

**APPLICATION FOR DEPENDENCY AND INDEMNITY COMPENSATION, DEATH
PENSION AND ACCRUED BENEFITS BY A SURVIVING SPOUSE OR CHILD
(INCLUDING DEATH COMPENSATION IF APPLICABLE)
VA FORM NUMBER 21-534**

A. QUESTIONS? GET FREE INFORMATION: If you have any questions about this form, how to fill it out, or need information about other Department of Veterans Affairs (VA) benefits, call us:

VA NATIONWIDE TOLL-FREE NUMBER:

1 -800 -827 -1000

(Hearing Impaired--TDD 1-800-829-4833)

B. YOU SHOULD USE THIS FORM TO:

(1) Apply for VA benefits you may be entitled to receive as a surviving spouse or child of a deceased veteran;

(2) Apply for any money VA owes the veteran but did not pay prior to death (called accrued benefits):

(3) If you apply for any one of these benefits, the law requires that we also consider you for the others.

(4) **SOCIAL SECURITY BENEFITS:** You can apply for Social Security (SS) benefits now by using the SSA-24 attached to this VA Form. (See pages 11 and 12.) You don't have to apply if you don't want to or if you already have. If you do want to apply, fill it out and leave it attached. We will send it to the Social Security Administration. They will then contact you.

C. WHEN YOU ARE DONE WITH THIS FORM: Mail it or take it to a VA Regional Office.

D. REGIONAL OFFICE ADDRESS: You should call the VA toll-free number, 1-800-827-1000, for the address or location of the Regional Office. You might find that office's address in the blue pages of your telephone book. It may be under "United States Government, Veterans Affairs."

IMPORTANT

E. PLEASE BEGIN BY FOLLOWING THE DETAILED INSTRUCTIONS. They begin on page 2.

F. PRINT ALL ANSWERS CLEARLY. If you must write the answers do so very clearly and plainly. If an answer is "None" or "O", write that. **YOUR ANSWER TO EVERY QUESTION IS IMPORTANT** to help us complete your claim.

G. YOU MUST SIGN AND DATE this application at the bottom of page 9.

H. MAKE A PHOTOCOPY OF THIS APPLICATION for your records before you mail it. Also, tear off and keep this instruction page and all other separate instruction pages.

INSTRUCTIONS FOR VA FORM 21-534

READ VERY CAREFULLY, DETACH, AND RETAIN THESE INSTRUCTION SHEETS FOR YOUR REFERENCE

CALL VA AT 1 800 827 1000 FOR FREE HELP WITH THIS FORM (HEARING IMPAIRED TDD 1 800 829 4833)

A. PAYMENT OF BENEFITS - GENERAL

(1) Dependency and Indemnity Compensation may be payable when (1) the veteran's death occurred in service, or (2) when a veteran dies of service-connected disability, or (3) in certain circumstances if a veteran rated totally disabled from service-connected disability dies from non-service-connected conditions.

(2) Death Pension may be payable when the death of a veteran with wartime service is not due to service, provided income is within applicable limits.

(3) A higher rate of benefits is payable to a surviving spouse who is a patient in a nursing home or otherwise determined to be in need of regular aid and attendance or who is permanently housebound due to disability.

(a) The rate of pension paid depends upon the amount of family income and the number of dependent children, according to a formula provided by law.

(b) If there is no surviving spouse, pension may be payable on behalf of a child or children.

(c) Because benefit rates and income limits are frequently changed, it is not possible to keep such information current in these instructions. Information regarding current income limitations and rates of benefits may be obtained by contacting your nearest VA office at 1 800 827 1000.

(4) Unless a claim for Dependency and Indemnity Compensation is filed within one year from date of death, that benefit is not payable from a date earlier than the date the claim is received in the VA.

(5) Unless a claim for pension is filed within 45 days from date of death, that benefit is not payable from a date earlier than the date the claim is received in the VA.

B. REPRESENTATION - You may be represented, without charge, by an accredited representative of a veterans organization or other service organization, recognized by the Secretary of the Veterans Affairs, or you may employ an attorney to assist you with your claim. Typical examples of counsel who may be available include attorneys in private practice or legal aid services. If you desire representation, let us know and we will send you the necessary forms. If you have already designated a representative, no further action is required on your part.

C. HEARINGS - You have the right to a personal hearing at any stage of claims processing, either before or after a decision is made. This right may be exercised with regard to an original claim, supplemental claim or with regard to any subsequent action affecting your entitlement. All you need do is inform the nearest VA office as to your desires, and we will arrange a time and place for the hearing. You may bring witnesses if you desire and their testimony will be entered in the record. VA will furnish the hearing room, provide hearing officials, and prepare the transcript of the proceedings. VA cannot pay any of your expenses in connection with the hearing.

D. HOW TO COMPLETE THE APPLICATION - ALL THE INFORMATION REQUESTED MUST BE ANSWERED FULLY AND CLEARLY OR ACTION ON YOUR CLAIM MAY BE DELAYED. IF YOU DO NOT KNOW THE ANSWER, WRITE "UNKNOWN."

E. MINORS AND INCOMPETENTS - If the person for whom the claim is being made is a minor or is incompetent, the application form should be completed and filed by the legal guardian or, if no legal guardian has been appointed, it may be completed and filed by some person acting on behalf of the minor or incompetent.

F. EVIDENCE - GENERAL - If you are unable to furnish with this application form any of the required evidence asked for anywhere in these instructions, state why you are unable on a separate sheet. Evidence filed previously with the Department of Veterans Affairs need not be filed again in connection with this claim at this time.

G. EVIDENCE - MEDICAL - A medical statement should accompany the application of a surviving spouse who is housebound or who requires the aid and attendance of another person if he or she is not a nursing home patient. A nursing home patient should furnish a statement signed by an official of the nursing home showing the date of admission and patient status. Also, indicate in Item 37, "Remarks," that you are a nursing home patient and give the name and address of the nursing home.

H. SERVICE INFORMATION (See application form, Part I, blocks 11A, 11B, 11C and 11D) - Complete information should be furnished for each period of the veteran's active service including service as a commissioned officer in the National Oceanic and Atmospheric Administration including officers of the Coast and Geodetic Survey and Environmental Science Services Administration or Public Health Service. If the veteran never filed a claim with the Department of Veterans Affairs, you should furnish the discharge or separation document issued by the service department for each period of service listed.

I. INFORMATION RELATING TO MARRIAGE (See application form Part II) - Complete information concerning all marriages entered into by either the surviving spouse or the veteran and the termination of such marriages must be furnished in Items 13 through 17. Specific details as to date, place and manner of dissolution of each marriage must be included. Show the month, day and year for "date". Show city and state for "place".

J. INFORMATION CONCERNING CHILDREN (See application form Part III)

(1) PROOF OF AGE AND RELATIONSHIP OF CHILD. Complete information concerning the birth of all children of the veteran must be furnished in Items 22 through 24. Show the month, day and year for "date." Show city and state for "place."

(2) HELPLESS CHILD. If any child is claimed as being permanently incapable of self-support by reason of mental or physical defect, it must be shown that such incapacity existed prior to the date the child attained age 18. The nature and extent of the physical or mental impairment should be shown by a statement from the attending physician or other medical evidence, forwarded with the application.

K. NET WORTH (See application form, Part IV)

(1) MINORS AND INCOMPETENTS.

(a) Custodian or Guardian of a Surviving Spouse - Report only the net worth of your ward.

(b) Custodian of Child(ren) - Report your net worth as well as the individual net worth of EACH CHILD for whom benefits are claimed.

(2) SURVIVING SPOUSE WITH CHILDREN. When a surviving spouse files application in his/her own right, the separate net worth of each child for whom benefits are claimed must also be reported.

(3) CHILDREN ALONE. When application is filed on behalf of a child in his or her own right, the child's net worth should be reported.

Item 25A - Include market value of stocks, checking accounts, bank deposits, savings and loan accounts, cash and currency.

Item 25B - Do not include the value of the single dwelling unit or that portion of real property used solely as your principal residence. On all other real estate reduce the market value by amount of any money owed on it such as mortgages or other indebtedness.

Item 25C - Report the total market value of all rights and interest in all other property not included in Items 25A and B. "Market value" is the price it would currently receive if sold in an open market. Do not include value of ordinary personal effects necessary for your daily living such as an automobile, clothing, furniture and the dwelling (single family unit) used as your principal residence.

Item 25D - Report the total of Items 25A through 25C. This should be your net worth.

L. INCOME OF SURVIVING SPOUSE AND/OR CHILD(REN) (See application form, Part V)

(1) MINORS AND INCOMPETENTS.

(a) Custodian or Guardian of a Surviving Spouse - Report only the income of your ward.

(b) Custodian of Child(ren) - Report your income as well as the individual income of each child for whom benefits are claimed.

(2) SURVIVING SPOUSE WITH CHILDREN. When a surviving spouse files application in his/her right, the separate income of each child for whom benefits are claimed must also be reported.

(3) FOREIGN CURRENCY EXCHANGE RATES. If you report income in foreign currency, we will convert it into dollars based on the average exchange rate for the preceding four quarters (as provided by the Department of the Treasury).

IMPORTANT

YOU MUST SHOW ALL TYPES OF PAYMENTS AND INCOMES FROM ALL SOURCES FOR YOURSELF, SPOUSE AND DEPENDENT CHILDREN BEFORE ANY DEDUCTIONS OR WITHHOLDINGS. UNDER 38 CFR 3.271(a), PAYMENTS OF ANY KIND FROM ANY SOURCE SHALL BE COUNTED AS INCOME UNLESS SPECIFICALLY EXCLUDED BY LAW. VA WILL DETERMINE ANY AMOUNT WHICH DOES NOT COUNT. INCLUDE ALL SEVERANCE PAY OR OTHER ACCRUED PAYMENTS OF ANY KIND OR FROM ANY SOURCE. WHEN NO INCOME IS RECEIVED OR EXPECTED FROM A SPECIFIED SOURCE, WRITE "NONE" IN THE APPROPRIATE BLOCK (ITEMS 26C THROUGH 28D). IF INCOME FROM ANY SOURCE IS ANTICIPATED BUT THE AMOUNT IS NOT YET DETERMINED, WRITE "UNDETERMINED" IN THE APPROPRIATE BLOCK. ATTACH SEPARATE SHEETS IF ADDITIONAL SPACE IS NEEDED.

Items 27F and 28D - When income is reported in these items, the source must be shown in "Remarks," Item 37. If that income is from two or more sources, list each amount separately and clearly indicate the source.

M. COURT OR CLAIM JUDGEMENT, SETTLEMENTS OR COMPROMISES. Money or property received as a result of a claim or legal action for damages based upon the death of the veteran may affect payment of Dependency and Indemnity Compensation or Pension. You must report whether a claim or court action is pending or whether a court decree or settlement or compromise of a claim for damages has been made.

N. DEDUCTIBLE EXPENSES (See application form, Part VI)

(1) If you have paid any expenses of last illness and burial or just debts of the veteran, report them in Part VI of the application. You should also report any expenses of last illness and burial of any children of the veteran, if applicable. Report only payments for which you will not be reimbursed. If you receive reimbursement after you have filed this claim, promptly advise the VA office handling your claim.

(2) Family medical expenses and educational or vocational rehabilitation expenses paid by you may affect your rate of pension. You should report these expenses at the end of the year.

(3) If you expect to have a continuing high level of unreimbursed medical expenses throughout the year (such as nursing home fees), please make a statement to that effect in "Remarks," Item 37.

PRIVACY ACT INFORMATION: No allowance of compensation or pension may be granted unless this form is completed fully as required by existing law (38 U.S.C. Chapters 13 and 15, Subchapter III). 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 under the law. Information submitted is subject to verification through computer matching programs with other agencies.

Income information and employment information furnished by you will be compared with information obtained by VA from the Secretary of Health and Human Services or the Secretary of the Treasury under clause (viii) of section 6103(1)(7)(D) of the Internal Revenue Code of 1986. Any information provided by you including your Social Security Number, may be used in matching programs conducted in connection with any proceeding for the collection of an amount owed the United States by virtue of your participation in any benefit program administered by the Department of Veterans Affairs.

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 1 hour and 15 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

Department of Veterans Affairs	(DO NOT WRITE IN THIS SPACE) VA DATE STAMP
APPLICATION FOR DEPENDENCY AND INDEMNITY COMPENSATION, DEATH PENSION AND ACCRUED BENEFITS BY A SURVIVING SPOUSE OR CHILD (INCLUDING DEATH COMPENSATION IF APPLICABLE)	

IMPORTANT - Read instructions carefully before completing this form. Answer all items fully. Detach and retain **ONLY** the instruction sheets. If more space is required, attach additional sheets and identify each answer by item number. Write clearly or print the answers.

1. NAME OF DECEASED VETERAN (<i>First, middle, last</i>)		2. VA FILE NO. XC/XSS	
3. IF VETERAN PREVIOUSLY APPLIED TO THE VA FOR ANY BENEFIT INSERT VA FILE NUMBER, IF KNOWN, AND IF DIFFERENT FROM ITEM 2	4. RAILROAD RETIREMENT	5. SOCIAL SECURITY NO. OF VETERAN	
6A. NAME OF CLAIMANT (<i>First, middle, last</i>)		6B. DAYTIME TELEPHONE NO. (<i>Include Area Code</i>)	
6C. MAILING ADDRESS OF CLAIMANT (<i>No. and street or rural route, City or P.O., State and ZIP Code</i>)		6D. RELATIONSHIP TO VETERAN (<i>Check One</i>) <input type="checkbox"/> SURVIVING SPOUSE <input type="checkbox"/> CHILD	
		6E. SOCIAL SECURITY NO. OF SURVIVING SPOUSE OR CLAIMANT	

PART I - IDENTIFICATION AND SERVICE INFORMATION OF VETERAN (See Instructions, Paragraph H)

7. DATE OF BIRTH	8. DATE OF DEATH	9. PLACE OF DEATH			
10. ARE YOU CLAIMING THAT THE CAUSE OF DEATH WAS DUE TO SERVICE? <input type="checkbox"/> YES <input type="checkbox"/> NO					
11A. ENTERED ACTIVE SERVICE		11B. SERVICE NO.	11C. SEPARATED FROM ACTIVE SERVICE		11D. GRADE, RANK OR RATING, ORGANIZATION AND BRANCH OF SERVICE
DATE	PLACE		DATE	PLACE	

12. IF VETERAN SERVED UNDER A NAME OTHER THAN THAT SHOWN IN ITEM 1, GIVE THAT FULL NAME, SERVICE DATES AND BRANCH OF SERVICE USING THAT NAME

PART II - INFORMATION RELATING TO MARRIAGE (See Instructions, Paragraph I)

INFORMATION RELATING TO VETERAN

13. HOW MANY TIMES WAS VETERAN MARRIED?

NOTE: Where a date is requested, show month, day, and year. Where a place is requested, show city and state.

14A. MARRIAGE		14B. TO WHOM MARRIED	14C. HOW MARRIAGE ENDED (<i>Death, divorce, etc.</i>)	14D. MARRIAGE ENDED	
DATE	PLACE			DATE	PLACE

INFORMATION RELATING TO SURVIVING SPOUSE

NOTE: If claimant is not veteran's surviving spouse, omit items 15 to 21 inclusive.

15. HOW MANY TIMES HAS SURVIVING SPOUSE BEEN MARRIED?			16. HAS SURVIVING SPOUSE REMARRIED SINCE DEATH OF VETERAN? <input type="checkbox"/> YES <input type="checkbox"/> NO		
NOTE: Where a date is requested, show month, day, and year. Where a place is requested, show city and state.					
17A. MARRIAGE		17B. TO WHOM MARRIED	17C. HOW MARRIAGE ENDED (<i>Death, divorce, etc.</i>)	17D. MARRIAGE ENDED	
DATE	PLACE			DATE	PLACE

YOU MUST SIGN AND DATE THIS FORM AT THE BOTTOM OF PAGE 9.

PART II - INFORMATION RELATING TO MARRIAGE (Continued)

18. DATE OF BIRTH OF SURVIVING SPOUSE	19. WAS A CHILD BORN OF THE SURVIVING SPOUSE'S MARRIAGE TO THE VETERAN OR WAS A CHILD BORN TO THEM PRIOR TO THE SURVIVING SPOUSE'S MARRIAGE TO THE VETERAN? <i>(Complete only if the surviving spouse was married to the veteran for less than one year)</i>
20. DID SURVIVING SPOUSE LIVE CONTINUOUSLY WITH THE VETERAN FROM DATE OF MARRIAGE TO DATE OF DEATH?	
<input type="checkbox"/> YE <input type="checkbox"/> NO <i>(If "NO," complete item 21)</i>	
21. CAUSE OF SEPARATION <i>(Explain fully, giving reason, date of separation, duration, etc. If separation was by court order, attach a copy of such order)</i>	

PART III - INFORMATION CONCERNING CHILDREN (See Instructions, Paragraph J)

IDENTIFICATION OF CHILDREN AND INFORMATION RELATIVE TO CUSTODY

NOTE - List below the name of each child of the veteran who is (1) under 18 years of age (or under 23 years of age if attending school) or (2) of any age if permanently incapable of self-support by reason of mental or physical defect. The term "child" includes an illegitimate, adopted, or stepchild of the veteran as well as any child whose marriage has been terminated by divorce, annulment, or death of a spouse. If the birth of a child of a veteran is expected, that fact should be stated.

22A. NAME OF CHILD <i>(First, middle initial, last)</i>	22B. DATE OF BIRTH <i>(Mo., day, yr.)</i>	22C. PLACE OF BIRTH <i>(CITY AND STATE)</i>	22D. SOCIAL SECURITY NO. OF CHILD	22E. IDENTIFY <i>(Check each applicable category)</i>				
				MARRIED PREVIOUSLY	STEPCHILD OR ADOPTED	ILLEGITIMATE	OVER 18 ATTENDING SCHOOL	SERIOUSLY DISABLED

23. NAME OF ANY CHILDREN NOT IN YOUR CUSTODY	24. MONTHLY AMOUNT YOU CONTRIBUTE TO CHILD'S SUPPORT
	\$
	\$
	\$
	\$

PART IV - NET WORTH OF SURVIVING SPOUSE AND/OR CHILD/REN (See Instructions, Paragraph K)

ITEM NO.	SOURCE	AMOUNTS				
		SURVIVING SPOUSE OR CUSTODIAN OF CHILDREN	NAME OF CHILD/REN			
25A.	STOCKS, BONDS, BANK DEPOSITS	\$	\$	\$	\$	\$
25B.	REAL ESTATE <i>(Do not include residence)</i>	\$	\$	\$	\$	\$
25C.	OTHER	\$	\$	\$	\$	\$
25D.	NET WORTH	\$	\$	\$	\$	\$

YOU MUST SIGN AND DATE THIS FORM AT THE BOTTOM OF PAGE 9.

PART V INCOME OF SURVIVING SPOUSE AND/OR CHILDREN AND CUSTODIAN OF CHILD/REN

(Important - Carefully read paragraph L of Instructions before completing this section)

SOCIAL SECURITY

26A. HAVE YOU APPLIED FOR OR ARE YOU RECEIVING OR ENTITLED TO RECEIVE BENEFITS FROM THE SOCIAL SECURITY ADMINISTRATION ON YOUR OWN BEHALF OR ON BEHALF OF A CHILD/REN IN YOUR CUSTODY? <input type="checkbox"/> YE <input type="checkbox"/> NO	26B. BEGINNING DATE (Month, year)
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	MONTHLY	SURVIVING SPOUSE OR CUSTODIAN OF CHILDREN	EACH CHILD'S SHARE
26C.	AMOUNT OF MONTHLY SOCIAL SECURITY CHECK	\$	\$
26D.	ADDITIONAL MEDICARE DEDUCTIO		
26E.	TOTAL MONTHLY BENEFITS (Sum of 26C and 26D)	\$	\$

26F. IS SOCIAL SECURITY BASED ON YOUR OWN EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	26G. DO YOU EXPECT YOUR SOCIAL SECURITY BENEFITS TO INCREASE AS A RESULT OF THE VETERAN'S DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
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REPORT GROSS MONTHLY INCOME, BY SOURCE, INCLUDING ANY MONTHLY DEDUCTIONS FOR EACH FAMILY MEMBER

ITE NO.	SOURC	SURVIVIN SPOUSE OR DIAN OF	AMOUNT OF INCOME			BEGINNING DATE
			NAME OF			MONTH/YEAR
			NAME	NAME	NAME	
27A.	U.S. CIVIL		\$	\$	\$	
27B.	U.S. RAILROAD		\$	\$	\$	
27C.	MILITARY		\$	\$	\$	
27D.	BLACK LUNG		\$	\$	\$	
27E.	SUPPLEMENTAL SECURITY INCOME/PUBLIC ASSISTANCE		\$	\$	\$	
27F.	ALL OTHER INCOME (Specify source - for additional space, use Item 37, "Remarks")		\$	\$	\$	

REPORT EXPECTED GROSS INCOME (OR ONE-TIME INCOME) FOR THE 12 MONTH PERIOD FROM DATE OF VETERAN'S DEATH OR, IF CLAIM IS FILED MORE THAN 45 DAYS AFTER THE VETERAN DIED, THE 12 MONTH PERIOD FROM THE DATE THE CLAIM IS SIGNED.

ITE NO.	SOURC	SURVIVIN SPOUSE OR DIAN OF	AMOUNT OF INCOME			BEGINNING DATE
			NAME OF CHILDREN			MONTH/YEAR
			NAME	NAME	NAME	
28A.	EARNING		\$	\$	\$	
28B.	DIVIDENDS, INTEREST,		\$	\$	\$	
28C.	LIFE		\$	\$	\$	
28D.	ALL OTHER INCOME (Specify source - for additional space, use Item 37, "Remarks")		\$	\$	\$	

YOU MUST SIGN AND DATE THIS FORM AT THE BOTTOM OF PAGE 9.

PART VI - DEDUCTIBLE EXPENSES

NOTE: Your income may be reduced by the amount of unreimbursed expenses of the veteran's or his/her child's last illness and burial and the veteran's just debts which were paid by you. Be sure to report any reimbursement received on these expenses or debts. See paragraph N of instructions for reporting payments and reimbursements made after filing of your claim.

29A. NAME AND ADDRESS OF PERSON TO WHOM PAID	29B. TOTAL AMT. OF EXPENSE OR DEBT	29C. NATURE OF EXPENSE OR DEBT	29D. DATE PAID	29E. AMOUNT PAID BY YOU
	\$			\$
	\$			\$
	\$			\$
	\$			\$
	\$			\$
	\$			\$

PART VII - MISCELLANEOUS INFORMATION

30. HAS A SURVIVING SPOUSE OR CHILD FILED A CLAIM FOR COMPENSATION FROM THE OFFICE OF WORKER'S COMPENSATION PROGRAMS BECAUSE OF DEATH OF VETERAN ON WHOSE SERVICE THIS CLAIM IS FILED?
 YES NO

31. IS A CLAIM OR COURT ACTION PENDING OR HAS A COURT DECREE AWARDING DAMAGES ON A SETTLEMENT OR COMPROMISE OF A CLAIM BASED ON THE DEATH OF THE VETERAN BEEN MADE?
 YES NO (If "YES," explain in Item 37, "Remarks")

32. IS A CLAIM FOR SURVIVOR BENEFIT PLAN (SBP) ANNUITY FROM A SERVICE DEPARTMENT PENDING OR HAS AN AWARD OF THE SBP ANNUITY BEEN MADE BASED ON THE DEATH OF THE VETERAN?
 YES NO (If "YES," explain in Item 37, "Remarks")

33A. HAS THE SURVIVING SPOUSE OR CHILD FILED A CLAIM PREVIOUSLY WITH THE VA? <input type="checkbox"/> YES <input type="checkbox"/> NO (If "YES," complete Items 33B through 35 inclusive)	33B. NAME OF PERSON ON WHOSE SERVICE CLAIM WAS MADE	33C. RELATIONSHIP TO CLAIMANT
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34. VA FILE NO.	35. OFFICE WHERE CLAIM WAS FILED (City and state)
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36A. ARE YOU NOW A PATIENT IN A NURSING HOME? <input type="checkbox"/> YES <input type="checkbox"/> NO (If "YES," complete Item 36B)	36B. DOES MEDICAID COVER ALL OR PART OF YOUR NURSING HOME COSTS? <input type="checkbox"/> YES <input type="checkbox"/> NO (If "YES," give the name and address of nursing home in Item 37, "Remarks")
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37. REMARKS (If additional space is needed, attach separate sheet)

37. REMARKS (Continued)

PART VIII - DIRECT DEPOSIT INFORMATION

All Federal payments made to a person who applied and became eligible for benefit payments after July 26, 1996, must be made by electronic funds transfer (EFT). This requirement cannot be waived by the VA unless you certify that you do not have an account with a financial institution or an authorized payment agent. VA payments to you will be made EFT unless you certify that you do not have an account with a financial institution or an authorized payment agent. Please attach a voided personal check or deposit slip or provide all of the following information:

38. ACCOUNT NUMBER - PLEASE CHECK THE APPROPRIATE BOX AND PROVIDE THAT ACCOUNT NUMBER, IF APPLICABLE

- CHECKING I CERTIFY THAT I DO NOT HAVE AN ACCOUNT WITH A FINANCIAL INSTITUTION OR CERTIFIED PAYMENT AGENT
 SAVINGS ACCOUNT NUMBER _____

39. NAME OF FINANCIAL INSTITUTION

40. ROUTING OR TRANSIT NUMBER

CERTIFICATION AND AUTHORIZATION FOR RELEASE OF INFORMATION - I CERTIFY THAT the foregoing statements are true and complete to the best of my knowledge and belief. 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 the **DEPARTMENT OF VETERANS AFFAIRS** any information about myself, and I waive any privilege which renders such information confidential.

41A. DAYTIME TELEPHONE NO. (Include Area Code)

41B. EVENING TELEPHONE NO. (Include Area Code)

42. SIGNATURE OF CLAIMANT, CUSTODIAN OR GUARDIAN

43. DATE SIGNED

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. The signature and printed names and addresses of the witnesses must be shown.


44A. SIGNATURE AND PRINTED NAME OF WITNESS

44B. ADDRESS OF WITNESS

45A. SIGNATURE AND PRINTED NAME OF WITNESS

45B. 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES		SOCIAL SECURITY ADMINISTRATION APPLICATION FOR SURVIVORS BENEFITS (PAYABLE UNDER TITLE II OF THE SOCIAL SECURITY ACT) IMPORTANT- Read instructions before completing form. Detach and retain ONLY the instruction sheet		(DO NOT WRITE IN THIS SPACE) VA DATE STAMP	
1. FIRST NAME - MIDDLE NAME - LAST NAME OF VETERAN <i>(Type or print)</i>			2. DATE OF DEATH		
NOTE: If the veteran's Social Security No. is unknown complete Items 4, 5, 6 and 7 about veteran.					
3. SOCIAL SECURITY NO. OF VETERAN		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. NAME OF FATHER		7. MAIDEN NAME OF MOTHER		8. DID THE VETERAN WORK IN THE RAILROAD INDUSTRY AT ANY TIME AFTER 1936? <input type="checkbox"/> YES <input type="checkbox"/> NO	
NOTE: The following information should be furnished for each period of the veteran's active service (regular or reserves) after September 7, 1939, in the military service of the United States or service as a commissioned officer in the Public Health Service or the National Oceanic and Atmospheric Administration or during WWII, Philippine or Filipino or Allied country military service. If additional space is needed, attach a separate sheet.					
9A. DATE ENTERED ACTIVE SERVICE		9B. SERVICE NO.	9C. DATE SEPARATED FROM ACTIVE SERVICE		9D. GRADE, RANK, OR RATING, ORGANIZATION AND BRANCH OF SERVICE
10. RELATIONSHIP OF APPLICANT TO VETERAN <input type="checkbox"/> SURVIVING SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT			11. DATE OF BIRTH OF APPLICANT		12. VA FILE NO.
CHILDREN: Show name of surviving children (including natural children, adopted children and stepchildren) or dependent grandchildren (including stepgrandchildren) who at any time since the veteran died, were unmarried and (a) under age 18; (b) age 18 to 19 and attending secondary school; (c) disabled or handicapped (18 or over and disability been before age 22).					
13A.			13B.		
13C.			13D.		
I know that anyone who makes or causes to be made a false statement or representation of a material fact in an application or for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law by fine, imprisonment, or both. I affirm that all information I have given in this document is true.					
14. DATE <i>(Month, day, year)</i>		15. SIGNATURE OF APPLICANT <i>(First name, middle initial, last name) (Sign in ink)</i> SIGN HERE 			
16. MAILING ADDRESS OF APPLICANT <i>(No. and street or rural route, city or P.O., State and ZIP Code)</i>				17. TELEPHONE NO. <i>(Include Area Code)</i>	
WITNESSES REQUIRED ONLY IF SIGNATURE OF APPLICANT IS MADE BY "X" MARK ABOVE					
18A. SIGNATURE OF WITNESS			18B. ADDRESS OF WITNESS <i>(No. and street, city, State and ZIP Code)</i>		
19A. SIGNATURE OF WITNESS			19B. ADDRESS OF WITNESS <i>(No. and street, city, State and ZIP Code)</i>		
ITEMS BELOW TO BE COMPLETED BY THE DEPARTMENT OF VETERANS AFFAIRS Use reverse for "Remarks"					
20. PROOFS RECEIVED <input type="checkbox"/> DEATH <input type="checkbox"/> MARRIAGE <input type="checkbox"/> AGE _____ (NAME) <input type="checkbox"/> OTHER <i>(Specify)</i> _____ (NAME) _____ (NAME)			21. PROOFS REQUESTED FROM CLAIMANT OR OTHER <i>(Specify)</i> <input type="checkbox"/> DEATH <input type="checkbox"/> MARRIAGE <input type="checkbox"/> AGE _____ (NAME) <input type="checkbox"/> OTHER <i>(Specify)</i> _____ (NAME) _____ (NAME)		
22. DATE		23. NAME AND ADDRESS OF TRANSMITTING VA OFFICE			

**IMPORTANT: PLEASE READ THE FOLLOWING BEFORE YOU COMPLETE THE SSA-24.
INSTRUCTIONS FOR COMPLETING FORM SSA-24, APPLICATION FOR SURVIVORS
BENEFITS (Payable Under Title II of the Social Security Act)**

This application form, SSA-24, is an Application for Survivors Benefits Payable under Title II of the Social Security Act, as amended. Under authority of section 202(o) of the Social Security Act the application requests information in order to determine eligibility to social security benefits.

You do not have to complete this application; there are no penalties under the law if you do not complete part or all of the SSA-24. However, it is usually to your advantage to provide the information because not providing it could prevent an accurate and timely decision on your claim or could result in the loss of some benefits or insurance coverage.

If you do wish to supply the information requested on the SSA-24, this information will be forwarded to the Social Security Administration and used by them to determine whether social security benefits may be payable to surviving dependent(s) of the veteran. Social Security will then contact you regarding any social security benefits payable based on information given on this form.

Please understand that Social Security may, in certain instances, disclose the information on this form to another Federal, State or local agency or individual without your written consent. This would be done in order to:

enable a third party or an agency to assist Social Security in establishing an individual's right to benefits or coverage;

comply with Federal laws which require or authorize the release of information from social security records; and

facilitate statistical research and audit activities necessary to assure the integrity and improvement of the social security programs.

If you should have any question about entitlement to social security benefits or the information you have provided on this form, please contact your local social security office.

Complete each item of the attached application, Form SSA-24, (except the Items 20 through 23). When signed and dated the form **SHOULD BE LEFT ATTACHED** to your completed VA Form 21-534, Application for Dependency and Indemnity Compensation, Death Pension and Accrued Benefits by a Surviving Spouse or Child (Including Death Compensation if Applicable).