



APPLICATION FOR DISABILITY COMPENSATION AND RELATED COMPENSATION BENEFITS

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

Received Centralized Mail Processing,
Janesville, WI 10/25/2021

IMPORTANT: Please read the Privacy Act and Respondent Burden on page 12 before completing the form.

1. SELECT THE TYPE OF CLAIM PROGRAM/PROCESS (Check the appropriate box) (See instruction pages 1-3 for definitions of the Fully Developed Claim (FDC) Program (Optional Expedited Process) or the Standard Claim Process. (See instruction page 5 for the definition of a Benefits Delivery at Discharge (BDD) Program Claim)

- ☒ FULLY DEVELOPED CLAIM (FDC) PROGRAM ☐ STANDARD CLAIM PROCESS
- ☐ IDES (Select this option **only** if you have been referred to the IDES Program by your Military Service Department)
- ☐ BDD Program Claim (Select this option **only** if you meet the criteria for the BDD Program specified on Instruction Page 5)

SECTION I: IDENTIFICATION AND CLAIM INFORMATION (If claim is not an original claim, only Section I, IV, and a signature are required)

NOTE: You may *either* complete the form online or by hand. If completed by hand, print the information requested in ink, neatly, and legibly to expedite processing of the form.

2. VETERAN/SERVICE MEMBER NAME (First, Middle Initial, Last)

H o m e r T C o r n b l a t t

3. VETERAN'S SOCIAL SECURITY NUMBER (SSN)

T R A - 2 1 - 9 5 9 2

4. HAVE YOU EVER FILED A CLAIM WITH VA?

☒ YES ☐ NO (If "Yes," provide your file number in Item 5)

5. VA FILE NUMBER

6 Y 1 5 X X 0 0

6. DATE OF BIRTH (MM-DD-YYYY)

0 1 - 1 5 - 1 9 9 6

7. VETERAN'S SERVICE NUMBER (If applicable)

8. SEX

☒ MALE ☐ FEMALE

9. BDD CLAIMS **ONLY:** PROVIDE THE DATE OR ANTICIPATED DATE OF RELEASE FROM ACTIVE DUTY (MM-DD-YYYY)

10. TELEPHONE NUMBER (Optional) (Include Area Code)

5 5 5 - 5 5 5 - 1 2 1 2

Enter International Phone Number (If applicable)

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

No. & Street 3 1 H o p k i n s P l a z a

Apt./Unit Number City B a l t i m o r e

State/Province M D Country U S ZIP Code/Postal Code 2 1 2 0 1 -

12. EMAIL ADDRESS (Optional) ☐ I agree to receive electronic correspondence from VA in regards to my claim.

H C o r n b l a t t @ e m a i l . c o m

☐ 13. 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 14A through 14C.

14A. TYPE OF ADDRESS CHANGE (Complete if applicable) (Check only one box)

☐ TEMPORARY ☐ PERMANENT

14B. NEW ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code -

14C. 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)

BEGINNING DATE: ENDING DATE:

SECTION III: HOMELESS INFORMATION

IMPORTANT: The following questions (Items 15A through 15F) should **only** be completed if you are currently homeless or at risk of becoming homeless. If this item does not apply to you, skip to Section IV.

15A. ARE YOU CURRENTLY HOMELESS?

- ☐ YES (If "Yes," complete Item 15B regarding your living situation)
- ☐ NO

15B. CHECK THE BOX THAT APPLIES TO YOUR LIVING SITUATION:

- ☐ LIVING IN A HOMELESS SHELTER
- ☐ NOT CURRENTLY IN A SHELTERED ENVIRONMENT (e.g., living in a car or tent)
- ☐ STAYING WITH ANOTHER PERSON
- ☐ FLEEING CURRENT RESIDENCE
- ☐ OTHER (Specify)

15C. ARE YOU CURRENTLY AT RISK OF BECOMING HOMELESS?

- ☐ YES (If "Yes," complete Item 15D regarding your living situation)
- ☐ NO

15D. CHECK THE BOX THAT APPLIES TO YOUR LIVING SITUATION:

- ☐ HOUSING WILL BE LOST IN 30 DAYS
- ☐ LEAVING PUBLICLY FUNDED SYSTEM OF CARE (e.g., homeless shelter)
- ☐ OTHER (Specify)

15E. POINT OF CONTACT (Name of person VA can contact in order to get in touch with you)

15F. POINT OF CONTACT TELEPHONE NUMBER (Include Area Code)

SECTION IV: CLAIM INFORMATION

16. LIST THE CURRENT DISABILITY(IES) OR SYMPTOMS THAT YOU CLAIM ARE RELATED TO YOUR MILITARY SERVICE AND/OR SERVICE-CONNECTED DISABILITY (If applicable, identify whether a disability is due to a service-connected disability; confinement as a prisoner of war; exposure to Agent Orange, asbestos, mustard gas, ionizing radiation, or Gulf War environmental hazards; or a disability for which compensation is payable under 38 U.S.C. 1151)

NOTE: List your claimed conditions below. See the following three examples for guidance on how to complete Section IV.

EXAMPLES OF DISABILITY(IES)		EXAMPLES OF EXPOSURE TYPE	EXAMPLES OF HOW THE DISABILITY(IES) RELATE TO SERVICE	EXAMPLES OF DATES
Example 1. HEARING LOSS		NOISE	HEAVY EQUIPMENT OPERATOR IN SERVICE	JULY 1968
Example 2. DIABETES		AGENT ORANGE	SERVICE IN VIETNAM WAR	DECEMBER 1972
Example 3. LEFT KNEE, SECONDARY TO RIGHT KNEE			INJURED LEFT KNEE WHEN BRACE ON RIGHT KNEE FAILED	6/11/2008
CURRENT DISABILITY(IES)		IF DUE TO EXPOSURE, EVENT, OR INJURY, PLEASE SPECIFY (e.g., Agent Orange, radiation)	EXPLAIN HOW THE DISABILITY(IES) RELATES TO THE IN-SERVICE EVENT/EXPOSURE/INJURY	APPROXIMATE DATE DISABILITY(IES) BEGAN OR WORSENER
1.	PTSD	Combat in Afghanistan	nightmares, anxiety	11/16/2020
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				

VETERANS SOCIAL SECURITY NO. T R A - 2 1 - 9 5 9 2

17. LIST VA MEDICAL CENTER(S) (VAMC) AND DEPARTMENT OF DEFENSE (DOD) MILITARY TREATMENT FACILITIES (MTF) WHERE YOU RECEIVED TREATMENT AFTER DISCHARGE FOR YOUR CLAIMED DISABILITY(IES) LISTED IN ITEM 16 AND PROVIDE APPROXIMATE BEGINNING DATE (Month and Year) OF TREATMENT:

NOTE: If treatment began from 2005 to present, you do not need to provide dates in Item 17B.

A. ENTER THE DISABILITY TREATED AND NAME/LOCATION OF THE TREATMENT FACILITY	B. DATE OF TREATMENT (MM-YYYY)	C. CHECK THE BOX IF YOU DO NOT HAVE DATE(S) OF TREATMENT
Baltimore Vet Center	1 0 - 2 0 2 0	<input type="radio"/> Don't have date
		<input type="radio"/> Don't have date
		<input type="radio"/> Don't have date
		<input type="radio"/> Don't have date

NOTE: IF YOU WISH TO CLAIM ANY OF THE FOLLOWING, COMPLETE AND ATTACH THE REQUIRED FORM(S) AS STATED BELOW.

(VA forms are available at www.va.gov/vaforms)

For:	Required Form(s):
Supplemental Claims	VA Form 20-0995, <i>Decision Review Request: Supplemental Claim</i>
Dependents	VA Form 21-686c and, if claiming a child aged 18-23 years and in school, VA Form 21-674
Individual Unemployability	VA Form 21-8940 and 21-4192
Post-Traumatic Stress Disorder	VA Form 21-0781 or 21-0781a
Specially Adapted Housing or Special Home Adaptation	VA Form 26-4555
Auto Allowance	VA Form 21-4502
Veteran/Spouse Aid and Attendance benefits	VA Form 21-2680 or, if based on nursing home attendance, VA Form 21-0779

SECTION V: SERVICE INFORMATION

18A. DID YOU SERVE UNDER ANOTHER NAME? <input type="radio"/> YES (If "Yes," complete Item 18B) <input checked="" type="radio"/> NO (If "No," skip to Item 19A)		18B. LIST THE OTHER NAME(S) YOU SERVED UNDER:	
19A. BRANCH OF SERVICE <input checked="" type="radio"/> ARMY <input type="radio"/> NAVY <input type="radio"/> MARINE CORPS <input type="radio"/> AIR FORCE <input type="radio"/> COAST GUARD <input type="radio"/> SPACE FORCE		19B. COMPONENT <input checked="" type="radio"/> ACTIVE <input type="radio"/> RESERVES <input type="radio"/> NATIONAL GUARD	
20A. MOST RECENT ACTIVE SERVICE DATES (MM,DD,YYYY) ENTRY DATE: Month Day Year 1 0 - 1 4 - 2 0 1 6 EXIT DATE: 1 0 - 1 7 - 2 0 2 0		20B. PLACE OF LAST OR ANTICIPATED F o r t H u a c h u c a	
20C. DID YOU SERVE IN A COMBAT ZONE SINCE 9-11-2001? <input checked="" type="radio"/> YES <input type="radio"/> NO	20D. ADDITIONAL PERIODS OF SERVICE (Indicate enlistment and discharge date(s), if applicable)		
21A. ARE YOU CURRENTLY SERVING OR HAVE YOU EVER SERVED IN THE RESERVES OR NATIONAL GUARD? <input type="radio"/> YES (If "Yes," complete Items 21B thru 21F) <input checked="" type="radio"/> NO (If "No," skip to Item 22A)		21B. COMPONENT <input type="radio"/> NATIONAL GUARD <input type="radio"/> RESERVES	21C. OBLIGATION TERM OF SERVICE Month Day Year From: - - To: - -
21D. CURRENT OR LAST ASSIGNED NAME AND ADDRESS OF UNIT:		21E. CURRENT OR ASSIGNED PHONE NUMBER OF UNIT (Include Area Code)	21F. ARE YOU CURRENTLY RECEIVING INACTIVE DUTY TRAINING PAY? <input type="radio"/> YES <input type="radio"/> NO
22A. ARE YOU CURRENTLY ACTIVATED ON FEDERAL ORDERS WITHIN THE NATIONAL GUARD OR RESERVES? <input type="radio"/> YES (If "Yes," complete Items 22B & 22C) <input checked="" type="radio"/> NO	22B. DATE OF ACTIVATION: Month Day Year - - -		22C. ANTICIPATED SEPARATION DATE: Month Day Year - - -
23A. HAVE YOU EVER BEEN A PRISONER OF WAR? <input type="radio"/> YES (If "Yes," complete Item 23B) <input checked="" type="radio"/> NO	23B. DATES OF CONFINEMENT		
	From: Month Day Year - - -		To: Month Day Year - - -
	Month Day Year - - -		Month Day Year - - -

VETERANS SOCIAL SECURITY NO. T R A — 2 1 — 9 5 9 2

SECTION VI: SERVICE PAY (Retired Pay, Separation Pay, and Disability Severance Pay)

24A. ARE YOU RECEIVING MILITARY RETIRED PAY?

- ☐ YES (If "Yes," complete Items 24C and 24D)
- ☒ NO

24B. WILL YOU RECEIVE MILITARY RETIRED PAY IN THE FUTURE?

- ☐ YES (If "Yes," explain below (e.g. future Reserve/National Guard retirement, pending MEB/PEB and also complete Items 24C and 24D))
- ☐ NO

24C. BRANCH OF SERVICE

- ☐ ARMY ☐ MARINE CORPS
- ☐ AIR FORCE ☐ COAST GUARD
- ☐ NAVY ☐ SPACE FORCE

24D. MONTHLY AMOUNT

\$, .00

25. RETIRED STATUS

- ☐ RETIRED ☐ PERMANENT DISABILITY RETIRED LIST
- ☐ TEMPORARY DISABILITY RETIRED LIST

IMPORTANT INFORMATION ON MILITARY RETIRED PAY (Includes all Uniformed Services Retired Pay):

Submission of this application constitutes a waiver of military retired pay in an amount equal to VA compensation awarded, if you are entitled to both benefits. Your retired pay may be reduced by the amount of VA compensation awarded. Receipt of the full amount of military retired pay and VA compensation at the same time **may** result in an overpayment, which **may** be subject to collection. If you qualify for concurrent receipt of VA compensation and military retired pay, the waiver of retired pay will not apply. If you do not want to waive any retired pay to receive VA compensation, you should check the box in **Item 26**.

Note that if you check the box in Item 26, you will not receive VA compensation, if granted. If you are currently in receipt of VA compensation and you check the box in Item 26, your VA compensation will be terminated, if you are also eligible for military retired pay.

IMPORTANT: VA COMPENSATION PAY IS NON-TAXABLE. THEREFORE, VA COMPENSATION PAY MAY BE THE GREATER BENEFIT.

- ☐ 26. Do NOT pay me VA compensation. I do NOT want to receive VA compensation in lieu of retired pay.

IMPORTANT INFORMATION ON SEPARATION/SEVERANCE PAY:

VA compensation, if granted, may be withheld to recoup any disability severance or separation pay such as involuntary separation pay, voluntary separation pay, or special separation benefit, you receive from your branch of service. In addition, if you receive a Voluntary Separation Incentive (VSI), your VSI payments may be reduced if you are awarded VA compensation. Receipt of VA compensation and VSI at the same time may result in an overpayment of VSI, which **may** be subject to collection.

27A. HAVE YOU EVER RECEIVED SEPARATION PAY, DISABILITY SEVERANCE PAY, OR ANY OTHER LUMP SUM PAYMENT FROM YOUR BRANCH OF SERVICE?

- ☐ YES (If "Yes," complete Items 27B through 27D)
- ☒ NO

27B. DATE PAYMENT RECEIVED (MM-DD-YYYY)

 - -

27C. BRANCH OF SERVICE

- ☐ ARMY ☐ NAVY ☐ MARINE CORPS
- ☐ AIR FORCE ☐ COAST GUARD ☐ SPACE FORCE

27D. AMOUNT RECEIVED

(Provide pre-tax amount)

\$, .00**IMPORTANT INFORMATION ON INACTIVE DUTY TRAINING PAY:**

You may elect to keep the active or inactive duty training pay you received from the military service department. However, to be legally entitled to keep your training pay, you must waive VA benefits for the number of days equal to the number of days for which you received training pay. In most instances, it will be to your advantage to waive your VA benefits and keep your training pay.

If you waive VA benefits to receive training pay by checking the box in **Item 28**, VA will retroactively adjust your VA award to withhold benefits equal to the total number of training days waived and at the monthly rate in effect for the fiscal year period for which you received training pay. This action may result in an overpayment of compensation, which **may** be subject to collection.

IMPORTANT: VA COMPENSATION PAY IS NON-TAXABLE. THEREFORE VA COMPENSATION PAY MAY BE THE GREATER BENEFIT.

- ☐ 28. Do NOT pay me VA compensation. I do NOT want to receive VA compensation in lieu of training pay.

SECTION VII: DIRECT DEPOSIT INFORMATION

The Department of the Treasury requires all Federal benefit payments be made by electronic funds transfer (EFT), also called direct deposit. To enroll in direct deposit, provide the information requested below, **and** attach either a voided personal check **or** a deposit slip. If you **do not** have a bank account, please visit <https://www.benefits.va.gov/benefits/banking.asp>. This website provides information about the Veterans Benefits Banking Program (VBBP), and a link to banks and credit unions that may fit your needs. You may also call 1-800-827-1000. If you elect not to enroll, you must contact representatives handling waiver requests for the Department of the Treasury at 1-888-224-2950. They will encourage your participation in EFT and address any questions or concerns you may have.

- ☐ 29. I CERTIFY THAT I DO NOT HAVE AN ACCOUNT WITH A FINANCIAL INSTITUTION OR CERTIFIED PAYMENT AGENT (If you check this box skip to Section VIII)

30. ACCOUNT NUMBER (Check only **one** box below and provide the account number)Account No.: ☐ CHECKING ☐ SAVINGS

31. NAME OF FINANCIAL INSTITUTION (Provide the name of the bank where you want your direct deposit)

A l r e a d y p r o v i d e

32. ROUTING OR TRANSIT NUMBER (The first nine numbers located at the bottom left of your check)

SECTION VIII: CLAIM CERTIFICATION AND SIGNATURE**VETERAN/SERVICEMEMBER CERTIFICATION AND SIGNATURE**

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. For the limited purpose of providing VA with this information as it may relate to my claim, I waive any privilege that may apply and would otherwise make the information confidential and not disclosable.

I certify I have received the notice attached to this application titled, *Notice to Veteran/Service Member of Evidence Necessary to Substantiate a Claim for Veterans Disability Compensation and Related Compensation 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 1, on page 8, indicating I want my claim processed under the standard claim process because I plan to submit additional evidence in support of my claim.

33A. VETERAN/SERVICE MEMBER SIGNATURE (REQUIRED)

Homer T Cornblatt

33B. DATE SIGNED (MM-DD-YYYY)

1 0 — 1 4 — 2 0 2 1

SECTION IX: WITNESSES TO SIGNATURE

34A. SIGNATURE OF WITNESS (Sign in ink) (Note: Only sign if veteran signed in Item 33A using an "X")

34B. PRINTED NAME AND ADDRESS OF WITNESS

35A. SIGNATURE OF WITNESS (Sign in ink) (Note: Only sign if veteran signed in Item 33A using an "X")

35B. PRINTED NAME AND ADDRESS OF WITNESS

**SECTION X: ALTERNATE SIGNER CERTIFICATION AND SIGNATURE
(NOTE: REQUIRED ONLY IF ITEM 33A IS BLANK)**

I certify that by signing on behalf of the claimant, that I am a court-appointed representative; **OR**, an attorney in fact or agent authorized to act on behalf of a claimant under a durable power of attorney; **OR**, a person who is responsible for the care of the claimant, to include but not limited to a spouse or other relative; **OR**, a manager or principal officer acting on behalf of an institution which is responsible for the care of an individual; **AND**, that the claimant is under the age of 18; **OR**, is mentally incompetent to provide substantially accurate information needed to complete the form, or to certify that the statements made on the form are true and complete; **OR**, is physically unable to sign this form.

I understand that I may be asked to confirm the truthfulness of the answers to the best of my knowledge under penalty of perjury. I also understand that VA may request further documentation or evidence to verify or confirm my authorization to sign or complete an application on behalf of the claimant if necessary. Examples of evidence which VA may request include: Social Security Number (SSN) or Taxpayer Identification Number (TIN); a certificate or order from a court with competent jurisdiction showing your authority to act for the claimant with a judge's signature and a date/time stamp; copy of documentation showing appointment of fiduciary; durable power of attorney showing the name and signature of the claimant and your authority as attorney in fact or agent; health care power of attorney, affidavit or notarized statement from an institution or person responsible for the care of the claimant indicating the capacity or responsibility of care provided; or any other documentation showing such authorization.

36A. ALTERNATE SIGNER SIGNATURE (REQUIRED)

36B. DATE SIGNED (MM-DD-YYYY)

— — — — —

**SECTION XI: POWER OF ATTORNEY (POA) SIGNATURE
(NOTE: POA'S CANNOT SIGN FOR AN ORIGINAL CLAIM ONLY)**

I certify that the claimant has authorized the undersigned representative to file this claim on behalf of the claimant and that the claimant is aware and accepts the information provided in this document. I certify that the claimant has authorized the undersigned representative to state that the claimant certifies the truth and completion of the information contained in this document to the best of claimant's knowledge.

NOTE: A POA's signature **will not** be accepted unless at the time of submission of this claim a valid VA Form 21-22, *Appointment of Veterans Service Organization as Claimant's Representative*, or VA Form 21-22a, *Appointment of Individual As Claimant's Representative*, indicating the appropriate POA is of record with VA.

37A. POA/AUTHORIZED REPRESENTATIVE SIGNATURE

37B. DATE SIGNED (MM-DD-YYYY)

— — — — —

PRIVACY ACT NOTICE: The form will be used to determine allowance to compensation 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 compensation. 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.

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.



Department of Veterans Affairs

**APPLICATION REQUEST TO ADD AND/OR
REMOVE DEPENDENTS****VA DATE STAMP**
(DO NOT WRITE
IN THIS SPACE)Received Centralized Mail Processing,
Janesville, WI 10/25/2021**INSTRUCTIONS:** Make sure you sign and date this form in Items 26A and 26B.
Note: Unless the claimant is the veteran's surviving spouse or a designated "alternate signer", the veteran **must** sign in Item 26A. When you have completed this form, you can mail or fax it to the address or the fax number shown at the bottom of Page 2. If you prefer you may complete and submit the form online at www.va.gov.**SECTION I: VETERAN/CLAIMANT'S IDENTIFICATION INFORMATION**(Note: Completion of this section is **REQUIRED** to process your request; any omission may delay processing)**NOTE:** You may complete the form online or by hand. If completed by hand, print the information requested in ink, neatly and legibly to help expedite processing of the form.

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

H o m e r T C o r n b l a t t

2. VETERAN'S SOCIAL SECURITY NUMBER

T R A - 2 1 - 9 5 9 2

3. VA FILE NUMBER

T R A 2 1 9 5 9 2

4. VETERAN'S DATE OF BIRTH

Month Day Year
0 1 - 1 5 - 1 9 9 6

5. CLAIMANT'S NAME (If other than veteran) (First, Middle Initial, Last)

6. CLAIMANT'S SOCIAL SECURITY NUMBER

7. VETERAN'S SERVICE NUMBER (If applicable)

8. TELEPHONE NUMBER (Include Area Code)

(555)555-1212

9. E-MAIL ADDRESS (Optional)

HCornblatt@email.com

10. COMPLETE MAILING ADDRESS OF VETERAN/CLAIMANT (Number and Street or Rural Route, P. O. Box, City, State, ZIP Code and Country)

No. & Street 3 1 H o p k i n s P l a z a
Apt./Unit Number City B a l t i m o r e
State/Province M D Country U S ZIP Code/Postal Code 2 1 2 0 1 -**SECTION II: INFORMATION NEEDED TO ADD SPOUSE**

11A. SPOUSE'S NAME (First, Middle Initial, Last)

S u s a n E C o r n b l a t t

11B. SPOUSE'S DATE OF BIRTH

Month Day Year
0 6 - 1 7 - 1 9 8 3

11C. SPOUSE'S SOCIAL SECURITY NUMBER (SSN) (If your spouse does not have an SSN, explain why in Section IX, Item 25, Remarks)

T R A - 8 3 - 5 9 6 5

11D. DATE OF MARRIAGE

Month Day Year
1 2 - 1 9 - 2 0 0 9

11E. PLACE OF MARRIAGE (City and State, County and State, or City and Country)

Baltimore, MD

11F. HOW WERE YOU MARRIED? (Check one)

- ☒
- RELIGIOUS CEREMONY (i.e. Minister, Priest, Rabbi, etc.) or CIVIL CEREMONY (i.e. Justice of the Peace)
-
- ☐
- COMMON LAW
- ☐
- TRIBAL
- ☐
- PROXY
-
- ☐
- OTHER (Explain)

12A. IS YOUR SPOUSE ALSO A VETERAN?

- ☐
- YES (If "YES," complete Items 12B and 12C)
-
- ☒
- NO

12B. SPOUSE'S VA FILE NUMBER (If applicable)

12C. SPOUSE'S SERVICE NUMBER (If applicable)

NOTE: If you are a veteran that VA is paying additional benefits for a stepchild and you no longer live with the stepchild's biological or adoptive parent, complete Section V.

13A. DO YOU LIVE TOGETHER?

- ☒
- YES
- ☐
- NO (If "NO," complete Items 13B and 13C)

13B. REASON FOR SEPARATION (For example, marital problems, job requirements, health, etc.)

13C. CURRENT MAILING ADDRESS OF SPOUSE (Number and Street or Rural Route, P.O. Box, City, State, ZIP Code and Country)

No. & Street 3 1 H o p k i n s P l a z a
Apt./Unit Number City B a l t i m o r e
State/Province M D Country U S ZIP Code/Postal Code 2 1 2 0 1 -

VETERAN'S SOCIAL SECURITY NO.

T R A - 2 1 - 9 5 9 2

NOTE: You **must** provide complete information about **your prior marriages** and **your current spouse's prior marriages**.

VETERAN/CLAIMANT'S PREVIOUS MARITAL INFORMATION

(If no prior marriages, this section may be left blank)

14A. DATE AND PLACE OF MARRIAGE		14B. TO WHOM MARRIED (First, Middle Initial, Last Name)	14C. REASON FOR TERMINATION (Death, Divorce, Annulment)	14D. DATE AND PLACE MARRIAGE TERMINATED	
MM/DD/YYYY	CITY & STATE, COUNTY & STATE, or CITY & COUNTRY			MM/DD/YYYY	CITY & STATE, COUNTY & STATE, or CITY & COUNTRY

CURRENT SPOUSE'S PREVIOUS MARITAL INFORMATION

(If no prior marriages, this section may be left blank)

15A. DATE AND PLACE OF MARRIAGE		15B. TO WHOM MARRIED (First, Middle Initial, Last Name)	15C. REASON FOR TERMINATION (Death, Divorce, Annulment)	15D. DATE AND PLACE MARRIAGE TERMINATED	
MM/DD/YYYY	CITY & STATE, COUNTY & STATE, or CITY & COUNTRY			MM/DD/YYYY	CITY & STATE, COUNTY & STATE, or CITY & COUNTRY

SECTION III: INFORMATION NEEDED TO ADD CHILD(REN)

(If claiming more than four children, fill out addendum (Page 12) and submit with application)

16A. NAME OF FIRST CHILD TO ADD (First, Middle Initial, Last)

B a r t S c o r n b l a t t

16B. SOCIAL SECURITY NUMBER

16C. DATE OF BIRTH

16D. PLACE OF BIRTH (Provide City and State, County and State, or City and Country)

Baltimore, MD

T R A - 9 4 - 9 7 9 8

Month Day Year
1 2 - 0 1 - 2 0 1 0

16E. IF THE CHILD DOES NOT LIVE WITH THE CLAIMANT, PROVIDE NAME OF PERSON THE CHILD RESIDES WITH

16F. IF THE CHILD DOES NOT LIVE WITH THE CLAIMANT, PROVIDE COMPLETE PHYSICAL ADDRESS WHERE CHILD RESIDES

16G. CHILD STATUS (Check all that apply)

- ☒ BIOLOGICAL
 ☐ 18-23 YEARS OLD AND IN SCHOOL (If checked, fill out VA Form 21-674)
 ☐ ADOPTED
 ☐ CHILD INCAPABLE OF SELF-SUPPORT
☐ CHILD PREVIOUSLY MARRIED (If checked, provide the date marriage ended and how the marriage ended in Item 16H)
 ☐ STEPCHILD (If checked, complete Item 16I)

16H. HOW AND WHEN MARRIAGE ENDED

DATE _____ (MM/DD/YYYY)
☐ ANNULLED
☐ DECLARED VOID
☐ OTHER (Explain)

16I. IF YOU CHECKED "STEPCHILD" IN ITEM 16G, IS STEPCHILD THE BIOLOGICAL CHILD OF YOUR SPOUSE?

- ☐ YES (If "Yes," provide the date the child entered veteran's household): _____ (MM/DD/YYYY)
☐ NO

VETERAN'S SOCIAL SECURITY NO.

T R A - 2 1 - 9 5 9 2

SECTION III: INFORMATION NEEDED TO ADD CHILD(REN) (Continued)
(If claiming more than four children, fill out addendum (Page 12) and submit with application)

17A. NAME OF **SECOND** CHILD TO ADD (First, Middle Initial, Last)

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17B. SOCIAL SECURITY NUMBER

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17C. DATE OF BIRTH

Month	Day	Year

17D. PLACE OF BIRTH (Provide City and State, County and State, or City and Country)

17E. IF THE CHILD DOES NOT LIVE WITH THE CLAIMANT PROVIDE NAME OF PERSON THE CHILD RESIDES WITH

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17F. IF THE CHILD DOES NOT LIVE WITH THE CLAIMANT, PROVIDE COMPLETE PHYSICAL ADDRESS WHERE CHILD RESIDES

17G. CHILD STATUS (Check all that apply)

- ☐ BIOLOGICAL
 ☐ 18-23 YEARS OLD AND IN SCHOOL (If checked, fill out VA Form 21-674)
 ☐ ADOPTED
 ☐ CHILD INCAPABLE OF SELF-SUPPORT
☐ CHILD PREVIOUSLY MARRIED (If checked, provide the date marriage ended and how the marriage ended in Item 17H)
 ☐ STEPCHILD (If checked, complete Item 17I)

17H. HOW AND WHEN MARRIAGE ENDED

DATE: _____ (MM/DD/YYYY) ☐ ANNULLED ☐ DECLARED VOID ☐ OTHER (Explain)

17I. IF YOU CHECKED "STEPCHILD" IN ITEM 17G, IS STEPCHILD THE BIOLOGICAL CHILD OF YOUR SPOUSE?

- ☐ YES (If "Yes," provide the date the child entered veteran's household): _____ (MM/DD/YYYY)
☐ NO

18A. NAME OF **THIRD** CHILD TO ADD (First, Middle Initial, Last)

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18B. SOCIAL SECURITY NUMBER

--	--	--	--	--	--	--	--	--

18C. DATE OF BIRTH

Month	Day	Year

18D. PLACE OF BIRTH (Provide City and State, County and State, or City and Country)

18E. IF THE CHILD DOES NOT LIVE WITH THE CLAIMANT PROVIDE NAME OF PERSON THE CHILD RESIDES WITH

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18F. IF THE CHILD DOES NOT LIVE WITH THE CLAIMANT, PROVIDE COMPLETE PHYSICAL ADDRESS WHERE CHILD RESIDES

18G. CHILD STATUS (Check all that apply)

- ☐ BIOLOGICAL
 ☐ 18-23 YEARS OLD AND IN SCHOOL (If checked, fill out VA Form 21-674)
 ☐ ADOPTED
 ☐ CHILD INCAPABLE OF SELF-SUPPORT
☐ CHILD PREVIOUSLY MARRIED (If checked, provide the date marriage ended and how the marriage ended in Item 18H)
 ☐ STEPCHILD (If checked, complete Item 18I)

18H. HOW AND WHEN MARRIAGE ENDED

DATE: _____ (MM/DD/YYYY) ☐ ANNULLED ☐ DECLARED VOID ☐ OTHER (Explain)

18I. IF YOU CHECKED "STEPCHILD" IN ITEM 18G, IS STEPCHILD THE BIOLOGICAL CHILD OF YOUR SPOUSE?

- ☐ YES (If "Yes," provide the date the child entered veteran's household): _____ (MM/DD/YYYY)
☐ NO

19A. NAME OF **FOURTH** CHILD TO ADD (First, Middle Initial, Last)

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19B. SOCIAL SECURITY NUMBER

--	--	--	--	--	--	--	--	--

19C. DATE OF BIRTH

Month	Day	Year

19D. PLACE OF BIRTH (Provide City and State, County and State, or City and Country)

19E. IF THE CHILD DOES NOT LIVE WITH THE CLAIMANT PROVIDE NAME OF PERSON THE CHILD RESIDES WITH

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19F. IF CHILD DOES NOT LIVE WITH THE CLAIMANT, PROVIDE COMPLETE PHYSICAL ADDRESS WHERE CHILD RESIDES

19G. CHILD STATUS (Check all that apply)

- ☐ BIOLOGICAL
 ☐ 18-23 YEARS OLD AND IN SCHOOL (If checked, fill out VA Form 21-674)
 ☐ ADOPTED
 ☐ CHILD INCAPABLE OF SELF-SUPPORT
☐ CHILD PREVIOUSLY MARRIED (If checked, provide the date marriage ended and how the marriage ended in Item 19H)
 ☐ STEPCHILD (If checked, complete Item 19I)

19H. HOW AND WHEN MARRIAGE ENDED

DATE: _____ (MM/DD/YYYY) ☐ ANNULLED ☐ DECLARED VOID ☐ OTHER (Explain)

19I. IF YOU CHECKED "STEPCHILD" IN ITEM 19G, IS STEPCHILD THE BIOLOGICAL CHILD OF YOUR SPOUSE?

- ☐ YES (If "Yes," provide the date the child entered veteran's household): _____ (MM/DD/YYYY)
☐ NO

T	R	A	-	2	1	-	9	5	9	2
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NOTE: If marriage ended as an annulment or declared void, use Section IX, Item 25, Remarks to explain.

20A. NAME OF FORMER SPOUSE (*First, Middle Initial, Last*)

[illegible]

20B. PLACE OF DIVORCE (Provide city and state, county and state, or city and country)

20C. DATE OF DIVORCE

Month

Day

Year

21A. DID YOU HAVE A STEPCHILD(REN) THAT WAS THE BIOLOGICAL OR ADOPTED CHILD(REN) OF THE FORMER SPOUSE LISTED IN ITEM 20A?

☐ YES (If "YES," list the name(s) of the stepchild(ren) here):

☐ NO (If "NO," skip to Section VI)

21B. ARE YOU STILL SUPPORTING YOUR STEPCHILD(REN) LISTED IN ITEM 21A?

☐ YES (If "YES," complete Items 21C through 21G)

☐ NO (If "NO," skip to Section VI)

21C. NAME OF STEPCHILD YOU ARE SUPPORTING	21D. IF STEPCHILD DOES NOT LIVE WITH YOU, PROVIDE THE NAME OF PERSON WITH WHOM STEPCHILD RESIDES	21E. IF STEPCHILD DOES NOT LIVE WITH YOU, PROVIDE A COMPLETE ADDRESS	21F. DATE STEPCHILD LEFT VETERAN'S HOUSEHOLD	21G. FINANCIAL SUPPORT PROVIDED
				<input type="checkbox"/> More than half <input type="checkbox"/> Half <input type="checkbox"/> Less than half
				<input type="checkbox"/> More than half <input type="checkbox"/> Half <input type="checkbox"/> Less than half
				<input type="checkbox"/> More than half <input type="checkbox"/> Half <input type="checkbox"/> Less than half
				<input type="checkbox"/> More than half <input type="checkbox"/> Half <input type="checkbox"/> Less than half

22A. DEPENDENT TYPE (Check all that apply)

☐ SPOUSE ☐ MINOR CHILD (UNDER 18 YEARS OLD) ☐ STEPCHILD ☐ ADOPTED ☐ DEPENDENT PARENT

☐ CHILD INCAPABLE OF SELF-SUPPORT ☐ 18-23 YEARS OLD AND IN SCHOOL

22B. NAME OF DEPENDENT(S)
(First, Middle Initial, Last)

22C. DATE OF DEATH
(MM/DD/YYYY)

22D. PLACE OF DEATH
(City & State, County & State, or City & Country)

23A. NAME OF CHILD (First, Middle Initial, Last)

[illegible]

23B. DATE OF MARRIAGE

Month

Day

Year

$$\begin{array}{|c|c|} \hline & \\ \hline \end{array} - \begin{array}{|c|c|} \hline & \\ \hline \end{array} - \begin{array}{|c|c|c|c|} \hline & & & \\ \hline \end{array}$$

(Please submit this page with the completed application if you have additional children to add to your claim. If more space is needed, please make additional copies of this page to submit with your application.)

1A. NAME OF CHILD TO ADD (<i>First, Middle Initial, Last</i>) <div></div>																																																											
1B. SOCIAL SECURITY NUMBER <div></div>																												1C. DATE OF BIRTH Month Day Year <div></div>																	1D. PLACE OF BIRTH (<i>Provide City and State, County and State, or City and Country</i>)														
1E. IF THE CHILD DOES NOT LIVE WITH THE CLAIMANT PROVIDE NAME OF PERSON THE CHILD RESIDES WITH <div></div>																																																											
1F. IF CHILD DOES NOT LIVE WITH THE CLAIMANT, PROVIDE COMPLETE PHYSICAL ADDRESS WHERE CHILD RESIDES																																																											
1G. CHILD STATUS (<i>Check all that apply</i>) <div><input type="checkbox"/> BIOLOGICAL <input type="checkbox"/> 18-23 YEARS OLD AND IN SCHOOL (<i>If checked, fill out VA Form 21-674</i>) <input type="checkbox"/> ADOPTED <input type="checkbox"/> CHILD INCAPABLE OF SELF-SUPPORT</div> <div><input type="checkbox"/> CHILD PREVIOUSLY MARRIED (<i>If checked, provide the date marriage ended and how the marriage ended in Item 1H</i>) <input type="checkbox"/> STEPCHILD (<i>If checked, complete Item 1I</i>)</div>																																																											
1H. HOW AND WHEN MARRIAGE ENDED DATE: _____ (<i>MM/DD/YYYY</i>) <input type="checkbox"/> ANNULLED <input type="checkbox"/> DECLARED VOID <input type="checkbox"/> OTHER (<i>Explain</i>)																																																											
1I. IF YOU CHECKED "STEPCHILD" IN ITEM 1G, IS STEPCHILD THE BIOLOGICAL CHILD OF YOUR SPOUSE? <div><input type="checkbox"/> YES (<i>If "Yes," provide the date the child entered veteran's household:</i> _____ (<i>MM/DD/YYYY</i>))</div> <div><input type="checkbox"/> NO</div>																																																											
2A. NAME OF CHILD TO ADD (<i>First, Middle Initial, Last</i>) <div></div>																																																											
2B. SOCIAL SECURITY NUMBER <div></div>																												2C. DATE OF BIRTH Month Day Year <div></div>																	2D. PLACE OF BIRTH (<i>Provide City and State, County and State, or City and Country</i>)														
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2H. HOW AND WHEN MARRIAGE ENDED DATE: _____ (<i>MM/DD/YYYY</i>) <input type="checkbox"/> ANNULLED <input type="checkbox"/> DECLARED VOID <input type="checkbox"/> OTHER (<i>Explain</i>)																																																											
2I. IF YOU CHECKED "STEPCHILD" IN ITEM 2G, IS STEPCHILD THE BIOLOGICAL CHILD OF YOUR SPOUSE? <div><input type="checkbox"/> YES (<i>If "Yes," provide the date the child entered veteran's household:</i> _____ (<i>MM/DD/YYYY</i>))</div> <div><input type="checkbox"/> NO</div>																																																											
3A. NAME OF CHILD TO ADD (<i>First, Middle Initial, Last</i>) <div></div>																																																											
3B. SOCIAL SECURITY NUMBER <div></div>																												3C. DATE OF BIRTH Month Day Year <div></div>																	3D. PLACE OF BIRTH (<i>Provide City and State, County and State, or City and Country</i>)														
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3H. HOW AND WHEN MARRIAGE DATE: _____ (<i>MM/DD/YYYY</i>) <input type="checkbox"/> ANNULLED <input type="checkbox"/> DECLARED VOID <input type="checkbox"/> OTHER (<i>Explain</i>)																																																											
3I. IF YOU CHECKED "STEPCHILD" IN ITEM 3G, IS STEPCHILD THE BIOLOGICAL CHILD OF YOUR SPOUSE? <div><input type="checkbox"/> YES (<i>If "Yes," provide the date the child entered veteran's household:</i> _____ (<i>MM/DD/YYYY</i>))</div> <div><input type="checkbox"/> NO</div>																																																											