED	23I. CHILD MARRIED	23J. CHILD PREVIOUSLY MARRIED
Mark1 Olson	06/01/2012 place1	111223331	☒	☒	☒	☒	☒	☒	☒
Mark2 Olson	06/02/2012 place2	111223332	☒	☒	☒	☒	☒	☒	☒
Mark3 Olson	06/03/2012 place3	111223333	☒	☒	☒	☒	☒	☒	☒

NOTE - In Items 24A through 24D, tell us about the children listed in Item 23A who ***do not*** live with you.

24A. NAME OF DEPENDENT CHILD *(First, middle initial, last)*	24B. CHILD'S COMPLETE ADDRESS *(Number and street or rural route, city or P.O., city, State, ZIP Code and country)*	24C. NAME OF PERSON THE CHILD LIVES WITH *(If applicable)*	24D. MONTHLY AMOUNT YOU CONTRIBUTE TO THE CHILD'S SUPPORT
outside1 Olson	str1, city1, MD, 21231, USA	person1 Olson	$ 1
outside2 Olson	str2, city1, MD, 21231, USA	person2 Olson	$ 2
outside3 Olson	str3, city1, MD, 21231, USA	person3 Olson	$ 3

SECTION VII: INCOME VERIFICATION - NET WORTH *(MUST COMPLETE)*

25. **NET WORTH** *(DO NOT LEAVE ANY ITEMS BLANK. If your household has no net worth in a particular source, write "0" or "none")*

Report total net worth for your household. You must report your net worth and the net worth of your dependents (spouse, child, etc.), if any. Identify the ***specific*** owner for each net worth source, yourself or another person in your household, as applicable.

SOURCE	AMOUNT	OWNER	SOURCE	AMOUNT	OWNER
CASH/NON-INTEREST BEARING BANK ACCOUNTS	$ 1	Myself	REAL PROPERTY *(Not your home, vehicle, furniture, or clothing)*	$ 5	Spouse
INTEREST-BEARING BANK ACCOUNTS	$ 2	Myself	ALL OTHER PROPERTY *(Please write source)*	$ 6	Myself
IRA'S, KEOGH PLANS, ETC.	$ 3	Myself	ALL OTHER PROPERTY *(Please write source)*	$ 7	Spouse
STOCKS, BONDS, MUTUAL FUNDS, ETC.	$ 4	Spouse	OTHER *(Provide source)* name1	$ 8	outside1 Olson

SECTION VIII: INCOME VERIFICATION - MONTHLY INCOME *(MUST COMPLETE)*

26. **GROSS MONTHLY INCOME** *(DO NOT LEAVE ANY ITEMS BLANK. If no income was received from a particular source, write "0" or "none")*

Report total monthly income for your household. You must report your income and the income of your dependents (spouse, child, etc.), if any. Identify the ***specific*** income recipient for each income source, yourself or another person in your household, as applicable.

SOURCE	AMOUNT	RECIPIENT	SOURCE	AMOUNT	RECIPIENT
SOCIAL SECURITY	$ 1	Myself	SERVICE RETIREMENT	$ 6	Spouse
SOCIAL SECURITY	$ 2	Spouse	SUPPLEMENTAL SECURITY INCOME *(SSI)*/PUBLIC ASSISTANCE	$ 7	Myself
U.S. CIVIL SERVICE	$ 3	Myself	OTHER *(Provide source)* name1	$ 8	Spouse
U.S. RAILROAD RETIREMENT	$ 4	Spouse	OTHER *(Provide source)* name2	$ 9	outside1 Olson
BLACK LUNG BENEFITS	$ 5	Myself	OTHER *(Provide source)* name3	$ 10	outside1 Olson

SECTION IX: EXPECTED INCOME *(MUST COMPLETE)*

27. **EXPECTED INCOME - NEXT 12 MONTHS** *(DO NOT LEAVE ANY ITEMS BLANK. If no income was received from a particular source, write "0" or "none")*

Report expected total household income for the next 12 months. You must report your expected income and the expected income of your dependents (spouse, child, etc.), if any. Identify the ***specific*** income recipient for each income source, yourself or another person in your household, as applicable.

SOURCE	AMOUNT	RECIPIENT	SOURCE	AMOUNT	RECIPIENT
GROSS WAGES AND SALARY	$ 1	Myself	OTHER INCOME EXPECTED *(Provide source)* name1	$ 4	Myself
GROSS WAGES AND SALARY	$ 2	Spouse	OTHER INCOME EXPECTED *(Provide source)* name2	$ 5	Spouse
TOTAL DIVIDENDS AND INTEREST	$ 3	Myself	OTHER INCOME EXPECTED *(Provide source)* name3	$ 6	parent Olson

SECTION X: MEDICAL, LEGAL, OR OTHER UNREIMBURSED EXPENSES *(MUST COMPLETE)*

28. MEDICAL, LEGAL, OR OTHER UNREIMBURSED EXPENSES *(IF NONE WRITE "0" OR "NONE")*

Report your family medical expenses and certain other expenses actually paid by you that may be deductible from your income. Show the amount of unreimbursed medical expenses, including the Medicare deduction you paid for yourself or relatives who are members of your household. Also, show unreimbursed last illness and burial expenses and educational or vocational rehabilitation expenses you paid. Last illness and burial expenses are unreimbursed amounts paid by you for the last illness and burial of a spouse or child at any time prior to the end of the year following the year of death. Educational or vocational rehabilitation expenses are amounts paid for courses of education, including tuition, fees, and materials. Show medical, legal or other expenses you paid because of a disability for which civilian disability benefits have been awarded. When determining your income, we may be able to deduct them from the disability benefits for the year in which the expenses are paid. ***Do not include any expenses for which you were reimbursed.***

AMOUNT PAID BY YOU	DATE PAID *(mm/dd/yy)*	PURPOSE *(Doctor's fees, hospital charges, attorney fees, tuition, education materials, etc.)*	PAID TO *(Name of doctor, hospital, pharmacy, etc.)*	RELATIONSHIP OF PERSON FOR WHOM EXPENSES PAID *(Spouse, child, etc.)*
$ 1	04/01/2012	purpose1	paidTo1	relationship1
$ 2	04/02/2012	purpose2	paidTo2	relationship2
$ 3	04/03/2012	purpose3	paidTo3	relationship3
$ 4	04/04/2012	purpose4	paidTo4	relationship4

SECTION XI: DIRECT DEPOSIT INFORMATION *(MUST COMPLETE)*

The Department of Treasury requires all Federal benefit payments be made by electronic funds transfer (EFT), also called direct deposit. Please attach a voided personal check or deposit slip or provide the information requested below in Items 29, 30, and 31 to enroll in direct deposit. If you ***do not*** have a bank account, you must receive your payment through Direct Express Debit MasterCard. To request a Direct Express Debit MasterCard you must apply at www.usdirectexpress.com or by telephone at 1-800-333-1795. If you elect not to enroll, you must contact representatives handling waiver requests for the Department of Treasury at 1-888-224-2950. They will encourage your participation in EFT and address any questions or concerns you may have.

29. ACCOUNT NUMBER *(Check the appropriate box and provide the account number, or simply write "Established" if you have a direct deposit with VA.)*

☒ CHECKING ☐ SAVINGS ☒ I CERTIFY THAT I DO NOT HAVE AN ACCOUNT WITH A FINANCIAL INSTITUTION OR CERTIFIED PAYMENT AGENT

Account No. 88888888888 Account No. _____

30. NAME OF FINANCIAL INSTITUTION *(Please provide the name of the bank where you want your direct deposit)*	31. ROUTING OR TRANSIT NUMBER *(The first nine numbers located at the bottom left of your check)*
foo bank	123456789

SECTION XII: CLAIM CERTIFICATION AND SIGNATURE *(MUST COMPLETE)*

I certify and authorize the release of information. I certify that the statements in this document are true and complete to the best of my knowledge. I authorize any 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.

I certify I have received the notice attached to this application titled *Notice to Veteran of Evidence Necessary to Substantiate a Claim for Veterans Non-Service Connected Pension Benefits.*

I certify I have enclosed all the information or evidence that will support my claim, to include an identification of relevant records available at a Federal facility, such as a VA medical center; **OR,** I have no information or evidence to give VA to support my claim; **OR**, I have checked the box in Item 32, indicating that I do not want my claim considered for rapid processing in the Fully Developed Claim (FDC) Program because I plan to submit further evidence in support of my claim.

32. The FDC Program is designed to rapidly process compensation or pension claims received with the evidence necessary to decide the claim. VA will *automatically* consider a claim submitted on this form for rapid processing under the FDC Program. Check the below box **ONLY if you DO NOT want your claim considered for rapid processing** under the FDC Program because you plan to submit further evidence in support of your claim.

☒ **I DO NOT want my claim considered for rapid processing** under the FDC Program because I plan to submit further evidence in support of my claim.

33A. VETERAN'S SIGNATURE ***(REQUIRED)*** *(Sign in ink)*	33B. DATE SIGNED

SECTION XIII: WITNESSES TO SIGNATURE *(MUST COMPLETE ONLY IF VETERAN SIGNED ITEM 33A WITH AN "X")*

34A. SIGNATURE OF WITNESS *(If veteran signed above using an "X")*	34B. PRINTED NAME AND ADDRESS OF WITNESS
35A. SIGNATURE OF WITNESS *(If veteran signed above using an "X")*	**35B. PRINTED NAME AND ADDRESS OF WITNESS**

PRIVACY ACT NOTICE: The form will be used to determine allowance to pension benefits (38 U.S.C. 5101). The responses you submit are considered confidential (38 U.S.C. 5701). VA may disclose the information that you provide, including Social Security numbers, outside VA if the disclosure is authorized under the Privacy Act, including the routine uses 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. The requested information is considered relevant and necessary to determine maximum benefits under the law. Information submitted is subject to verification through computer matching programs with other agencies. VA may make a "routine use" disclosure for: 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. Your obligation to respond is required in order to obtain or retain benefits. Information that you furnish may be utilized in computer matching programs with other Federal or State agencies for the purpose of determining your eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of your participation in any benefit program administered by the Department of Veterans Affairs. Social Security information: You are required to provide the Social Security number requested under 38 U.S.C. 5101(c)(1). VA may disclose Social Security numbers as authorized under the Privacy Act, and, specifically may disclose them for purposes stated above.

RESPONDENT BURDEN: We need this information to determine your eligibility for pension. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 25 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.