OMB Control No. 2900-0001
Respondent Burden: 15 minutes

Department of Veterans Affairs

VA DATE STAMP
DO NOT WRITE IN THIS SPACE

VETERAN'S SUPPLEMENTAL CLAIM FOR COMPENSATION

IMPORTANT: PLEASE READ THE PRIVACY ACT NOTICE AND RESPONDENT BURDEN INFORMATION BELOW BEFORE COMPLETING THIS FORM.

PART I - VETERAN'S IDENTIFYING INFORMATION

1. NAME OF VETERAN *(First, Middle, Last)*
Gulf War Veteran

2. VETERAN'S SOCIAL SECURITY NUMBER

3. VA FILE NUMBER

4. VETERAN'S ADDRESS *(Number, street or rural route, City or P.O., State and ZIP Code)*

5. TELEPHONE NUMBER(S)

A. DAYTIME *(Include Area Code)*

B. EVENING *(Include Area Code)*

6. E-MAIL ADDRESS *(If applicable)*

PART II - INFORMATION ABOUT CLAIM

7. I WOULD LIKE TO FILE A CLAIM FOR: (Check all that apply)

☒ **INCREASED EVALUATION** OF THE DISABILITY(IES) FOR WHICH I AM ALREADY SERVICE CONNECTED
(Provide the name of the disability(ies))
Migraine, Sinusitis

☒ **SERVICE CONNECTION** FOR NEW DISABILITY(IES) (List your new disability(ies))
Undiagnosed symptom of muscle pains as per CFR 38 section 3.317
Undiagnosed symptom of diarrhea as per CFR 38 Section 3.317

☐ **REOPENING** OF PREVIOUSLY DENIED DISABILITY(IES) (List your previously denied disability(ies))

☐ **DISABILITY(IES) SECONDARY** TO MY EXISTING SERVICE CONNECTED DISABILITY(IES)
(Provide the name of the disability(ies) and your service connected condition(s))

8A. NAME AND LOCATION OF VA MEDICAL CENTER THAT HAS MY RELEVANT TREATMENT RECORDS

8B. NAME AND ADDRESS OF MILITARY FACILITY THAT HAS MY RELEVANT TREATMENT RECORDS

8C. DO YOU HAVE PRIVATE TREATMENT RECORDS?

☒ YES ☐ NO

(If "Yes," please attach the treatment records to this form. If you would like to have VA request your private treatment records, please attach a VA Form 21-4142, Authorization and Consent to Release Information to the Department of Veterans Affairs, for each private treatment provider. The form is available at www.va.gov/vaforms.)

9. I WOULD LIKE TO FILE A CLAIM FOR OTHER VA BENEFITS (Check appropriate box)

☐ AID AND ATTENDANCE ☐ OTHER *(Specify benefit)*

☐ AUTOMOBILE ALLOWANCE

10. I WOULD LIKE TO FILE A CLAIM FOR ADDITIONAL BENEFITS BECAUSE MY SPOUSE IS SERIOUSLY DISABLED (Please provide spouse's name and social security number in Items 10A & 10B) ☐

A. SPOUSE'S NAME

B. SPOUSE'S SOCIAL SECURITY NO.

11A. VETERAN'S SIGNATURE (Do NOT print)

11B. DATE SIGNED

PRIVACY ACT NOTICE: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e. 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) as 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. Your obligation to respond is required to obtain or retain benefits. Giving us your SSN account information is mandatory. Applicants are required to provide their SSN under Title 38 USC 5101 (c) (1). The VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine maximum benefits under the law. The responses you submit are considered confidential (38 U.S.C. 5701). 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.

RESPONDENT BURDEN: We need this information to make an eligibility determination for veterans' filing supplemental compensation claims (38 U.S.C. 5101). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 15 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.whitehouse.gov/omb/library/OMBINV.VA.EPA.html#VA. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

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St. Pete,

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410th EVAC

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