



Department of Veterans Affairs

VA DATE STAMP  
(DO NOT WRITE IN THIS SPACE)

## APPLICATION FOR DISABILITY COMPENSATION AND RELATED COMPENSATION BENEFITS

**IMPORTANT:** Please read the Privacy Act and Respondent Burden on Page 14 before completing the form. Use this form to determine your eligibility for compensation. For more information, you can 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). If you prefer you may complete and submit the form online at [www.va.gov](http://www.va.gov). VA forms are available at [www.va.gov/vaforms](http://www.va.gov/vaforms).

1. SELECT THE TYPE OF CLAIM PROGRAM/PROCESS THAT APPLIES TO YOU. **NOTE:** Your claim will be processed as described on pages 1 through 8 unless one of the following special programs is selected. See Instruction pages 1 through 3 for definitions of the Fully Developed Claim (FDC) Program (Optional Expedited Process) or the Standard Claim Process.

- 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: VETERAN'S IDENTIFICATION INFORMATION

(If claim is not an original claim, only Section I, IV (if applicable), V 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, insert one letter per box, and completely fill in each applicable check box to help expedite processing of the form.

2. VETERAN/SERVICEMEMBER'S NAME (First, Middle Initial, Last)

M I C H A E L      T R O G E R S

3. SOCIAL SECURITY NUMBER (SSN)

6 4 1 - 8 2 - 4 3 9 7

4. HAVE YOU EVER FILED A CLAIM WITH VA?

YES     NO

(If "Yes," provide your file number in Item 5)

5. VA FILE NUMBER

4 7 D 9 F 2 Q 8

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

0 3 - 1 5 - 1 9 7 0

7. SERVICE NUMBER/DOD ID NUMBER (If applicable)

U S 3 X 9 1 5 7 2

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

  -   -    -    

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

5 5 5 - 9 0 8 - 2 7 3 4

Enter International Phone Number (If applicable)

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

No. & Street 7 8 2 5 O A K H O L L O W R D

Apt./Unit Number      City R I V E R T O N

State/Province K Y      Country U S      ZIP Code/Postal Code 4 0 4 7 2 -

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

M I C H A E L . T . R @ G M A I L . C O M

12. 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 13A through 13C.

13A. TYPE OF ADDRESS CHANGE (Complete if applicable) (Check only one box)

TEMPORARY       PERMANENT

13B. NEW ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)

No. & Street 7 8 2 5 O A K H O L L O W R D

Apt./Unit Number      City R I V E R T O N

State/Province K Y      Country U S      ZIP Code/Postal Code 4 0 4 7 2 -

13C. 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)

Month      Day      Year  
BEGINNING DATE:      -      -      -

Month      Day      Year  
ENDING DATE:      -      -      -