

제대 군인 유족 안내서

주한미군 기지 & 미 8군 제대군인협회
& 미 8군 부상자 및 영현 부서
한국, 캠프 험프리스
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목차:

1. 목적	3
2. 도움 요청	3
3. 제대 군인의 사망 신고	3
4. 정부 금융 기관 연락	4
5. 미 8군 영현 부서	8
6. 사망 확인서 발급	10
7. 개인 서류 및 안내서 지참	13
8. 생명 보험	13
9. 신분증	14
10. 의료 서비스	14
11. 매장 및 장례 지원	18
12. 기타	18

부록

- A. SF 1174 신청서 (사망 군인 미지급 보상금 청구 신청)
- B. DD 2656-7 신청서 (연금 확인)
- C. VA 양식 21P-534EZ (유족보상금, 유족연금, 혹은 미지급급여)
- D. SF 1199A 양식 (자동입금 신청서)
- E. W4-P 정기 연금 / 연금지급 원천징수 증명서

개정판 추가 내용

- 1. 미국 대사관 해외 사망신고서 수정본
- 2. 비미국 시민에 대한 유족급여보장제도 및 사회보장세금 감축/완화를 위한 절차 추가
- 3. 인터넷에서 구할 수 있거나 자주 변경되는 정보 팸플렛 제거

표지 사진 – 제공: 업스플래쉬(UpSplash), 촬영자: 채드 스탬브리지, 촬영 장소: 알링턴 국립 묘지, 촬영
일시: 2022년 3월 24일 <https://unsplash.com/photos/HUpoQ-W26Z4>

1. 목적: 본 안내서는 제대 군인의 사망과 관련된 후속 처리 과정에서 유족에게 도움을 제공하기 위한 목적으로 작성되었습니다. 본 안내서는 한국 사정을 위주로 작성되었지만 다양한 지역에서 활용 가능하며 지역별 차이점은 미미한 수준입니다.

2. 도움 요청: 제대 군인의 유족에게 도움을 제공할 수 있는 기관이 몇 군데 있습니다.

1. 한국에는 미국 재향 군인회 (American Legion) 자원 봉사자들이 있으며 이들은 부상자 관련 지원을 제공하기 위한 교육을 받았습니다. 또한, 전역지원실 한국 지부(RSO Korea) 웹사이트에서 봉사자 명단을 확인하실 수 있습니다. (<https://www.rsokorea.org/retiree-widow-support-office.html>.)

2. 미 8군 부상자 지원부서에 현역 부상자 지원 장교를 요청할 수 있으며, 요청 시 여러분을 직접 도와줄 현역 군인을 지정해 줄 것입니다. 대개의 경우 사망한 제대 군인과 같은 계급의 군인이 배정됩니다.

3. 제대 군인의 사망 신고

가. 지역 당국에 연락하기

제대 군인이 사망할 경우 해당 지역 당국에 사망 사실을 제대로 신고하는 것이 중요합니다.

(1) 제대 군인이 가정에서 사망한 경우 지역 경찰에 연락 하십시오. 지역 당국에서 조사를 실시할 수도 있기 때문에 시신을 옮겨서는 안됩니다. 한국에서는 119로 신고하시면 됩니다.

(2) 병원에서 사망한 경우 위 절차는 불필요합니다.

나. 각 군 부상자 지원 부서에 연락하기

지역 당국에 신고한 뒤에는 부상자 지원 부서에 연락을 하십시오. 캠프 험프리스에 있는 미 8군 부상자 지원 부서 또는 미국 내 부상자 지원 부서에 연락 하시면 됩니다. 정부 기관 연락 및 서류 작업과 관련하여 도움을 받고자 하는 경우에는 부상자 지원 장교를 요청하십시오. 연락처 정보는 아래와 같습니다.

- 한국 부상자 지원 부서 – 05033-55-2734 혹은 010-4552-1712
- 육군 부상자 담당부서 – 1-800-626-3317
- 공군 – (757) 764-5231 / 1-800-433-0048
- 해병대 – (703) 784-9512 / 1-800-847-1597
- 해군 – 901-874-2501 / 1-800-368-3202
- 해안 경비대 – (757) 686- 4032

다. 미국 대사관에 연락하기

미국 대사관(유선 전화 02-397-4114 또는 전자우편 seoulinfoacs@state.gov)으로 연락하여 사망 사실을 신고하십시오. 미 대사관에서 미국 시민권자의 해외 사망 증명서(미국의 사망

증명서와 같은 개념)를 발급해 줄 것입니다. 미국 시민권자의 해외 사망 증명서 발급과 관련하여 추가 정보가 필요한 경우 6-나 문단을 참고해주시요.

라. 가족에게 연락하기

고인의 직계 가족에게 연락하여 사망 사실을 알리십시오.

4. 정부 금융기관에 연락하기

제대 군인에게 매달 돈을 지급하고 있는 정부 금융기관에 사망 신고를 하십시오. 해당 기관은 예정된 월 지급금 이체를 중단하여 지급 오류를 예방하거나, 이미 발생한 지급 오류에 대하여 반환(회수)을 진행할 수 있습니다. 사망 신고를 하고 나면 얼마 지나지 않아 추가적인 지시사항, 정보, 서식이 담긴 우편물을 받게 될 것입니다. 해당 지시사항을 따라 우편물에 동봉된 신청서를 작성하시고 고인의 사망 진단서 공증 사본(원본대조필) 1 부와 함께 안내된 주소로 최대한 빠른 시일 내에 회신하시어 유족 혜택 수령을 개시하시기 바랍니다.

가. 국방회계경리국(DFAS) / 유족연금제도(SBP)

(1) 국방회계경리국 부상자 관리팀(1-800-321-1080)으로 연락하십시오. 연락하기 전에 고인의 사회보장번호(SSN)와 사망 일자를 확인하시기 바랍니다. 해외에 거주 중인 유족들은 216-522-5955 로 전화하여 3 번 옵션을 선택하면 담당자와 연결 가능합니다.

(2) 사망 신고 2 주 이내로 국방회계경리국으로부터 SF 1174 신청서(사망한 군인의 미지급 보상금에 대한 지급 신청) 를 동봉한 우편물이 도착할 것입니다. 여기에는 DD 2656-7(연금 확인) 계좌 신청서와 고인이 유족연금프로그램에 가입한 경우 안내 사항이 포함됩니다. 우편물에 동봉된 신청서를 작성하시고 고인의 사망 증명서 공증 사본(원본대조필) 1 부와 함께 안내된 주소로 회신하십시오.

(3) 미지급 급여 및 수당

제대 군인이 사망할 시, 고인의 마지막 급여 및 수령 예정인 기타 모든 금액은 고인이 사전에 지정한 수익자에게 지급되며 대개의 경우 수익자는 유족입니다. 제대 군인의 사망이 국방회계경리국에 보고되는 즉시 국방회계경리국은 고인의 마지막 달에 해당하는 급여를 회수하고 계좌에 대한 감사를 실시합니다. 고인이 받아야 하는 금액이 남아있을 경우 기지정된 잔여 급여 수익자에게 지급될 것입니다. 신청을 원하시면 SF 1174 신청서를 작성하십시오.

(4) 유족 연금제도(SBP)

사망한 제대 군인이 유족연금제도에 가입했었다면 고인의 배우자나 피부양 자녀는 연금 수령 자격을 얻을 수 있습니다. 유족 연금 신청을 원하시는 경우 DD 2656-7 신청서(유족 연금 확인)를 작성하시고 온라인으로 직접 송금을 신청하신 뒤에 W4-P 신청서(연금 지급을 위한 원천징수 증명서)를 작성하시기 바랍니다.

(5) 고인의 배우자가 미국 시민권자가 아닌 경우 국방회계경리국은 연금의 30%를 자동으로 공제할 것 입니다.

가. 국방회계경리국은 비거주 외국인에게 지급되는 유족연금제도의 연금을 미국 원천소득으로 간주합니다. 기본적으로 IRC 1441 에 따라 과세 대상 금액의 30%가 연방세로 원천징수됩니다.

나. 한미 조세 조약에 따라 원천징수 세율을 낮추거나 면제하려는 경우, 조세 조약 제 20 조 제 1 항 (연금 및 이와 유사한 보수)에 따르면, 과거 고용으로 인해 한국 거주자에게 지급되는 연금 및 유사한 보수는 한국에서만 과세됩니다. 따라서 한국 거주자의 원천 징수 세율은 0%가 되어야 합니다. 이를 위해 IRS 양식 W-8BEN 을 작성하고, 한국 거주임을 명시하며, 제 20 조 제 1 항에 따른 조약 혜택을 청구하고, SBP 수급자 계좌번호 (마지막 4 자리만 제출 가능)를 포함해야 합니다. 작성한 약식 W-8BEN 은 아래 주소로 제출하십시오.

- 국방회계경리국
- 미군 연금 지급 담당 부서
- 미국, IN 46249-1300, 인디애나폴리스

다. 과거 원천징수액에 대한 환급을 신청하려는 경우 IRS 양식 1040-NR (미국 비거주 외국인 소득세 신고서)를 제출해야 합니다. SBP 에 대한 양식 1042-S 또는 사회보장연금 (SSA)에 대한 양식 SSA-1042S 를 첨부하고, 여권 사본 또는 해외 거주 증명서류, 그리고 해당 조약 조항을 인용한 세금조약 진술서를 함께 제출해야 합니다. 환급 신청 기한은 세금 신고서 제출기한으로부터 3 년 이내입니다.

나. 사회보장국(SSA)

(1) 사회보장국(유선전화: 800-772-1213)에 전화하거나 미국 대사관 마닐라 연방연금부서(FBU Manila, 전자우편: FBU.Manila@ssa.gov)로 이메일을 보내시어 사망 신고를 하십시오.

(2) 유족의 연령에 따라 사회보장국 유족 연금 수령을 개시할 수 있으며 빠르면 60 세부터 가능하고 늦게는 정년 퇴직 연령(출생년도로 결정)부터도 가능합니다. 장애인인 경우 50 세부터도 수령이 가능합니다. 대개의 경우 사회보장 유족 연금은 사망한 제대 군인이 생전에 받던 금액과 동일합니다. 연금 수령을 60 세에 조기 시작하고자 선택하는 경우 최대 30% 감소된 금액을 영구적으로 수령하게 됩니다. 월 수령액은 연금 수령 개시 시점에 따라 크게 차이가 나며 퇴직 연령에 따라서도 크게 달라집니다. 간단히 설명하면, 적은 금액을 장기간에 걸쳐 수령할 수도 있고 많은 금액을 단기간 동안 수령할 수도 있습니다. 연금 수령을 개시할 때 받는 금액이 앞으로 평생동안 받게 될 금액의 기준이 됩니다. 다만, 매년 물가에 따라 금액은 조정될 수 있고 직장 경력에 따라서 경제 활동을 계속할 경우 더 높은 연금을 받을 수도 있습니다.

(3) 연금을 언제부터 수령할지에 대한 결정은 각자 개인적인 상황을 고려하여 내리시기 바랍니다. 월 수령액은 더 적지만 조기에 받기 시작하는 것과 정년 퇴직 연령이 되었을 때까지 기다려서 더 큰 금액을 짧은 기간동안 받는 것 중 어느 쪽이 더 나을까요? 이에 대한 답은 개인이 처한 상황에 달려있으며 현재 필요한 현금의 양, 건강 상태 및 기대 수명, 은퇴 후 경제생활 계획, 기타 은퇴 후 수입원 여부, 미래에 필요할 것으로 예상되는 금액, 의무 지출 항목, 그리고 본인의 사회보장연금과 같은 여러가지 요인에 따라 달라질 수 있습니다. 사회보장연금 수령 개시 시기를 정하는 중요한 결정을 하기에 앞서 모든 사항을 자세히 비교하고 각자 처한 상황을 고려하시기 바랍니다.

(4) 만약 현재 이미 사회보장연금을 수령하고 계시다면 귀하가 기존에 받던 연금과 고인이 된 제대 군인이 받던 연금 중 한 종류의 사회보장연금만 받게 됩니다 (유족 연금). 사회보장제도에서 둘 중 높은 금액으로 변경 조치할 것이며, 둘 다 받을 수는 없습니다.

(5) 사회보장연금의 사망 혜택에는 255 달러의 일회성 지급이 포함됩니다. 이 255 달러는 고인이 된 군인이 사망 당시 함께 거주하던 유족에게 일회성으로 지급되는 혜택입니다.

(6) 만약 유족이 미국 시민권자가 아닌 경우, 사회보장국은 귀하의 사회보장 퇴직 연금의 85%에 해당하는 금액으로부터 30%의 소득세를 단일세율로 공제하도록 되어있습니다. 이로 인해 귀하의 월 수령액의 25.5%가 원천징수됩니다.

가. 사회보장국은 비거주 외국인에게 지급되는 연금을 미국 원천소득으로 간주합니다. 기본적으로 IRC 871 에 따라 과세 대상 금액의 30%가 연방세로 원천징수됩니다.

나. 한미 조세 조약에 따라 원천징수 세율을 낮추거나 면제하려는 경우, 조세 조약 제 20 조 제 1 항 (연금 및 이와 유사한 보수)에 따르면, 과거 고용으로 인해 한국 거주자에게 지급되는 연금 및 유사한 보수는 한국에서만 과세됩니다. 따라서 한국 거주자의 원천 징수 세율은 0%가 되어야 합니다. 이를 위해 제 18 조 2 항을 인용한 IRS 양식 W-8BEN 혹은 SSA-21 양식 (미국 외 거주자 청구 보완 서류) 를 작성하고 사회보장번호와 한국 주소를 작성하십시오. 둘 중 하나의 양식을 마닐라에 있는 아래 연방연금부서에 제출하십시오.

사회보장국

미국 대사관 – 연방복지부서

록사스 대로 1201 에르미타

필리핀 마닐라 우편번호 0930

이메일: FBU. Manila@ssa.gov

다. 과거 원천징수세 환급을 신청하려면 ISR 양식 1040-NR (미국 비거주 외국인 소득세 신고서)를 제출해야 합니다. 이때 1042-S (SBP 관련) 양식 또는 SSA-1042S (사회보장연금 관련) 을 첨부하고, 여권 사본이나, 해외 거주 증명서, 그리고 해당 조약 조항을 명시한 세금조약 진술서를 포함해야 합니다. 신청 기한은 세금 심고서 제출 마감일로부터 3 년 이내입니다.

(6) 사망 연금. 사회보장제도에서 제공하는 사망 연금 혜택이 몇가지 있습니다. 아래 주소로 사망 확인서와 함께 SSA-8 를 보내주시기 바랍니다.

사회보장국

미국 대사관 – 연방복지부서

록사스 대로 1201 에르미타

필리핀 마닐라 우편번호 0930

이메일: FBU. Manila@ssa.gov

(7) 자세한 정보가 필요하신 경우 첨부된 사회보장제도 안내서 또는 홈페이지 (<https://www.ssa.gov/benefits/survivors/>)를 참고하시기 바랍니다.

다. 미 보훈부(VA)

(1) 제대 군인의 사망 시 미 보훈부(1-800-827-1000)로 사망 사실을 신고하시고 유족 혜택에 대하여 문의하시기 바랍니다. 아래를 보시면 몇 가지 혜택 예시가 나와있으며 자세한 정보는 홈페이지(<http://www.va.gov/>)를 참고하시기 바랍니다. 사망 원인이 기재된 사망진단서와 함께 VA 양식 21P-534EZ (유족급여 및 생존자 연금 신청서)를 미국 보훈부 (VA)로 우편 발송하시기 바랍니다.

(2) 장애 수당

장애 보상금을 받던 제대 군인은 보훈부(800-827-1000)로 전화하시기 바랍니다. 제대 군인이 복무 중 당한 부상 및 질병으로 사망했거나 복무와 관련된 장애로서 영구적이고 전면적인 장애(P&T)로 분류되어 10년 간 보훈부 보상금을 받고 있었다면, 세금을 부과하지 않는 지원금인 전몰 순직 군인 유족 보상금(DIC)을 받을 자격이 주어집니다. 자세한 정보를 원하실 경우 홈페이지 (<https://www.va.gov/disability/dependency-indemnity-compensation/>) 참고하시기 바랍니다.

(3) 보훈부 생명 보험에 관한 정보가 필요하신 분은 8 번째 문단을 참고하시기 바랍니다.

(4) 유족 및 부양가족 교육지원제도 (DEA, 챕터 35)는 현역 복무 중 사망했거나 복무 중 발생한 질병이나 부상으로 인하여 영구적이고 전적인 장애 판정을 받은 재향군인의 부양 가족 (배우자 및 자녀)에게 교육 및 직업훈련 기회를 제공하는 제도입니다.

(5) 추가적인 혜택이 궁금하신 분은 아래 링크를 통해 ‘보훈부 부양가족 및 유족 혜택 요약집’을 참고하시기 바랍니다. <https://www.va.gov/family-and-caregiver-benefits/>.

라. 사망한 제대 군인이 현직 또는 은퇴한 연방 민간인 직원일 경우 인사관리처(888-767-6738)로 연락하시기 바랍니다.

(1) 아래 서류를 보내주십시오.

- SF 2800: 사망급여 신청서 - 사망자가 퇴직연금 수급자 또는 전직 공무원이었던 경우
- SF 2800A: 재직 중 사망 확인서 - 사망 시점에 재직자였던 경우
- SF 3104: 사망급여 신청서 (FERS)
- SF 3104B: 급여 선택
- FE-6: 연방공무원 사망보험금 청구서
- W- 8BEN: 외국인 신분 증명서
- SF1153 미지급 보수 청구서
- SF1153 첨부서류 4: 급여 지급 방식 선택서

(2) 공무원 인사 관리국 (OPM) 주소: 공무원 인사관리국, 우편사서함 45 호, 펜실베이니아주 보이어스 16017-0045

5. 8 군 영현 부서

가. 8 군 영현 부서에서는 장례 서비스 옵션을 제공하고 있으며 비용은 가장 가까운 친족 부담입니다. 예상 비용은 2024년 1월을 기준으로 산정되었으며 서비스 제공 시점에 따라

달라질 수 있습니다. 사망한 제대 군인과 그 유족에 대한 장례 지원은 영현 부서의 업무량에 따라 달라질 수 있습니다.

(1) 화장. 성인의 예상 화장 비용은 80 만원입니다. 성인용 화장용 관의 예상 비용은 218 달러입니다. 유골함은 선택사항으로 비용을 지불할 시 제공 가능하며 개인적으로 준비한 유골함을 사용할 수도 있습니다. 화장은 대한민국 세종특별자치시 연기면 산울리 은하수공원 장례식장에서 이루어집니다. 시신의 운반만 원하는 경우 주한미군 영현 부서가 장례식장에서 유족이 선택한 화장터로 시신을 운반해드릴 것입니다. 관을 덮을 국기는 미국 대사관이나 미 본토 장례식장에서 보낼 것이며 가장 가까운 친족이 신청해야 합니다.

(2) 연습. 주한미군 영현 부서는 요청 시 연습을 제공할 수 있습니다. 예상 비용은 9 달러입니다.

(3) 미 본토 또는 선택한 국가로 시신을 수송할 경우 민항기를 이용하며 미 본토로 가는 경우는 보통 델타항공을 이용합니다. 예상 비용은 3,000-4,500 달러이며 미국에서의 장례식 비용은 포함되지 않은 금액입니다. 포함된 항목으로는 항공기 수송 비용(2,000-3,000 달러), 연습(9 달러), 관(나무관 849 달러, 철재관 1584 달러), 관 운반용 받침대(무료), 사망 장소에서 8 군 영현 부서로의 이동 비용, 8 군 영현 부서에서 인천 국제공항까지의 수송 비용(무료)이 있습니다. 관을 덮을 국기는 미국 대사관이나 미 본토 장례식장에서 보낼 것이며 가장 가까운 친족이 신청해야 합니다. 도착 후 공항에서부터 장례식장까지의 시신 운반은 미측 장례식장에서 담당해야 하며 추가 비용이 소요됩니다.

나. 가장 가까운 친족이 한국 내 시설에서 장례를 치르겠다고 결정할 경우 지역 병원과 연계된 지정 장례식장을 이용할 수 있습니다.

(1) 가장 가까운 친족은 한국에서 발급하는 사망 확인서를 병원에서 유료로 발급받을 수 있으며 사망 확인서를 미 대사관에 제출해야 합니다.

(2) 가장 가까운 친족은 시신을 인도받기 전에 한국에서 발생한 모든 의료비와 장례 관련 비용을 지불 완료해야 합니다.

(3) 고인의 가장 가까운 친족은 장례 관련 일정을 계획하고 미 대사관에 필요한 서류를 제출하는 과정에서 영현 부서의 도움을 받을 수 있습니다.

다. 가장 가까운 친족이 영현 부서를 이용하겠다고 선택하는 경우:

(1) 지역 병원은 시신을 인도 시 영현 부서에 한국에서 발급한 사망 확인서를 제공합니다.

(2) 가장 가까운 친족은 시신을 인도받기 전에 한국에서 발생한 모든 의료비와 장례 관련 비용을 지불 완료해야 합니다.

(3) 미국 시민의 해외 사망보고서 발급을 준비하기 위해 가장 가까운 친족이 이메일로 관련 정보를 요청하게 됩니다. 이때 미국 대사관은 사망 증명서 전자 사본 1 부와, 해당되는 경우 화장 허가서를 제공합니다.

(4) 영현 부서는 장례 관련 일정을 계획하고 미 대사관에 필요한 서류를 제출하는 과정에서 도움을 제공할 것입니다.

라. 영현 부서로 납부하는 모든 금액은 달러화 기준이며 납부 방식은 머니오더(money order) 또는 현금이어야 합니다. 화장 비용은 원화 현금으로 결제하거나 유족의 한국 은행 계좌에서 화장 업체로 전자 송금하는 방식으로 납부 가능합니다.

마. 미 본토에 있는 장례식장은 장례 서비스에 대하여 추가적인 비용을 청구할 것입니다. 공항에서 시신을 인도받아 묘지로 운반하는 데에만 최소 3000 달러의 비용을 청구할 수 있다고 예상하셔야 합니다.

바. 만약 사망한 제대 군인이 GS 직원, 비충당자금 직원, 또는 SOFA 지위의 계약 업체 직원이거나 사망 당시 출장(TDY)중이었다면, 주요 장례 절차에 대한 비용은 미 육군에서 지불할 것이며, 유족이 일단 지불한 뒤에 고용주로부터 비용을 돌려받을 수도 있습니다.

6. 사망 확인서 발급

가. **지역 병원.** 고인의 사망을 신고한 병원에서는 사망 확인서를 발급해줍니다. 사망 확인서는 가능하면 영문본이 선호되며, 고인의 사망 원인이 기재되어 있어야 합니다. 사망 원인이 기재되어 있지 않을 시 생명보험금의 지급은 이루어지지 않습니다. 또한 당신의 배우자가 보훈부로부터 상이등급 평가를 받은 상이로 인해 사망하였을 경우, 고인의 배우자는 보훈부의 전몰·순직군인 부양가족 보상금을 받을 수 있는 자격대상이 됩니다. 사망 확인서는 병원으로부터 최소 20 부 발급 받으시기 바랍니다. 사망 확인서 발급에는 비용이 발생할 수 있습니다.

나. **미국 대사관.** 미국 대사관 (유선 전화 02-397-4114 또는 전자우편 (seoulinfoacs@state.gov) 으로 연락하여 미국 시민권자의 해외 사망 증명서 (<https://kr.usembassy.gov/services-death-of-a-u-s-citizen/> 참고, CRODA 는 미국 시민 해외 사망보고서로 미국의 사망 증명서와 같은 개념)를 발급 받으십시오.

(1) 미국 시민이 해외에서 사망한 경우 미국 대사관은 미국 시민 해외 사망 보고서 (CRODA) 를 발급 합니다. 이는 미국 시민의 사망, 유해 처리, 그리고 유산 (개인 재산) 관리에 관한 기본적인 사실을 기록한 행정 문서입니다. 가장 가까운 친족 또는 법적 대리인은 관련 서류를 전자식으로 다음 이메일 주소로 보내야 합니다. SeoulinfoACS@state.gov.

(2) 미국 대사관은 모든 필수 서류를 접수한 후 일반적으로 1~3 영업일 내에 처리합니다. 원활한 소통을 위해 모든 문의는 이메일을 통해서만 진행됩니다. 제출한 서류의 처리 상태에 대한 문의는 모든 필수 서류 제출 후 3 영업일이 지나기 전까지는 회신하지 않습니다. 3 영업일 이내에 추가 문의를 할 경우 CRODA 발급 절차가 지연될 수 있으므로 유의하시기 바랍니다.

(3) 긴급 항공 이동을 위해 화장 허가서, CRODA 또는 영사 사망 증명서가 필요한 경우 아래와 같은 이메일 제목으로 주한 미대사관에 이메일을 보내야 합니다.

[Date of travel and/or cremation: Urgent Request for CRODA and/or Cremation Letter, Last Name (of the deceased), First Name (of the deceased)]

[여행 및/또는 화장 날짜: CRODA 및/또는 화장 허가서 긴급 요청, 사망자 성, 사망자 이름
또한 이메일 본문에는 가능한 한 자세한 정보를 기재하고, 아래 필수 제출 서류의 스캔본/첨부파일을 함께 보내야 합니다.

(4) CRODA 발급에 필요한 서류

가. 사망자 여권 신원정보면 사본. 모든 필수 서류를 이메일로 제출한 뒤, 사망자의 원본 여권은 사기 방지를 위해 미 대사관에 우편으로 보내십시오. 우체국을 이용해 아래 주소로 발송하시기 바랍니다. 이 업무는 대면 예약을 제공하지 않음으로 여권을 우편 발송해 주십시오.
주소: 주한미국대사관 시민서비스과 (ACS) 서울특별시 종로구 세종대로 188 (03141)

나. 병원에서 발급한 사망진단서 사본 (영문 또는 국문). 이메일 첨부파일 형태로 스캔본을 보내면 충분합니다. 현지 병원 사망진단서 또는 부검결과서에는 반드시 사망자의 여권에 기재된 이름과 동일한 이름이 표기되어 있어야 합니다. 미국 대사관은 사망자의 이름이 한글로 표기된 한국어 사망진단서도 접수하며, 공증 번역이나 영문 공인 번역본은 요구하지 않습니다.

다. 가장 가까운 친족, 생존 배우자, 가장 가까운 친족 구성원 또는 지정된 법적 대리인의 여권 또는 공식 신분증 (예: 운전 면허증) 사본. 이메일 첨부파일 형태의 스캔본으로 제출하면 충분합니다. 참고: 유해 처분 (화장 및 매장 등)은 일반적으로 미국 주법이나 외국 법률에 명시되어 있지 않습니다. 관습법 또는 통상적 관례에 따라, 사망자의 유언서나 법적 문서에도 별도 지정이 없는 한, 생존 배우자, 가장 가까운 친척, 또는 법적 대리인이 유해 처분 방식을

결정합니다. 일반적인 상속 및 가족관계 순위 (유언이 없을 시 친족관계에 따른 우선순위)는 다음과 같습니다.

1. 배우자
2. 자녀
3. 부모
4. 형제 및 자매
5. 조부모
6. 이모 및 삼촌
7. 사촌

라. 사망자와의 법적 관계를 증명할 수 있는 서류 다음 중 하나를 제출하십시오.

- 사망자의 유언장 또는 최종 유언서 사본으로 귀하가 법적 대리인 또는 유산 집행인으로 지정되어 사망자의 사무를 처리할 책임이 있음을 명시한 문서 또는
- 혼인관계증명서, 출생증명서, 또는 그 밖의 공식문서로 귀하가 사망자와 가족관계에 있음을 증명하는 서류

마. 위임장 또는 동의서의 서명된 사본을 스캔하여 이메일 첨부파일로 제출하면 충분합니다. 생존 배우자, 가장 가까운 가족 구성원, 또는 지정된 법적 대리인이 CRODA 발급 절차를 대신 처리할 다른 사람을 지정하고자 하는 경우, 그 사람에게 해당 업무를 위임한다는 내용의 위임장 또는 동의서를 제출해야 합니다. 또한 해당 대리인의 신분증 사본 (예: 여권 또는 운전면허증) 도 함께 제출해야 합니다. (예: 생존 배우자가 자녀에게 대신 사망사고 절차를 진행하도록 위임하는 경우, 이 서류가 필수로 요구됩니다.)

바. 사망자의 마지막 미국 내 주소와 대한민국 내 주소를 기재하십시오. 해당되지 않는 경우, “해당없음” 이라고 표시하십시오.

사. 사망자의 유해 처리에 대한 정보를 아래 중 하나로 선택하여 명시하십시오.

- 현지 매장
- 현지 화장
- 시신을 미국 또는 제 3 국으로 운송
- 유골을 미국 또는 제 3 국으로 운송
- 유골을 직접 휴대하여 미국 또는 제 3 국으로 운반

아. 대한민국에서 화장을 하거나, 유골을 미국으로 반출할 예정일 경우, 현지 화장장에 미국 대사관 발급 화장허가서가 필요한지 문의하십시오. 이 문서는 주한 미국대사관 (서울)에서 발급하는 서류입니다. 일반적으로, 외국인등록증, 거주 자격 또는 유효한 비자가 없는 미국 시민권자는 이 서류를 제출해야 합니다. 이메일로 요청하시면 전자 형태의 화장허가서를 발급해 드릴 수 있습니다. 참고: 일부 화장장은 전자 사본이 아닌 원본 서류만 접수할 수 있습니다. 그런 경우에는 긴급 예약을 위해 이메일로 연락해 주시기 바랍니다.

자. 사망자의 유해를 미국으로 반출 (직접 휴대 또는 운송) 할 계획이 있는 경우, 이 사실을 이메일 회신 시 명시해 주십시오. 미국 대사관은 이를 근거로 전자 형태의 영사 사망증명서를 발급합니다.

7. 개인 서류 및 안내서 지침

가족 관계를 증명하거나 또는 청구를 해야 할 경우를 대비하여 아래의 서류를 준비해두십시오. 각 서류의 원본은 항상 본인이 보관하시되 각 기관에서 서류 사본을 요구할 경우 인증된 사본을 제출하십시오.

- DD 214, 미군 전출 / 전역 증명서
- 여권
- 군 신분증
- 외국인등록증
- 혼인관계증명서
- 보훈부 상이평가 서류
- 유언장
- 생명보험증서(가입되어 있을 시)
- 보험 증권 및 혹은 보험 증명서(COI)

8. 생명 보험

가. 미 보훈부

(1) 제대군인 단체 생명보험(VGLI). 고인이 VGLI 에 가입된 제대군인일 시 1-800-419-1473 로 연락하거나 홈페이지(<https://www.va.gov/life-insurance/options-eligibility/vgli/>)를 참고하시기 바랍니다. 메일 양식은 SGLI 8283 입니다.

(2) 상이 제대군인 생명보험(S-DVI). 고인이 S-DVI 에 가입된 제대군인일 시 1-800-669-8477 로 연락하거나 홈페이지(<https://www.va.gov/life-insurance/options-eligibility/s-dvi/>)를 참고하시기 바랍니다.

(3) 군복무자 단체 생명보험(SGLI). 고인이 SGLI 에 가입된 제대군인일 시 1-800-419-1473 로 연락하십시오. 일반적으로 제대군인의 경우 전역 후 4 개월 이내까지는 현역과 동일한 생명보험을 적용 받으며, 완전한 장애를 입은 상태로 전역했을 경우에는 전역 후 2 년 이내까지 적용됩니다. 관련 내용은 홈페이지(<https://www.va.gov/life-insurance/options-eligibility/sqli/>)를 참고하시기 바랍니다.

(4) 미 보훈부에서는 제 2 차 세계 대전 및 6.25 전쟁 복무자 및 제대군인 대상 생명보험을 제공하고 있습니다. 관련 생명보험 4 종의 경우 현재 신규 가입자는 받고 있지 않습니다. 자세한 정보는 홈페이지 (<https://www.benefits.va.gov/insurance/select.asp>)를 참고하시기 바랍니다.

나. 민간 생명 보험. 고인이 가입되어있던 생명보험 회사가 있을 시 연락하여 고인의 사망 사실을 신고하십시오. 민간 생명 보험이란 고인이 개인적으로 가입한 생명보험 및 고인이 사망 직전까지 직장에 고용된 상태였을 경우 해당 직장을 통해 가입한 생명 보험을 포함합니다. 생명보험 회사는 귀하에게 생명보험금 수령을 위해 필요한 조치사항과 서류 양식을 제공할 것입니다. 생명보험 회사들은 일반적으로 사망 확인서 원본 또는 인증된 사본을 요구할 것입니다.

9. 신분증. 신분증 발급 부서와 같은 곳에 위치해있는 가장 가까운 DEERS 부서를 방문하십시오. 고인의 신분증을 반납한 뒤 귀하의 신분증을 최신화하여 발급 받아야 합니다. 귀하의 신분증 최신화를 위한 DEERS 부서 방문 시 고인의 사망 확인서 사본 및 고인의 정부 신분증 2 종의 사본을 지참하십시오. 관련 정보는 홈페이지(<https://www.cac.mil/Next-Generation-Uniformed-Services-ID-Card/>)를 참고하시기 바랍니다.

10. 의료 서비스. 제대군인의 부양가족으로서 귀하는 트라이케어 의료 서비스를 받을 수 있는 자격대상입니다. 65 세 이전까지는 매월 비용을 지불해야 하는 트라이케어 셀렉트에 가입할 수 있습니다. 65 세가 되기 3 개월 전에 메디케어 파트 B 에 가입해야 트라이케어 포 라이프의 수혜 자격대상이 됩니다.

가. 트라이케어.

(1) 제대군인을 위한 트라이케어 셀렉트 오버시즈 수혜자는 스스로 건강관리를 하며 일반적으로 진료의뢰서 없이 아무 민간 의료 서비스 제공기관에 의료 서비스를 구할 수

있습니다. 하지만 특정한 의료 서비스, 예를 들어 물질사용장애로 인한 비응급 입원 혹은 정신건강 관리 등의 경우 사전에 진료의뢰서 발급을 필요로 할 수 있습니다.

귀하는 매년 가입비/가입유지비와 공제금(디덕터블) 및 분담금액(코스트쉐어)을 지불해야 합니다. 미국 본토 및 미국령 바깥에서 트라이케어와 협력관계를 맺고 있지 않은 비 네트워크 의료 서비스 제공기관들은 의료 서비스에 대해 임의의 금액을 청구할 수 있습니다.

공제금(디덕터블) 및 분담금액(코스트쉐어) 외 트라이케어에서 부담하는 최대 비용을 초과한 금액에 대해서는 귀하가 직접 부담해야 합니다. 귀하는 의료 서비스에 대해 직접 선지불을 하고 이후 트라이케어에 환급 청구를 해야 할 것을 염두에 두고 있어야 합니다. 트라이케어와 진료협약을 맺은 특정 한국 병원들은 트라이케어로 바로 청구합니다. 이 경우 귀하는 공제금(디덕터블) 및 공동부담금(코페이먼트)만 지불하면 됩니다. 관련 정보는 홈페이지 (<https://www.tricare-overseas.com/beneficiaries/plans-and-programs/tricare-overseas-program-top-select/tricare-select-retirees>)를 참고하시기 바랍니다.

(2) 트라이케어 포 라이프. 메디케어는 미 본토 및 미국령에서 적용됩니다. 메디케어는 외국에서 적용되지 않습니다. 트라이케어 포 라이프 수혜 자격대상일 시, 귀하가 외국에 거주하거나 외국을 방문할 경우 트라이케어가 주 지불자로 기능하며 귀하는 트라이케어의 연간 공제금(디덕터블) 및 분담금액(코스트쉐어)을 지불합니다.

귀하가 외국에 거주할 경우, 비록 메디케어가 외국에까지 서비스되진 않으나 메디케어 파트 B 에 가입되어 있어야만 트라이케어 수혜 자격대상이 됩니다. 트라이케어 포 라이프 수혜자는 스스로 건강관리를 하며 일반적으로 진료의뢰서 없이 아무 민간 의료 서비스 제공기관에 의료 서비스를 구할 수 있습니다. 하지만 특정한 의료 서비스, 예를 들어 물질사용장애로 인한 비응급 입원 혹은 정신건강 관리 등의 경우 사전에 진료의뢰서 발급을 필요로 할 수 있습니다. 귀하는 매년 공제금(디덕터블) 및 공동부담금(코페이먼트)을 지불해야 합니다. 미국 본토 및 미국령 바깥에서 트라이케어와 협력관계를 맺고 있지 않은 비 네트워크 의료 서비스 제공기관들은 의료 서비스에 대해 임의의 금액을 청구할 수 있습니다. 공제금(디덕터블) 및 분담금액(코스트쉐어) 외 트라이케어에서 부담하는 최대 비용을 초과한 금액에 대해서는 귀하가 직접 부담해야 합니다. 귀하는 의료 서비스에 대해 직접 선지불을 하고 이후 트라이케어에 환급 청구를 해야 할 것을 염두에 두고 있어야 합니다. 트라이케어와 진료협약을 맺은 특정 한국 병원들은 트라이케어로 바로 청구합니다. 이 경우 귀하는 공제금(디덕터블) 및 공동부담금(코페이먼트)만 지불하면 됩니다. 관련 정보는 홈페이지(<https://www.tricare-overseas.com/beneficiaries/plans-and-programs/tricare-for-life>)를 참고하시기 바랍니다.

나. 메디케어. 메디케어 수혜자가 제대한 신분이며 귀하나 배우자가 메디케어 세금을 지불하여 보험료 무료 메디케어 파트 A 수혜 자격대상일 경우, 귀하는 외국에 거주하더라도 메디케어 파트 B에 가입해야만 트라이케어 수혜자가 될 수 있습니다. 본 규칙은 메디케어가 일반적으로 미국 본토 및 미국령 외에서 받은 의료 서비스에 혜택을 제공하지 않음에도 불구하고 모든 트라이케어 수혜 자격대상에게 적용되는 규칙입니다.

메디케어 파트 A 수혜 대상자인 제대 군인 및 가족은 메디케어 파트 B에 가입해야만 트라이케어 수혜 자격대상이 될 수 있습니다. 이는 상이를 입어 제대한 군인 및 가족, 그리고 60세 이상인 주 방위군 제대 군인 및 가족과 60세 이상인 예비군 제대 군인 및 가족에게도 동일하게 적용됩니다. 메디케어 B 가입이 가능해지는 초기 가입 기간에 바로 가입하여 메디케어 파트 B 프리미엄이 인상되는 것을 피하십시오. 파트 B 가입이 가능해졌음에도 가입하지 않을 경우 가입하지 않은 매 12개월마다 10%의 벌금이 가산되어 부과됩니다. 메디케어 파트 A 및 B에 모두 가입되어 있을 경우, 자동으로 트라이케어 포 라이프 수혜 자격대상이 됩니다. 귀하가 트라이케어 수혜 자격대상자가 아닐 경우 의료 서비스에 대한 환급을 청구할 수 없다는 점에 유의하십시오. 관련 정보는 홈페이지

(http://www.tricare.mil/Plans/Eligibility/MedicareEligible/Retiree_and_Family.aspx)를 참고하시기 바랍니다.

다. 영내 군 의료시설. 제대 군인 및 가족은 영내 군 의료시설에서 예약이 꼭 차있지 않는 한 당일진료를 제공받을 수 있습니다. 단, 이는 만성질환이 아닌 급성 질환에 한정됩니다. 다만 1차 진료 제공자가 지정되는 트라이케어 셀렉트 플러스 혹은 트라이케어 포 라이프 플러스 가입자는 예외입니다. 플러스 프로그램은 현재 가동 중이지 않으며 신규 가입자 또한 받고 있지 않습니다. 응급의료는 응급실에서 제공됩니다. 제대 군인은 영내 및 영외 처방전을 처방받기 위해 약국을 이용할 수 있습니다.

라. 영외 의료시설. 지역 한국 네트워크 병원들은 미군 의료 네트워크의 한 부분으로서, 국제진료센터를 보유하고 있으며 한반도에서 수준 높은 보건의료를 제공합니다. 모든 트라이케어 네트워크 병원들은 국제의료기관평가위원회(JCI) 혹은 대한병원협회의 인증을 받은 기관들입니다. 귀하는 한국인 의료진 중 많은 이들이 영어를 구사하며 상당한 숫자가 미국에서 수학한 바 있다는 점에 즐거운 놀라움을 경험할 수도 있습니다. 상기 트라이케어 네트워크 병원 중 몇몇 병원은 트라이케어에 직접 비용 청구를 하며, 이 경우 귀하는 공제금(디덕터블) 및 공동부담금(코페이)만 지불하면 됩니다. 브라이언 울긋 육군 커뮤니티 병원(BDAACH)에서는 한국 병원 방문을 위한 책자를 발행하였으며 해당 책자에는 트라이케어 네트워크에 가입되어

있는 한국 병원들이 기재되어 있습니다. 해당 책자 열람은 홈페이지

(<https://api.army.mil/e2/c/downloads/575282.pdf>)를 참고하시기 바랍니다.

마. 한국 국민건강보험 (KNHI). 귀하가 한국에서 비 SOFA 신분으로 몇달 간 체류할 시, 한국 정부는 귀하에게 한국 국민건강보험에 가입해야 한다는 통지를 발송할 것입니다.

(1) 하지만, 귀하는 트라이케어 의료보험 대상자이므로, 한국 국민건강보험에 가입하지 않아도 됩니다. 한국 국민건강보험공단측에서는 이러한 사항을 알려주지는 않습니다. 한국 국민건강보험은 미국 메디케어 파트 A & B 와 비슷하나 65 세 이상 연령 제한이 따로 없고, 가격은 대략 동일합니다. 귀하가 한국 국민건강보험 가입자일 경우 트라이케어 가입자와 마찬가지로 일반적인 상황에서 상급병원으로 바로 가지는 못 할 것 입니다. 귀하는 한국인 의사로부터 진료의뢰서를 받은 뒤 상급병원에 갈 수 있습니다. 의료비 일부는 국민건강보험에서 선부담하며, 잔여 의료비는 귀하가 트라이케어에 청구해야 합니다.

(2) 일부 제대 군인들은 메디케어를 해지하고 한국 국민건강보험에만 가입한 바 있습니다. 이럴 경우 발생하는 단점은 귀하가 메디케어 수혜 자격대상이더라도 더 이상 트라이케어 수혜 자격대상이 될 수 없다는 점입니다. 또한 미국에 갈 시, 단기방문일 경우에도 귀하는 미국 건강보험의 혜택을 받을 수 없습니다. 메디케어를 중단한 후 나중에 재신청할 경우, 그동안 메디케어를 중단한 햇수마다 보험료에 10% 씩 벌금이 가산되어 영구히 부과됩니다.

(3) 한국의 의료기관은 진료과목 수와 병원 규모에 따라 1 차, 2 차, 3 차 의료기관으로 구분됩니다. 3 차 병원을 이용하기 위해서는 1 차 또는 2 차 의료기관에서 발급한 진료의뢰서가 필요합니다. 진료의뢰서 없이 3 차 병원에 직접 방문할 경우, 건강보험 혜택을 받을 수 없으며, 고액의 진료비를 본인이 부담해야 합니다. 외국인의 경우, 3 차 병원의 국제진료센터를 통해 직접 진료를 받을 수 있지만, 비용이 더 비싸다는 점을 유의해야 합니다.

단계	1 차 의료기관	2 차 의료기관	3 차 의료기관
유형	의원 및 보건소	병원 및 종합병원	상급종합병원
제공되는 의료 서비스	외래 진료, 예방접종, 기본적인 건강관리	일반 진료 및 입원 서비스	정밀 진단, 난치성 질환 치료, 고도의 전문 의료 서비스
예시	의원, 보건소, 보건지소, 건강관리센터, 모자보건센터, 산부인과의원, 건강검진센터	다양한 진료과를 갖춘 종합병원	대학병원 및 대형 종합병원

3 차 의료기관의 진료를 받기 위해서는, 1 차 의료기관 또는 2 차 의료기관에서 발급받은 진료의뢰서를 제출해야 합니다. 진료의뢰서 없이 3 차 의료기관을 직접 방문할 경우, 초진

진료비가 더 비싸게 부과될 수 있습니다. 하지만, 응급환자, 분만중인 산모, 혈우병 환자, 치과 진료, 재활의학과 진료, 가정의학과 진료의 경우에는 진료의뢰서 없이도 3차 의료기관에서 진료를 받을 수 있습니다.

(4) 참고자료

- <https://www.nhis.or.kr/english/index.do>
- <https://www.junggu.seoul.kr/english/content.do?cmsid=14855>
- <https://blog.southofseoul.net/3-important-differences-between-primary-healthcare-in-south-korea-and-the-u-s/>

11. 매장 및 장례 지원

가. 고인의 장례식 혹은 추모 예식을 치르는 방식엔 여러가지가 존재하며 이 중 선택할 수 있습니다.

(1) 많은 한국 병원들은 장례 서비스를 제공합니다. 귀하는 이러한 한국식 장례식(조문)을 선택하여 친구 및 가족들로 하여금 귀하의 배우자를 찾아 문상을 하도록 할 수 있습니다. 이러한 방식은 귀하께서 한국인 친구 및 친척이 많을 경우, 해당 인원을 모두 영내로 출입시키는데 따르는 어려움을 피할 수 있다는 측면에서 좋은 선택이 될 수 있습니다.

(2) 영내 군 예배당에서도 추모 예식이 가능합니다. 이 방안은 영내 출입 권한이 있는 군인 친구가 많을 수록 좋은 선택이 될 것 입니다. 많은 한국인 친구들 및 가족들은 영내 출입을 하는데 어려움을 겪을 것 입니다.

(3) 희망할 시 영외에서 한국식 장례식 및 영내에서 추모식을 둘다 진행할 수 있습니다.

나. 군 장례 예우는 미 보훈부 / 부상자 지원 센터의 가용 여부에 따라 진행됩니다. 군 장례 예우의 완전한 형태는 미 육군 야전교범 3-21.5 제 14 장에 정의되어 있으며 제대 부상자 지원 장교, 선임 부사관, 예포병 5명 이상으로 이뤄진 예포대, 관 운반자 최소 6명(예포대원과 동일 인원이어도 가능), 장송나팔 연주, 군기, 성직자(군인 혹은 민간인), 영구차 혹은 탄약마차(고인이 해당 예우 대상자이며 탄약마차가 가용할 시, 통상 알링턴 국립묘지에서만 가용합니다)로 이루어져 있습니다. 군 장례 예우의 완전한 형태에서 일부 요소가 부재할 경우엔 변형 예우로 칭하며 이는 보통 유가족의 요청에 따른 것입니다. 외국에서 군 장례 예우를 받는 것은 보다 힘든 일입니다. 미국 내에서는 일반적으로 제대군인 지원조직이 묘지에서 진행되는 장례식 도중 군 장례 예우를 제공하나, 외국에서는 가용할 경우에만 제공됩니다.

12. 기타

가. 고인의 유산이 귀하와 공동명의로 되어있지 않다면 일반적으로 고인의 유언 검인 절차를 밟아야 할 것 입니다.

(1) 유산이 공동명의로 되어있지 않다면 귀하는 유언 검인 절차를 거주지가 위치한 주에서 밟아야 합니다. 이 경우 유언 검인 관련 서류를 준비하여 법원에 제출할 미국 변호사를 구해야 할 것 입니다. 이와 관련하여 법적 비용이 발생할 것 입니다.

(2) 해외에서 작성된 미국의 유언장 및 유언집행장은 일정 요건을 충족할 경우 한국에서도 효력을 인정받을 수 있습니다. 한국 법은 다음 중 하나의 법에 따라 작성된 경우, 해당 유언장을 유효한 것으로 간주합니다.

- 유언 또는 사망 당시 본인의 본국법에 따른 경우
- 유언 또는 사망 당시 거주국의 법에 따른 경우
- 유언이 작성된 장소의 법에 따른 경우
- 부동산이 소재한 지역의 법에 따른 경우

나. 은행에 사망 사실 신고 및 계좌정보 최신화

(1) 영내 미국 은행

(가) 은행에 고인의 사망 사실을 신고할 시 공동명의계좌가 아닌 경우 고인의 계좌는 잠금 상태가 됩니다.

(나) 공동명의 신용카드의 경우 사망 사실 신고 후 일반적으로 해지됩니다.

(다) 공동명의계좌가 있을 시 고인의 이름을 삭제하고 필요 시 다른 공동명의자의 이름을 추가하여 정보를 갱신하십시오.

(2) 외국 은행. 한국의 은행계좌는 일반적으로 공동명의계좌가 아닙니다. 고인이 된 배우자의 계좌에서 자금을 인출하기 위해서는 한국 변호사를 구해야 할 수도 있습니다. 또한 귀하는 고인의 금융자산을 취득함에 따라 세금을 내야할 수도 있습니다.

다. 미국 재향 군인회(AML), 해외 참전 제대군인회(VFW) 등 제대군인 지원 단체에 고인의 사망 사실을 신고하시기 바랍니다.

라. 신용평가기관에 고인의 사망 사실을 통보하여 고인의 정보 및 신용평가를 사용한 신분도용을 방지하십시오.

Appendix A - SF Form 1174, Claim for Unpaid Compensation of Deceased Member of the Uniformed Service (사망 군인 미지급 보상금 청구 신청)

Part D

1. If none of the above survives and an executor or administrator has been appointed, the following statements should be

I/we have been duly appointed _____ of the estate of the deceased, as evidence, as evidenced by
(Executor or administrator)

certificate of appointment herewith, administration having been taken out in the interest of

(Name, address, and relationship of interested relative or creditor)

and such appointment is still in full force and effect.

NOTE, --If making claim as the executor or administrator of the estate of the deceased, no witnesses are required, but a court certificate evidencing your appointment must be submitted.

2. If no administrator or executor has been appointed, will one be _____
(Yes or No)

**DESIGNATED BENEFICIARY, SURVIVING SPOUSE, CHILDREN, PARENTS, OR LEGAL REPRESENTATIVES DO NOT
FILL IN PART E. ALL OTHER MUST.**

Part E

Have the funeral expenses been paid _____ (If paid, receipted bill of the undertaker must be attached hereto.)
(Yes or No)

Whose money was used to pay the funeral expenses _____

**FINES, PENALTIES, and FORFEITERS are imposed by law for the making of false or fraudulent
claims against the United States or making of false statements in connection therewith.**

(Signature of claimant)

(Date)

(Signature of claimant)

(Date)

(Street address)

(Street address)

(City, State and ZIP code)

(City, State and ZIP code)

TWO WITNESSES ARE REQUIRED

We certify that we are well acquainted with the _____ and that
(Name(s) of claimant)
the signature(s) of the claimant(s) was (were) affixed in our presence.

(Signature of witness)

(Signature of witness)

(Street address)

(Street address)

(City, State and ZIP code)

(City, State and ZIP code)

All Federal checks in possession of the claimant, drawn to the order of the decedent, in payment of pay and allowance should accompany this claim.

Appendix B - DD Form 2656-7, Verification of Annuity (연금 확인)

VERIFICATION FOR SURVIVOR ANNUITY

OMB No. 0704 - 0569
OMB approval expires
20260831

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. Chapter 73, subchapters II and III Survival Benefit Plan; DoD Instruction 1332.42, Survivor Annuity Program Administration; and E.O. 9397 (SSN), as amended.
PRINCIPAL PURPOSE(S): Used by the surviving spouse, dependent child(ren), surviving former spouse(s), and/or natural persons with an insurable interest (as defined in the Glossary, DoDI 1332.42) to verify eligibility for an annuity under the Retired Serviceman's Family Protection Plan (RSFPP), Survivor Benefit Plan (SBP), and/or Reserve Component Survivor Benefit Plan (RCSBP).

ROUTINE USE(S): The System of Record Notice (SORN) T7347b is published at: <https://www.federalregister.gov/documents/2009/01/07/E9-41/privacy-act-of-1974-systems-of-records>

DISCLOSURE: Voluntary; however, failure to provide identifying information may delay the verification process and any subsequent payment.

INSTRUCTIONS

Please verify that the information provided below is correct. Please provide any missing information and line through and correct any errors. After verifying the information provided, please sign the form below and return it to: **Defense Finance and Accounting Service, U.S. Military Annuitant Pay, 8899 E. 56th Street, Indianapolis, IN 46249-1300** or fax it to DFAS toll-free at **1-800-982-8459**. If you have questions or need assistance completing this form, please contact DFAS toll-free at **1-800-321-1080**.

1. DECEASED MEMBER DATA VERIFICATION

a. DECEASED MEMBER'S NAME (Last, First, Middle Initial)

b. SOCIAL SECURITY NUMBER

c. DATE OF BIRTH (YYYYMMDD)

d. DATE OF DEATH (YYYYMMDD)

e. BRANCH OF SERVICE

f. RANK/RATE

2. CLAIMANT VERIFICATION

a. CLAIMANT'S NAME (Last, First, Middle Initial)

b. SOCIAL SECURITY NUMBER

c. DATE OF BIRTH (YYYYMMDD)

d. TELEPHONE (Include Area Code)

e. CITIZEN OF (Country)

f. IF YOU ARE A NONRESIDENT ALIEN, X HERE, ENTER YOUR COUNTRY OF RESIDENCE, AND SEE NOTE.

NOTE: ALIEN TAX WITHHELD: Nonresident aliens are automatically taxed at the rate of 30 percent, unless there is a tax treaty between the United States and the foreign country permitting a lesser rate. If the country in which the annuitant lives has a tax treaty with the United States, then complete IRS Form W-8BEN, *Certificate of Foreign Status of Beneficial Owner for United States Tax Withholding* showing the country of residence. This Form may be obtained from any United States Internal Revenue Service office, United States consulate office, on the Internet at www.irs.gov/pub/irs-pdf/fw8ben.pdf, or by calling the Defense Finance and Accounting Service, toll free **1-800-321-1080** or from overseas **(216) 522-5955**. The Defense Finance and Accounting Service will mail foreign annuitants IRS Form 1042-S, *Foreign Person's U.S. Source Income Subject to Withholding*, at the end of each year for tax reporting purposes.

g. TYPE OF BENEFIT CLAIMED

 SBP
 RCSBP
 RSFPP

h. RELATIONSHIP TO DECEDENT (X One)

 SPOUSE
 CHILD
 FORMER SPOUSE
 INSURABLE INTEREST

i. CORRESPONDENCE ADDRESS (Street, Apartment Number, City, State and ZIP Code)

3. THE FOLLOWING SECTION APPLIES TO SPOUSE APPLICANTS ONLY

a. I CERTIFY THAT I WAS LEGALLY MARRIED TO THE MEMBER ON THE DATE OF DEATH:

 YES NO(1) If YES, please verify date of marriage to member:
(If blank or incorrect, please provide correct marriage date)

(2) If NO, please provide the date of divorce: (YYYYMMDD)

b. ARE THERE CHILDREN UNDER AGE 23 OR INCAPACITATED OF THE DECEASED MEMBER?

(If YES, please provide the following for each child:)

 YES NO

(1) NAME (Last, First Middle Initial)

(2) SSN

(3) DATE OF BIRTH (YYYYMMDD)

I understand that my annuity may be affected if I am receiving any other military survivor annuity of any kind from this deceased member or any other deceased member. I also understand that I am obligated to notify DFAS of any other annuities that might affect my entitlement.

c. ARE YOU RECEIVING ANY OTHER ANNUITY FROM DFAS BASED ON THE MILITARY RECORD OF ANY OTHER DECEASED MILITARY RETIREE? (If YES, please provide the following:)

 YES NO

(1) Name of Deceased Retiree (Last, First, Middle Initial)

(2) SSN

(3) Coverage Type

 SBP
 RSFPP

(4) Monthly Benefit Amount

\$

DECEASED MEMBER'S NAME (Last, First, Middle Initial)		SOCIAL SECURITY NUMBER	
4. THE FOLLOWING SECTION APPLIES TO CHILD APPLICANTS ONLY			
a. ARE YOU MARRIED?	<input type="checkbox"/> YES <input type="checkbox"/> NO	b. IF YOU ARE 18 YEARS OF AGE OR OLDER, ARE YOU A FULL-TIME STUDENT?	<input type="checkbox"/> YES <input type="checkbox"/> NO
5. THE FOLLOWING SECTION APPLIES TO FORMER SPOUSE APPLICANTS ONLY			
a. DATE OF DIVORCE FROM DECEASED MEMBER (YYYYMMDD)		b. DATE OF REMARRIAGE (YYYYMMDD)	
6. STATEMENT OF UNDERSTANDING - DEPENDENCY AND INDEMNITY COMPENSATION (DIC) (This applies to spouse applicants only.)			
<p>The surviving spouse of a deceased member may be eligible for DIC, payable by the Department of Veterans Affairs (VA) if the member dies from a disease or injury incurred or aggravated in the line of duty while on active duty, active duty for training, or inactive duty for training. A spouse receiving DIC may not receive the full amount of an annuity under SBP, or RCSBP. In order to eliminate problems resulting from an annuity overpayment due to concurrent DIC payments, a statement of understanding is provided for your signature.</p> <p>I UNDERSTAND THAT:</p> <ul style="list-style-type: none"> - I cannot receive both the full amounts of my annuity and DIC from the same deceased member. - DFAS will establish my annuity in full if DIC or other survivor annuity payments data, as may be applicable, is not known at time of establishment. - I am only entitled to the amount of the annuity that exceeds the DIC payment that may be payable, or the DIC only if that payment is greater than the annuity. Note: All SBP premiums paid will be refunded if the SBP annuity is not payable because the DIC payment is greater. In cases where the annuity is greater than the DIC payment, the cost will be recalculated and the difference between the SBP premiums paid and the recalculated cost will be refunded. - If any overpayment of benefits occurs as the result of being awarded DIC, my signature on this statement authorizes the VA to repay DFAS the amount of the overpayment from the DIC payments to which I am or may become eligible. - In the event I apply to the VA for DIC, I agree to notify DFAS of that application to include the address of the VA Office applied to, VA Claim number, and if applicable, the amount of award. 			
a. HAVE YOU APPLIED OR DO YOU INTEND TO APPLY TO THE VETERAN'S ADMINISTRATION (VA) FOR BENEFITS? (If YES, please provide the following:)			<input type="checkbox"/> YES <input type="checkbox"/> NO
(1) VA Claim Number	(2) VA Monthly Award Amount \$	(3) Mailing Address of VA Office Handling Your Account (Street, City, State, ZIP Code)	
7. CLAIM CERTIFICATION AND SIGNATURE (To be completed by ALL applicants)			
<p>The claimant or authorized representative must sign. The signature must be that of: the applicant; or for the annuitant by: the custodial natural parent or the legal representative; guardian; or custodian. Failure to sign will delay payment of the annuity.</p>			
a. SIGNATURE OF APPLICANT OR LEGAL REPRESENTATIVE (If applicable)		b. DATE SIGNED (YYYYMMDD)	
<p>The public reporting burden for this collection of information is estimated to average 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. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Washington Headquarters Services, at whs.mc-alex.esd.mbx.dd-dod-informationcollections@mail.mil. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.</p>			

Appendix C - VA Form 21P-534EZ, Application for D.I.C., Survivors Pension, and/or
Accrued Benefits (유족보상금, 유족연금, 혹은 미지급급여)

NOTICE TO SURVIVOR OF EVIDENCE NECESSARY TO SUBSTANTIATE A CLAIM FOR DEPENDENCY AND INDEMNITY COMPENSATION, SURVIVORS PENSION, AND/OR ACCRUED BENEFITS

This notice provides information regarding evidence necessary to substantiate a claim for:

- Survivors Pension
- Dependency Indemnity Compensation (D.I.C.)
- D.I.C. under 38 U.S.C. 1151
- D.I.C. re-evaluation based on PL 117-16 (PACT ACT)
- Increased Survivor Benefits Based on Need for Special Monthly Pension or Special Monthly D.I.C.
- Accrued Benefits
- Benefits Based on a Veteran's Seriously Disabled Child

If you are making a claim for:

- Parents' D.I.C. and/or accrued benefits for parents use - VA Form 21P-535, *Application for Dependency and Indemnity Compensation by Parent(s) (Including Accrued Benefits and Death Compensation when Applicable)*
- Veteran's disability compensation use - VA Form 21-526EZ, *Application for Disability Compensation and Related Compensation Benefits*
- Veteran's pension benefits use - VA Form 21P-527EZ, *Application for Veterans Pension*
- Accrued benefits only use - VA Form 21P-601, *Application for Accrued Benefits Due a Deceased Beneficiary*

If you are **not** ready to submit a claim for D.I.C., Survivors Pension, and/or Accrued Benefits, please complete a VA Form 21-0966, *Intent to File a Claim for Compensation and/or Pension, or Survivors Pension and/or D.I.C.*, to protect your date of claim. If you complete the VA Form 21P-534EZ within one year of filing the VA Form 21-0966, your completed application will be considered filed as of the date of receipt of the VA Form 21-0966.

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

ASSISTANCE WITH COMPLETING YOUR CLAIM

Veteran Service Officer (VSO)

You may wish to contact an accredited Veteran Service Officer to assist you with your application. For a list of accredited veteran's service organizations go to <https://www.va.gov/vso/>. You may also contact your state office of Veterans Affairs at <https://www.va.gov/statedva.htm>, should you need further assistance with the application process. To assign a VSO as your power of attorney for the claims process please submit VA Form 21-22, *Appointment of Veteran Service Organization as Claimant's Representative*.

Private Attorney and Claims Agents

Attorneys and claims agents are available to assist you in completing your application. To verify if your attorney or claims agent is accredited by the Department of Veterans Affairs go to: <https://www.va.gov/ogc/apps/accreditation/index.asp>. To assign a private attorney or claims agent as your power of attorney for the claims process please submit a VA Form 21-22a, *Appointment of Individual as Claimant's Representative*.

Fees for Claims

Section 5904, Title 38, United States Code (codified in § 14.636, Title 38, Code of Federal Regulations) contains provisions regarding fees that may be charged, allowed, or paid for services provided by a VA-accredited attorney or agent in connection with a proceeding before the Department of Veterans Affairs with respect to a claim for benefits under laws administered by the Department. Generally, a VA-accredited attorney or agent may charge you a fee for assisting in seeking further review of a claim for VA benefits only after VA has issued an initial decision on the claim and the attorney or agent has complied with the applicable power-of-attorney and the fee agreement requirements.

WHEN TO USE THIS FORM

The attached application and the worksheets are needed to submit a claim for D.I.C., Survivors Pension, and/or Accrued Benefits. The application is comprised of 14 sections. This notice details the evidence necessary to substantiate your claim.

NOTE: PLEASE LEAVE ITEMS IN THE SECTION BLANK THAT DO NOT APPLY.

SECTION I: Veteran's Identification Information	SECTION VIII: Nursing Home or Increased Survivors Entitlement Based on a Claim For Special Monthly Pension
SECTION II: Claimant's Contact Information	
SECTION III: Veteran's Service Information	SECTION IX: Income and Assets
SECTION IV: Marital Information	SECTION X: Information About Your Medical or Other Expenses
SECTION V: Marital History	SECTION XI: Direct Deposit Information
SECTION VI: Child of the Veteran Information	SECTION XII: Claim Certification and Signature
SECTION VII: D.I.C.	SECTION XIII: Witness to Signature
	SECTION XIV: Alternate Signer Certification and Signature

WANT TO GET YOUR CLAIM PROCESSED FASTER?

Participation in the FDC Program is:

- An Optional Expedited process (enrollment is automatic unless you opt-out).
- Will not affect the quality of care you receive or the benefits to which you are entitled.

You will be removed from the FDC program if:

- It is determined that other non-federal records exist, and VA needs the records to decide your claim.

See below for more information.

- If you wish to file your own claim in the FDC Program, see FDC Program.
- If you wish to file your claim under the process in which VA traditionally processes claims, see Standard Claim Process.

FDC Program Criteria

To qualify for the FDC Program you must:

1. Submit your claim on a completed, signed and dated VA Form 21P-534EZ, *Application for D.I.C., Survivors Pension, and/or Accrued Benefits* (Attached).

2. Submit simultaneously with your claim:

- A copy of the veteran's death certificate (unless the veteran died on active duty); AND

If claiming Survivor's Pension:

- All necessary income and asset information; AND
- Any additional forms and evidence as the situation requires. Special Circumstances below indicate the most common circumstances. The application and other VA Forms may require additional evidence.

If claiming D.I.C.:

- All, if any, of the veteran's relevant, private medical treatment records and an identification of any of the veteran's treatment records available at a Federal facility, such as a VA medical center, that supports your claim that a service-connected disability caused the veteran's death or the veteran's death was caused by the VA;
- Any and all Service Treatment and Personnel Records in the custody of the veteran's Guard or Reserve Unit(s) if applicable; AND
- Any additional forms and evidence as the situation requires. Special Circumstances below indicate the most common circumstances. The application and other VA Forms may require additional evidence.

3. Report for any VA examinations VA determines are necessary to decide your claim.

For more information on the FDC Program, visit our website at <https://www.choose.va.gov/pensions>. For more information on VA benefits, visit our website at www.va.gov, contact us at <https://www.va.gov/contact-us> or call us toll-free at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the number is 711.

SPECIAL CIRCUMSTANCES:

Additional forms may be needed to remain eligible for the FDC Program.

This includes VA Form 21P-0969, *Income and Asset Statement in Support of Claim for Pension or Parents' D.I.C.*, which may be required if you:

- Have multiple income sources
- Have more than \$25,000 in assets
- Additional forms as noted on the VA Form 21P-0969 may be required

If claiming Special Monthly Pension or Special Monthly D.I.C.:

- Please have a Physician, Physician Assistant (PA), Certified Nurse Practitioner (CNP), or Clinic Nurse Specialist (CNS) complete VA Form 21-2680, *Examination for Household Status or Permanent Need for Regular Aid and Attendance*, **OR**
- If you are a patient in a nursing home complete VA Form 21-0779, *Request for Nursing Home Information in Connection with Claim for Aid and Attendance*

If claiming benefits for a child of the veteran:

- And they are in school between the ages of 18 and 23, a completed VA Form 21-674, *Request for Approval of School Attendance*
- If the child was adopted, please submit the adoption papers or amended birth certificate
- If claiming benefits for a child of the veteran who became seriously disabled prior to reaching the age of 18, submit all, if any, relevant private medical treatment records for the child's pertinent disabilities

WHAT YOU NEED TO DO

You must submit all relevant evidence in your possession and provide VA information sufficient to enable it to obtain all relevant evidence not in your possession. If your claim involves a disability the veteran had before entering service and that was made worse by service, please provide any information or evidence in your possession regarding the health condition that existed before the veteran's entry into service. A substantially complete claim must contain: (1) The claimant's name; (2) Their relationship to the veteran (3) Sufficient service information for VA to verify the claimed service, if applicable; (4) The benefit sought and any medical condition(s) on which it is based; (5) The claimant's signature; (6) A statement of income, if applicable.

FDC PROGRAM (OPTIONAL EXPEDITED PROCESS)	STANDARD CLAIM PROCESS
<p>You must:</p> <ul style="list-style-type: none"> • Submit your claim in accordance with the "FDC Criteria" (see page 2) 	<p>You must:</p> <ul style="list-style-type: none"> • If you know of evidence not in your possessions and want VA to try to get it for you, give VA enough information about the evidence so that we can request it from the person or agency that has it. <p>NOTE: If the holder of the evidence declines to give it to VA, asks for a fee to provide it, or otherwise cannot get the evidence, VA will notify you and provide you with an opportunity to submit the information or evidence. It is your responsibility to make sure we receive all requested records that are not in the possession of a Federal department or agency.</p>

HOW VA WILL HELP YOU OBTAIN EVIDENCE FOR YOUR CLAIM

VA will retrieve evidence on your behalf in some circumstances. If VA is unable to retrieve the necessary evidence, we will notify you and provide you with an opportunity to submit the information or evidence. It is your responsibility to make sure we receive all requested records that are not in the possession of a federal department or agency.

FDC PROGRAM (OPTIONAL EXPEDITED PROCESS)	STANDARD CLAIM PROCESS
<p>VA will:</p> <ul style="list-style-type: none"> • Retrieve relevant records from a Federal facility, such as a VA medical center, that you adequately identify and authorize VA to obtain. • Get a medical opinion if we determine it is necessary to decide your claim 	<p>VA will:</p> <ul style="list-style-type: none"> • Retrieve relevant records from a Federal facility that you adequately identify and authorize VA to obtain. • Get a medical opinion if we determine it is necessary to decide your claim • Make every reasonable effort to obtain relevant records not held by a Federal facility that you adequately identify and authorize VA to obtain. These may include records from State or local governments and privately held evidence and information you tell us about, such as private doctor or hospital records from current or former employers.

WHEN YOU SHOULD SEND WHAT WE NEED

FDC PROGRAM (OPTIONAL EXPEDITED PROCESS)	STANDARD CLAIM PROCESS
<p>You must:</p> <ul style="list-style-type: none"> • Send the information and evidence simultaneously with your claim. <p>NOTE: If you submit additional information or evidence after you submit your "fully developed" claim, then VA will remove the claim from the FDC Program expedited process and process it in the Standard Claim process. If we decide your claim before one year from the date we received the claim, you will still have the remainder of the one-year period to submit additional information or evidence necessary to support the claim.</p>	<p>You are strongly encouraged to:</p> <ul style="list-style-type: none"> • Send any information or evidence as soon as you can. <p>NOTE: You have up to one year from the date we receive the claim to submit the information and evidence necessary to support your claim. If we decide the claim before one year from the date we received the claim, you will still have the remainder of the one year period to submit additional information or evidence necessary to support the claim.</p>

WHAT THE EVIDENCE MUST SHOW TO SUPPORT YOUR CLAIM

If you are claiming...	See Evidence Tables titled...
Survivor's Pension (a needs based benefit based on the veteran's wartime service)	Military Service Verification Survivor's Pension
D.I.C. because the veteran's death was related to the veteran's service, OR D.I.C. because the veteran was receiving or entitled to receive benefits for a service-connected disability rated totally disabling	Dependency and Indemnity Compensation (D.I.C.)
D.I.C. because the veteran's death was a result of VA medical treatment, vocational rehabilitation, or compensated work therapy	D.I.C. under 38 U.S.C. 1151
D.I.C. re-evaluation of a previously denied claim based on eligibility under PL 117-168 (PACT Act)	D.I.C. re-evaluation based on PL 117-168 (PACT Act)
D.I.C. that was previously denied by VA	Supplemental D.I.C.
Special Monthly Pension or Special Monthly D.I.C. based on the need for aid and attendance or housebound benefits	Increased Survivor Benefits Based on Special Monthly Pension or Special Monthly D.I.C.
Benefits that were due to the veteran at the time of the veteran's death	Accrued Benefits
Benefits because the child of the veteran is severely disabled	Child incapable of self-support

EVIDENCE TABLES

MILITARY SERVICE VERIFICATION

To support your claim for **Survivors benefits**, the veteran's military service must be verified. The following evidence can be submitted to verify the veteran's military service:

- A photocopy of the veteran's DD 214 (or equivalent) for all periods of military service. You may request a copy of the DD 214 through the National Archives' National Personnel Records Center (NPRC) using Standard Form 180 (SF-180, 09/2021 version), *Request Pertaining to Military Records*, (available at <https://www.gsa.gov/forms>) or through your local public custodian of records

Fire Related Military Records

As you may know, there was a fire at the National Archives and Records Administration on July 12, 1973, which destroyed approximately:

- 80 percent of the records NPRC held for Veterans who were discharged from the Army between November 1, 1912, and January 1, 1960, and
- 75 percent of the records NPRC held for Veterans with surnames beginning (alphabetically) with Hubbard and running through the end of the alphabet, and who were discharged from the Air Force between September 25, 1947, and January 1, 1964.

If the veteran's military records were stored there on that date, they may have been destroyed in the fire. If you believe the veteran's military records may have been destroyed in the fire, NA Form 13075, *Questionnaire About Military Service*, should be completed to avoid delays in processing your claim. NA Form 13075 is available at:

<https://www.archives.gov/files/st-louis/military-personnel/na-13075-questionnaire-about-military-service.pdf>.

NOTE: The Veterans Benefits Administration (VBA) is no longer able to retrieve or return original documents submitted. Please **do not** submit original documents to VA since they **will not** be returned to you.

SURVIVORS PENSION

To support your claim for **Survivors Pension**, the evidence must show:

1. The veteran met certain minimum active service requirements during a period of war. Generally, those requirements are:

- 90 days of service during a period of war; **OR**
- 90 days of consecutive service at least one day of which was during a period of war; **OR**
- 90 days of combined service during more than one period of war
(**Note:** If the veteran's service began after September 7, 1980, additional length-of-service requirements may apply, typically requiring two years of continuous service or completion of active-duty obligations.); **OR**
- any length of active service during a period of war when:
 - at the time of death, the veteran was receiving (or entitled to receive) VA disability compensation or retirement pay for a service-connected disability; **OR**
 - the veteran was discharged from active service due to a service-connected disability.

2. Your income and assets do not exceed certain requirements.

Assets means the fair market value of all property that an individual owns, including all real and personal property (excluding the value of the primary residence including the residential lot area that does not exceed 2 acres, unless the additional acreage is not marketable) less the amount of mortgages or other encumbrances specific to the mortgaged or encumbered property. Personal property means the value of personal effects that are in excess of being suitable and consistent with a reasonable mode of life.

EVIDENCE TABLES (Continued)

DEPENDENCY AND INDEMNITY COMPENSATION (D.I.C.)

To support a claim for **Dependency and Indemnity Compensation (D.I.C.) based on a service-connected disability**:

- The veteran died while on active service; **OR**
- The veteran had a service-connected disability(ies) that was either the principal or contributory cause of the veteran's death; **OR**
- The veteran died from non-service-connected injury or disease **AND** was receiving, or entitled to receive VA compensation for a service-connected disability rated totally disabling:
 - For at least 10 years immediately before death; **OR**
 - For at least 5 years after the veteran's release from active duty preceding death; **OR**
 - For at least 1 year before death, if the veteran was a former prisoner of war who died after September 30, 1999.

To support a claim for **D.I.C. based on a disability that was not service-connected** or for which the veteran did not file a claim during their lifetime, the evidence must show:

- An injury or disease that was incurred or aggravated during active service, or an event in service that caused an injury or disease; **AND**
- A physical or mental disability that was either the principle or contributory cause of death. This may be shown by medical evidence or by lay evidence of persistent and recurrent symptoms of disability that were visible or observable; **AND**
- A relationship between the disability associated with the cause of death and an injury, disease, or event in service. This may be shown by medical records or medical opinion or, in certain cases, by lay evidence.

To support your claim for **D.I.C. based upon the service person's active duty for training**, the evidence must show:

- The service person was disabled during active duty for training due to a disease or injury incurred in the line of duty and the disease or injury caused or contributed to the service person's death.

NOTE: If VA granted service connection for a disease or injury during the service person's lifetime, evidence that the service-connected disease or injury caused or contributed to the service person's death may satisfy this requirement.

To support a claim for **D.I.C. based on a disability that was not service-connected** or for which the service person did not file a claim during their lifetime, the evidence must show:

- The service person was disabled during active duty for training due to a disease or injury incurred in the line of duty; **AND**
- A physical or mental disability that was either the principle or contributory cause of death. This may be shown by medical evidence or by lay evidence of persistent and recurrent symptoms of disability that were visible or observable; **AND**
- A relationship between the principal or contributory cause of death and the disability due to injury or disease, incurred in the line of duty. This may be shown by medical records or medical opinions or, in certain cases, by lay evidence.

To support your claim for **D.I.C. based upon the service person's inactive duty training**, the evidence must show:

- The service person died during inactive duty training due to an injury incurred or aggravated in the line of duty, or acute myocardial infarction, cardiac arrest, or cerebrovascular accident during such training; **OR**
- The service person was disabled during inactive duty training due to an injury incurred or aggravated in the line of duty, or acute myocardial infarction, cardiac arrest, or cerebrovascular accident that occurred during such training; and that injury, acute myocardial infarction, cardiac arrest, or cerebrovascular accident caused or contributed to the service person's death.

NOTE: If VA granted service connection for an injury, acute myocardial infarction, or cerebrovascular accident during the service person's lifetime, evidence that the service-connected condition caused or contributed to the service person's death may satisfy this requirement.

To support a claim for **D.I.C. based on a disability that was not service-connected** or for which the service person did not file a claim during their lifetime, the evidence must show:

- The service person was disabled during inactive duty training due to an injury incurred or aggravated in the line of duty, or acute myocardial infarction, cardiac arrest, or cerebrovascular accident that occurred during such training; **AND**
- The injury, acute myocardial infarction, cardiac arrest, or cerebrovascular accident caused or contributed to the service person's death.

D.I.C. UNDER 38 U.S.C. 1151

In order to support your claim for **D.I.C. under 38 U.S.C. 1151**, the evidence must show:

- The deceased veteran died as a result of undergoing VA hospitalization, medical or surgical treatment, examination, or training; **AND**
- The death was:
 - the direct result of VA fault such as carelessness, negligence, lack of proper skill, or error in judgment; **OR**
 - the direct result of an event that was not a reasonably expected result or complication of the VA care or treatment; **OR**
 - the direct result of participation in a VA Vocational Rehabilitation and Employment or compensated work therapy program.

EVIDENCE TABLES (Continued)

D.I.C. RE-EVALUATION BASED ON PL 117-168 (PACT ACT)

Public Law 117-168 (PACT ACT) was signed into law on August 10, 2022. This resulted in a substantial expansion of a veteran's military service that qualifies for presumptive toxic exposure and new presumptive conditions linked to that exposure. The law allows prior claimants for D.I.C. to request a re-evaluation based on the expanded eligibility within the PACT Act. More information about the PACT Act can be found at <https://www.va.gov/resources/the-pact-act-and-your-va-benefits/>.

In order to support your claim for **D.I.C. re-evaluation based on PL 117-168 (PACT Act)** the evidence must show:

- A claim was submitted and denied prior to August 10, 2022, the date the PACT Act went into effect; **AND**
- The claimant has elected re-evaluation of the previously denied claim.

SUPPLEMENTAL D.I.C.

In order to reopen a **claim previously denied by VA**, we need:

- The prescribed supplemental claim form, VA Form 20-0995, *Decision Review Request: Supplemental Claim*; **AND**
- New and relevant evidence. New and relevant evidence must raise a reasonable possibility of substantiating your claim. The evidence cannot simply be repetitive or cumulative of the evidence we had when we previously decided your claim. VA will make reasonable efforts to help you obtain currently existing evidence. However, we cannot provide a medical examination or obtain a medical opinion until your claim is successfully reopened.
 - To qualify as new, the evidence must currently exist and be submitted to VA for the first time
 - In order to be considered relevant, the additional existing evidence must pertain to the reason your claim was previously denied

INCREASED SURVIVOR BENEFITS BASED ON SPECIAL MONTHLY PENSION OR SPECIAL MONTHLY D.I.C.

In order to support your claim for **increased survivor benefits based on the need for aid and attendance**, the evidence must show:

- you have corrected vision of 5/200 or less in both eyes; **OR**
- you have concentric contraction of the visual field to 5 degrees; **OR**
- you are a patient in a nursing home due to mental or physical incapacity; **OR**
- you require the aid of another person to perform personal functions required in everyday living, such as bathing, feeding, dressing yourself, attending to the wants of nature, adjusting prosthetic devices, or protecting yourself from the hazards of your daily environment (38 Code of Federal Regulations 3.352(a)); **OR**
- you are bedridden, in that your disability or disabilities requires that you remain in bed apart from any prescribed course of convalescence or treatment (38 Code of Federal Regulations 3.352(a)); **OR**

In order to support your claim for **increased benefits based on being housebound**, the evidence must show:

- you are substantially confined to your immediate premises because of permanent disability

ACCRUED BENEFITS

To support a claim for **accrued benefits**, the evidence must show:

- Benefits were due the veteran based on existing ratings, decisions, or evidence in VA's possession at the time of death, but the benefits were not paid before the veteran's death; **AND**
- You are the surviving spouse, child, or dependent parent of the deceased veteran

VA pays accrued benefits in the following order of priority:

1. Spouse
2. Children of the veteran (in equal shares)
3. Dependent parents (in equal shares)

NOTE: Child means an unmarried child of the veteran who is under 18 years of age, or at least 18 but under 23 years of age and pursuing an approved course of education or became incapable of self-support prior to reaching age 18.

If there are no living persons who are entitled on the basis of relationship, accrued benefits may be used to reimburse the person or persons who paid for or are responsible to pay the expenses of last illness and burial of a beneficiary. The claim should be filed by the person or persons whose funds were or will be used to pay such expenses using VA Form 21P-601, *Application for Accrued Amounts Due a Deceased Beneficiary*.

CHILD INCAPABLE OF SELF-SUPPORT

To support a **claim for benefits based on a veteran's child being incapable of self-support**, the evidence must show that the child, before their 18th birthday became permanently incapable of self-support due to mental or physical disability. The information necessary to establish the extent of the child's disability includes:

- the extent to which the child is and was, prior to reaching their 18th birthday, physically or mentally deficient as evidenced by factors such as their ability to perform self-care functions, and ordinary tasks expected of a child of that age
- whether or not the child attended school and, if so, the maximum grade attended
- if any material improvement in the child's condition has occurred
- if the child has ever been employed and, if so, the nature and dates of such employment, and amount of pay received
- whether or not the child has ever been married, and
- a description of the child's present condition

PRESUMPTIVE SERVICE CONNECTION

To support a claim for presumptive service connection the evidence must show:

- The veteran served in a recognized location that qualifies for the presumption of exposure; **AND/OR**
- The veteran died of a disability that qualifies for the presumption of service connection. This may be shown by medical evidence or by lay evidence of persistent and recurrent symptoms of disability that are visible or observable

Under certain circumstances, VA may presume that certain current diseases were caused by service, even if there is no specific evidence proving this in your particular claim. Service connection is presumed for certain diseases for the following veterans:

- Former prisoners of war;
- Veterans who have certain chronic or tropical diseases that become evident within a specific period of time after discharge from service;
- Veterans who were exposed to ionizing radiation, mustard gas, or Lewisite while in service;
- Veterans who were exposed to certain herbicides, such as by service in/on:
 - Vietnam or qualifying offshore waters, from January 9, 1962, through May 7, 1975;
 - a unit determined by VA or the Department of Defense to have operated in the Korean DMZ, from September 1, 1967, through August 31, 1971;
 - individuals who performed service in the Air Force or Air Force Reserve and regularly and repeatedly operated, maintained, or served on board C-123 aircraft known to have used to spray an herbicide agent during the Vietnam era;
 - Thailand at any United States or Royal Thai base, from January 9, 1962, through June 30, 1976;
 - Laos, from December 1, 1965, through September 30, 1969;
 - Cambodia at Mimot or Krek, Kampong Cham Province, from April 16, 1969, through April 30, 1969;
 - Guam or American Samoa, or in the territorial waters thereof, from January 9, 1962, through July 31, 1980;
 - Johnston Atoll or on a ship that called at Johnston Atoll, from January 1, 1972, through September 30, 1977.
- Veterans who served at Camp Lejeune for no less than 30 days (consecutive or nonconsecutive) between August 1, 1953 and December 31, 1987; **OR**
- Veterans who served in the Gulf War:
 - On or after August 2, 1990, and served in:
 - Bahrain; Iraq; the neutral zone between Iraq and Saudi Arabia; Kuwait; Oman; Qatar; Saudi Arabia; Somalia; United Arab Emirates; the Gulf of Aden; the Gulf of Oman; the Persian Gulf; the Arabian Sea; the Red Sea; Afghanistan; Israel; Egypt; Turkey; Syria; or Jordan; **OR**
 - On or after September 11, 2001, and served in:
 - Afghanistan; Djibouti; Egypt; Jordan; Lebanon; Syria; Yemen; or Uzbekistan.

IMPORTANT INFORMATION REGARDING MARRIAGE

If you are certifying that you are married for the purpose of VA benefits, your marriage must be recognized by the place where you and/or your spouse resided at the time of marriage, or where you and/or your spouse resided when you filed your claim (or a later date when you became eligible for benefits) (38 U.S.C. § 103(c)). Additional guidance on when VA recognizes marriages is available at <http://www.va.gov/opa/marriage/>.

HOW VA DETERMINES THE EFFECTIVE DATE

If we grant a claim for Survivors benefits, the beginning date of your entitlement will generally be the date we received your claim. However, if VA receives your claim within one year after the date of the veteran's death, entitlement will be from the first day of the month in which the veteran died. The veteran's death certificate is evidence relevant to determining the effective date of any benefits we award.

Special monthly pension may be available for a veteran's surviving spouse who is unable to perform certain activities of daily living, are a patient in a nursing home, or are substantially confined to their immediate premises. Special monthly pension may be effective from the date medical evidence first shows entitlement.

WHERE TO SEND COMPLETED APPLICATION AND EVIDENCE

When you have completed this application, you can either submit online or mail it to the Pension Intake Center listed below. Be sure to attach any materials that support and explain your claim. Also, make a photocopy of your application and any evidence you send to VA before submitting.

MAIL TO	SUBMIT ONLINE
Department of Veterans Affairs Pension Intake Center P.O. Box 5365 Janesville, WI 53547-5365	VA gov: www.va.gov Direct Upload via: access.va.gov

TERMS AND CALCULATIONS FOR SURVIVOR'S PENSION

Maximum Annual Pension Rate (MAPR)

This is the maximum payable amount of the benefit. Your MAPR is based on how many dependents you have and if your disabilities qualify you for Housebound or Aid and Attendance benefits. The MAPR is reviewed each year for cost-of-living adjustments.

Medical Deductible

The unreimbursed expenses must exceed 5 percent of the applicable MAPR. The deductible increases based on the number of dependents but is not adjusted for aid and attendance (A&A) or housebound.

Countable Medical Expenses

Your countable unreimbursed medical expenses are only those expenses that exceed the medical deductible. Medical expenses are typically considered on a calendar year basis.

- Recurring Medical Expenses
Examples may include Medicare Part B, Medical Insurance, In-Home Care Provider, or care provided by a care facility
- One-time Medical Expenses
Examples include Medical Co-Payments, Prescription Medications, and Durable Medical Equipment.

Countable Income

We count the income you report or the income we discover from data matching programs with other federal sources. If our data match shows a significant discrepancy, you will be removed from the FDC program and asked to clarify the discrepancy. We count incomes in three ways:

- One-time income is income that you receive once, and the VA will count it for one year from the receipt date.
Examples include Lottery winnings, gifts, capital gains from property sales, irregular IRA or stock disbursements
- Irregular-income is income that you receive at different time or in irregular amounts throughout the year and VA will count it for one year from the receipt date. Examples include odd job or contract work and interest income from fluctuating rates.
- Recurring income is counted continuously until we are informed that you are no longer in receipt of it.
Examples include wages from employment, retirement payments, required minimal distributions from an IRA.

Income for VA Purposes (IVAP)

The VA counts all your income and considers any unreimbursed medical expenses reported when determining your IVAP. The following calculation is a way for you to estimate your IVAP.

Countable Yearly Income – Countable Medical Expenses (less medical deductible) = Income for VA Purposes.

Pension Rate

Your maximum annual benefit is the difference of the current MAPR and what the VA calculates as your IVAP. To convert into a monthly benefit, take this amount and divide by 12 then rounded down to the nearest dollar.

Maximum Annual Pension Rate - Income for VA purposes = Annual Pension Rate.

Net Worth

The net worth limit is increased by the same percentage as the Social Security increase when there is a cost-of-living adjustment. For purposes of entitlement to VA pension, net worth includes your assets and your and your dependent's annual income. If your child has net worth that exceeds the limit, VA won't consider them to be a dependent when determining your pension entitlement.

Additional information about how VA calculates net worth, income, and benefit rates can be found at:

<https://www.va.gov/pension/survivors-pension-rates/>

SURVIVORS BENEFITS APPLICATION CHECKLIST

In addition to your application, VA may require some of the evidence described in this checklist. Failure to provide needed evidence, may delay the decision on your claim. This checklist does not apply to claims for Accrued benefits. Please carefully read pages 5 and 6 of the Instructions if you are claiming service-connected death (Dependency and Indemnity Compensation (D.I.C.)) only. Please note, the items marked with an asterisk (*) are required.

VERIFICATION OF VETERANS DEATH* *(Requested on page 2 of Instructions)*

- A Death certificate for the veteran, clearly showing the primary cause(s) of death and any contributing factors or conditions *(If the veteran's death certificate lists the cause of death as "Pending," please have the medical examiner submit evidence that shows the cause of death).*

SERVICE VERIFICATION* *(Requested on page 4 of Instructions and Section III of the form)*

- Copy of the veteran's DD Form 214 (or equivalent) for all periods of military service. Must demonstrate military service dates, type of service and character of discharge.

INCOME AND NET WORTH *(Requested on page 2 of Instructions and Section IX of the form)*

- VA Form 21P-0969, *Income and Asset Statement in Support of Claim for Pension or Parents' D.I.C.*, is required if instructed in Section IX of this application form. **NOTE:** If you have specific types of income or assets the VA Form 21P-0969 requires additional evidence:
- Farm - VA Form 21P-4165, *Pension Claim Questionnaire for Farm Income*
 - Business - VA Form 21P-4185, *Report of Income from Property or Business*
 - Rental Property - VA Form 21P-4185, *Report of Income from Property or Business*
 - Royalties - VA Form 21-4138, *Statement in Support of Claim* (provide details, such as Royalty source, joint owners, etc.)
 - Trust - Submit complete Trust documents to include the Schedule of Assets
 - Interest, Dividends or Financial Investments - Current account statements from financial Institution (Bank, Investment, Annuity, etc.)

SPECIAL CIRCUMSTANCES REGARDING YOUR MEDICAL CARE

(Requested on page 2 of Instructions and in Sections VIII and X of the form)

Claim for Special Monthly Pension (SMP) - Aid and Attendance or Household Status

- VA Form 21-2680, *Examination for Housebound Status or Permanent Need for Regular Aid and Attendance*

Claim for Medicare Nursing Home and/or \$90.00 Rate Reduction Request

- VA Form 21-0779, *Request for Nursing Home Information in Connection with Claim for Aid and Attendance*

Claim for Fiduciary Assistance

- VA Form 21-2680, *Examination for Housebound Status or Permanent Need for Regular Aid and Attendance*

Statement of Medical Care

- Care Worksheets (found on pages 19 and 20 of the form)
- Proof of Payment from care provided (canceled checks, bank statements, etc.)
- Signed verification from care service provider

DEPENDENT CHILDREN* *(Requested on page 2 of Instructions and Section VI of the form)*

- A birth certificate must be included clearly showing the veteran as the parent if you do not reside within the U.S. or its territories. (A state includes the District of Columbia, Puerto Rico and other territories and possessions of the U.S.)
- If child(ren) is/are adopted the adoption decree or a revised birth certificate is required.
- If your child is over 18 but under 23 please submit VA Form 21-674, *Request for Approval of School Attendance*.
- Medical records for each seriously disabled child.

MEDICAL EXPENSES *(Requested in Section X of the form)*

- If additional space is needed, submit VA Form 21P-8416, *Medical Expense Report*.

VETERAN'S SOCIAL SECURITY NUMBER - -

SECTION III: VETERAN'S SERVICE INFORMATION (Continued)

3B. DATE VETERAN ENTERED ACTIVE DUTY (MM/DD/YYYY) <input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	3C. DATE VETERAN RELEASED FROM ACTIVE DUTY (MM/DD/YYYY) <input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
3D. BRANCH OF SERVICE <input type="checkbox"/> ARMY <input type="checkbox"/> NAVY <input type="checkbox"/> AIR FORCE <input type="checkbox"/> MARINE CORPS <input type="checkbox"/> COAST GUARD <input type="checkbox"/> SPACE FORCE <input type="checkbox"/> NOAA <input type="checkbox"/> USPHS	3E. PLACE OF LAST SEPARATION
3F. WAS THE VETERAN ACTIVATED TO FEDERAL/ACTIVE DUTY UNDER AUTHORITY OF TITLE 10, U.S.C. (National Guard) <input type="checkbox"/> YES <input type="checkbox"/> NO (If "NO," skip to Item 3J)	3G. DATE OF ACTIVATION (MM/DD/YYYY) <input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
3H. WHAT IS THE NAME AND ADDRESS OF THE VETERAN'S RESERVE/NATIONAL GUARD UNIT? <input type="text"/> <input type="text"/> <input type="text"/>	3I. WHAT IS THE TELEPHONE NUMBER OF THE RESERVE/NATIONAL GUARD UNIT? (Include Area Code) <input type="text"/> - <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
3J. WAS THE VETERAN EVER A PRISONER OF WAR? <input type="checkbox"/> YES <input type="checkbox"/> NO (If "NO," skip to Section IV)	3K. DATES OF CONFINEMENT (MM/DD/YYYY) START: <input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> END: <input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

SECTION IV: MARITAL INFORMATION

(COMPLETE ONLY IF CLAIMING BENEFITS AS THE SURVIVING SPOUSE OF THE VETERAN)
 (Skip to Section VI if you are NOT claiming benefits as the surviving spouse of the veteran)

TELL US ABOUT YOUR MARRIAGE TO THE VETERAN

4A. AT THE TIME OF YOUR MARRIAGE TO THE VETERAN, WERE YOU AWARE OF ANY REASON THE MARRIAGE MIGHT NOT BE LEGALLY VALID? <input type="checkbox"/> YES <input type="checkbox"/> NO (If "YES," provide explanation below)		
4B. WERE YOU MARRIED TO THE VETERAN AT THE TIME OF HIS/HER DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO (If "NO," complete Item 4C)	4C. HOW DID YOUR MARRIAGE TO THE VETERAN END? <input type="checkbox"/> DEATH <input type="checkbox"/> DIVORCE <input type="checkbox"/> OTHER (Explain)	
4D. DATES OF YOUR MARRIAGE TO THE VETERAN (MM/DD/YYYY) START: <input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> END: <input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	4E. PLACE OF MARRIAGE (City/State or Country)	4F. PLACE OF MARRIAGE TERMINATION (City/State or Country)
4G. TYPE OF MARRIAGE (Ceremonial, Common-Law, Proxy, Tribal, etc.) <input type="checkbox"/> CEREMONIAL <input type="checkbox"/> OTHER (Explain):		
4H. WAS A CHILD BORN TO YOU AND THE VETERAN DURING YOUR MARRIAGE OR PRIOR TO YOUR MARRIAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	4I. ARE YOU EXPECTING THE BIRTH OF THE VETERAN'S CHILD? <input type="checkbox"/> YES <input type="checkbox"/> NO	4J. DID YOU LIVE CONTINUOUSLY WITH THE VETERAN FROM THE DATE OF MARRIAGE TO THE DATE OF HIS/HER DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO (If "YES," skip to Item 4L)
4K. WAS THE SEPARATION DUE TO MARITAL DISCORD, MEDICAL, OR FINANCIAL REASONS? <input type="checkbox"/> YES <input type="checkbox"/> NO (If "YES," provide explanation in space provided) NOTE: Give, the reason, date(s), and duration of the separation (If the separation was by court order, attach a copy of the order)		

TELL US ABOUT YOUR REMARRIAGE AFTER THE VETERAN'S DEATH

4L. HAVE YOU REMARRIED SINCE THE DEATH OF THE VETERAN? <input type="checkbox"/> YES <input type="checkbox"/> NO (If "NO," skip to Item 5A)	4M. WHAT ARE THE DATES OF YOUR REMARRIAGE? (MM/DD/YYYY) START: <input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> END: <input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
4N. HOW DID YOUR REMARRIAGE END? <input type="checkbox"/> DEATH <input type="checkbox"/> DIVORCE <input type="checkbox"/> DID NOT END <input type="checkbox"/> OTHER (Explain)	
4O. DID YOU HAVE ADDITIONAL MARRIAGES AFTER THE VETERAN'S DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO (If "YES," please submit a VA Form 21-4138, Statement in Support of Claim, as needed to provide the information for each marriage)	

VETERAN'S SOCIAL SECURITY NUMBER - -

SECTION V: MARITAL HISTORY	
Tell us about any other marriages you and/or the veteran had. If you and the veteran did not have any additional marriages skip to Section VI.	
VETERAN'S PRIOR MARRIAGES <i>(If None, skip to Item 5L)</i>	
5A. NAME OF PERSON VETERAN WAS PREVIOUSLY MARRIED TO <i>(First, Middle Initial, Last)</i> <input type="text"/> <input type="text"/>	
5B. HOW DID THE VETERAN'S PREVIOUS MARRIAGE END? <input type="checkbox"/> DEATH <input type="checkbox"/> DIVORCE <input type="checkbox"/> OTHER <i>(Explain)</i>	5C. WHAT ARE THE DATES OF THE VETERAN'S PREVIOUS MARRIAGE? <i>(MM/DD/YYYY)</i> START: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> END: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
5D. PLACE OF MARRIAGE <i>(City/State or Country)</i>	5E. PLACE OF MARRIAGE TERMINATION <i>(City/State or Country)</i>
5F. NAME OF PERSON VETERAN WAS PREVIOUSLY MARRIED TO <i>(First, Middle Initial, Last)</i> <input type="text"/> <input type="text"/>	
5G. HOW DID THE VETERAN'S PREVIOUS MARRIAGE END? <input type="checkbox"/> DEATH <input type="checkbox"/> DIVORCE <input type="checkbox"/> OTHER <i>(Explain)</i>	5H. WHAT ARE THE DATES OF THE VETERAN'S PREVIOUS MARRIAGE? <i>(MM/DD/YYYY)</i> START: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> END: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
5I. PLACE OF MARRIAGE <i>(City/State or Country)</i>	5J. PLACE OF MARRIAGE TERMINATION <i>(City/State or Country)</i>
5K. DO YOU HAVE ADDITIONAL MARRIAGES TO REPORT FOR THE VETERAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>(If "YES," please submit a VA Form 21-686c, Application to Request to Add And/Or Remove Dependents, or VA Form 21-4138, Statement in Support of Claim, as needed to provide the information for additional marital history)</i>	
TELL US ABOUT YOUR MARRIAGES PRIOR TO MARRYING THE VETERAN <i>(If None, skip to Section VI)</i>	
5L. NAME OF PERSON YOU WERE MARRIED TO PRIOR TO MARRYING THE VETERAN <i>(First, Middle Initial, Last)</i> <input type="text"/> <input type="text"/>	
5M. HOW DID YOUR PREVIOUS MARRIAGE END? <input type="checkbox"/> DEATH <input type="checkbox"/> DIVORCE <input type="checkbox"/> OTHER <i>(Explain)</i>	5N. WHAT ARE THE DATES OF YOUR PREVIOUS MARRIAGE? <i>(MM/DD/YYYY)</i> START: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> END: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
5O. PLACE OF MARRIAGE <i>(City/State or Country)</i>	5P. PLACE OF MARRIAGE TERMINATION <i>(City/State or Country)</i>
5Q. NAME OF PERSON YOU WERE MARRIED TO PRIOR TO MARRYING THE VETERAN <i>(First, Middle Initial, Last)</i> <input type="text"/> <input type="text"/>	
5R. HOW DID YOUR PREVIOUS MARRIAGE END? <input type="checkbox"/> DEATH <input type="checkbox"/> DIVORCE <input type="checkbox"/> OTHER <i>(Explain)</i>	5S. WHAT ARE THE DATES OF YOUR PREVIOUS MARRIAGE? <i>(MM/DD/YYYY)</i> START: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> END: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
5T. PLACE OF MARRIAGE <i>(City/State or Country)</i>	5U. PLACE OF MARRIAGE TERMINATION <i>(City/State or Country)</i>
5V. DO YOU HAVE ADDITIONAL MARRIAGES TO REPORT? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>(If "YES," please submit a VA Form 21-686c, Application to Request to Add And/Or Remove Dependents, or VA Form 21-4138, Statement in Support of Claim, as needed to provide the information for additional marital history)</i>	

□□□□ - □□□□ - □□□□□□

SECTION VII: DEPENDENCY AND INDEMNITY COMPENSATION (D.I.C.)

(Skip to Section VIII if you are NOT claiming D.I.C.)

7A. WHAT BENEFIT ARE YOU CLAIMING? (Check one)

- D.I.C. D.I.C. under U.S.C. 1151 (**Note:** D.I.C. under 38 U.S.C. is a rare benefit. Please refer to the Instructions page 5 for guidance on 38 U.S.C. 1151) D.I.C. due to claimant election of a re-evaluation of a previously denied claim based on expanded eligibility under PL 117-168 (PACT Act) (**Note:** Please refer to Instructions page 6 for guidance on PACT Act)

7B. LIST ANY VA MEDICAL CENTERS WHERE THE VETERAN RECEIVED TREATMENT PERTAINING TO YOUR CLAIM AND PROVIDE TREATMENT DATES

NAME AND LOCATION OF VA MEDICAL CENTER	DATE(S) OF TREATMENT (MM/DD/YYYY)
	START: □□ / □□ / □□□□ END: □□ / □□ / □□□□
	START: □□ / □□ / □□□□ END: □□ / □□ / □□□□
	START: □□ / □□ / □□□□ END: □□ / □□ / □□□□

SECTION VIII: NURSING HOME OR INCREASED SURVIVORS ENTITLEMENT

8A. ARE YOU CLAIMING SPECIAL MONTHLY PENSION OR SPECIAL MONTHLY D.I.C. BECAUSE YOU NEED THE REGULAR ASSISTANCE OF ANOTHER PERSON, HAVE SEVERE VISUAL PROBLEMS, OR ARE GENERALLY CONFINED TO YOUR IMMEDIATE PREMISES?

- YES NO (*If "YES," please complete a VA Form 21-2680, Examination for Housebound Status or Permanent Need for Regular Aid and Attendance. Please make sure every box is complete and signed by a Physician, Physician Assistant (PA), Certified Nurse Practitioner (CNP/CRNP), or Clinical Nurse Specialist (CNS)*)

8B. ARE YOU NOW IN A NURSING HOME?

- YES NO (*If "YES," complete VA Form 21-0779, Request for Nursing Home Information in Connection with Claim for Aid and Attendance. For additional information see Instructions, page 6 under "Increased Survivor Benefits Based on Special Monthly Pension or Special Monthly D.I.C."*) (*If "NO," skip to Item 9A*)

SECTION IX: INCOME AND ASSETS

(Skip to Section X if you are NOT claiming survivors pension benefits)

NOTE: Assets are all the money and property you or your dependents own. Assets **do not** include your/your family's primary residence or personal effects such as appliances and vehicles you or your dependents need for transportation.

IMPORTANT:

- If you are a surviving spouse claimant, you must report income and assets for yourself and for any child of the veteran who lives with you or for whom you are responsible unless a court has decided you do not have custody of the child.
- If you are a surviving child claimant (which means the child is not in the custody of a surviving spouse), you must report income and assets for yourself, your custodian, and your custodian's spouse.

9A. DO YOU OR YOUR DEPENDENTS HAVE OVER \$25,000.00 IN ASSETS (NOT INCLUDING THE VALUE OF YOUR PRIMARY RESIDENCE)?

- YES NO (*If "YES," please submit VA Form 21P-0969, Income and Asset Statement in Support of Claim for Pension or Parents' Dependency and Indemnity Compensation (D.I.C.)*)

(If "No," provide an estimate of the total value of your assets below)

\$ □□□□, □□□□.□□

9B. IN THE THREE CALENDAR YEARS BEFORE THIS YEAR, DID YOU OR YOUR DEPENDENTS TRANSFER ANY ASSETS? (*Examples of asset transfers include giving assets away, selling assets, purchasing an annuity, or using assets to establish a trust.*)

- YES NO (*If "YES," please submit VA Form 21P-0969, Income and Asset Statement in Support of Claim for Pension or Parents' Dependency and Indemnity Compensation (D.I.C.)*)

9C. DO YOU OR YOUR DEPENDENTS OWN YOUR/YOUR FAMILY'S PRIMARY RESIDENCE?

- YES NO (*If "NO," skip to Item 9G*)

9D. IS THE VALUE OF THE LOT ON WHICH THE PRIMARY RESIDENCE SITS OVER 2 ACRES (87,120 SQ FT)?

- YES NO (*If "NO," skip to Item 9G*)

9E. IF PRIMARY RESIDENCE SITS ON A LOT OVER 2 ACRES (87,120 SQ FT), WHAT IS THE VALUE OF LAND OVER 2 ACRES? (*Do NOT include the value of the residence or the first 2 acres.*)

\$ □□, □□□□, □□□□.00

9F. IS THE LAND OVER 2 ACRES (87,120 SQ FT) MARKETABLE?

- YES NO (*If "YES," please submit VA Form 21P-0969*)

9G. DO YOU OR YOUR DEPENDENTS HAVE MORE THAN FOUR (4) SOURCES OF INCOME?

- YES NO (*If "YES," please submit VA Form 21P-0969 and ONLY report your Social Security Income in Item 9I*)

9H. OTHER THAN SOCIAL SECURITY, DID YOU OR YOUR DEPENDENTS RECEIVE ANY INCOME LAST YEAR THAT YOU NO LONGER RECEIVE?

- YES NO (*If "YES," please submit VA Form 21P-0969*)

□□□□ - □□□□ - □□□□□□

SECTION IX: INCOME AND ASSETS *(Continued)*
(Skip to Section X if you are NOT claiming survivors pension benefits)

Please use the space below to report any income you currently receive.

IMPORTANT: If you have been directed to complete a VA Form 21P-0969, *Income and Asset Statement in Support of Claim for Pension or Parents' D.I.C.*, in previous Items 9A through 9H, VA only requires that Social Security income be reported below in Items 9I through 9L. All other income should be reported on the VA Form 21P-0969 and will be counted as reported, **do not** duplicate.

NOTE: Gross income is defined as any income you received prior to deductions. If reporting income in Items 9I through 9L, any items skipped or left blank will be considered as unspecified income and could require a request for additional information potentially delaying your claim. If you leave entire question blank we will assume you have no income to report.

<p>9I(1) WHO IS THE INCOME RECIPIENT? <i>(Select one)</i></p> <p><input type="checkbox"/> SURVIVING SPOUSE <input type="checkbox"/> CHILD <i>(Specify)</i></p> <p>_____</p>	<p>9I(2) SPECIFY THE TYPE OF INCOME</p> <p><input type="checkbox"/> SOCIAL SECURITY <input type="checkbox"/> INTEREST/DIVIDENDS <input type="checkbox"/> CIVIL SERVICE <input type="checkbox"/> PENSION/RETIREMENT <input type="checkbox"/> OTHER <i>(Specify type of income)</i></p>	<p>9I(3) SPECIFY INCOME PAYER <i>(Name of business, financial institution, etc.)</i></p> <p>_____</p> <p>9I(4) CURRENT GROSS MONTHLY INCOME</p> <p>\$ □□□□, □□□□. □□□□</p>
<p>9J(1) WHO IS THE INCOME RECIPIENT? <i>(Select one)</i></p> <p><input type="checkbox"/> SURVIVING SPOUSE <input type="checkbox"/> CHILD <i>(Specify)</i></p> <p>_____</p>	<p>9J(2) SPECIFY THE TYPE OF INCOME</p> <p><input type="checkbox"/> SOCIAL SECURITY <input type="checkbox"/> INTEREST/DIVIDENDS <input type="checkbox"/> CIVIL SERVICE <input type="checkbox"/> PENSION/RETIREMENT <input type="checkbox"/> OTHER <i>(Specify type of income)</i></p>	<p>9J(3) SPECIFY INCOME PAYER <i>(Name of business, financial institution, etc.)</i></p> <p>_____</p> <p>9J(4) CURRENT GROSS MONTHLY INCOME</p> <p>\$ □□□□, □□□□. □□□□</p>
<p>9K(1) WHO IS THE INCOME RECIPIENT? <i>(Select one)</i></p> <p><input type="checkbox"/> SURVIVING SPOUSE <input type="checkbox"/> CHILD <i>(Specify)</i></p> <p>_____</p>	<p>9K(2) SPECIFY THE TYPE OF INCOME</p> <p><input type="checkbox"/> SOCIAL SECURITY <input type="checkbox"/> INTEREST/DIVIDENDS <input type="checkbox"/> CIVIL SERVICE <input type="checkbox"/> PENSION/RETIREMENT <input type="checkbox"/> OTHER <i>(Specify type of income)</i></p>	<p>9K(3) SPECIFY INCOME PAYER <i>(Name of business, financial institution, etc.)</i></p> <p>_____</p> <p>9K(4) CURRENT GROSS MONTHLY INCOME</p> <p>\$ □□□□, □□□□. □□□□</p>
<p>9L(1) WHO IS THE INCOME RECIPIENT? <i>(Select one)</i></p> <p><input type="checkbox"/> SURVIVING SPOUSE <input type="checkbox"/> CHILD <i>(Specify)</i></p> <p>_____</p>	<p>9L(2) SPECIFY THE TYPE OF INCOME</p> <p><input type="checkbox"/> SOCIAL SECURITY <input type="checkbox"/> INTEREST/DIVIDENDS <input type="checkbox"/> CIVIL SERVICE <input type="checkbox"/> PENSION/RETIREMENT <input type="checkbox"/> OTHER <i>(Specify type of income)</i></p>	<p>9L(3) SPECIFY INCOME PAYER <i>(Name of business, financial institution, etc.)</i></p> <p>_____</p> <p>9L(4) CURRENT GROSS MONTHLY INCOME</p> <p>\$ □□□□, □□□□. □□□□</p>

SECTION X: INFORMATION ABOUT YOUR MEDICAL OR OTHER EXPENSES

Family medical expenses and certain other expenses you actually paid may be deductible from your income. Show the amount of unreimbursed medical expenses, including the Medicare deduction, you paid over the last year (or expect to pay and continue indefinitely) 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 you paid for the last illness and burial of a spouse or child, educational or vocational rehabilitation expenses are amounts you paid for courses of education including tuition, fees, and materials. Do not include any expenses for which you were/will be reimbursed. Please make sure to complete all criteria below (if applicable). If you need more space, complete and attach a separate VA Form 21P-8416, *Medical Expense Report*.

IMPORTANT: Out of pocket expenses paid by you or a VA-approved dependent may be claimed. Do **NOT** include expenses paid by other family members, insurance, etc.

10A. ARE YOU OR YOUR DEPENDENTS CLAIMING UNREIMBURSED MEDICAL EXPENSES OR OTHER EXPENSES?

YES NO *(If "NO," skip to Section XI)*

IN-HOME CARE OR CARE FACILITY

IMPORTANT: If you are claiming expenses for in-home care or assisted living, adult day care, or similar facility, you must complete the applicable worksheet(s) on pages 19 and 20 for each provider.

<p>10B(1). WHOSE EXPENSES WERE PAID? <i>(Select one)</i></p> <p><input type="checkbox"/> SURVIVING SPOUSE <input type="checkbox"/> OTHER <i>(Specify below)</i></p>	<p>10B(2). NAME OF PROVIDER AND TYPE OF CARE</p> <p>_____</p> <p>CHECK ONE:</p> <p><input type="checkbox"/> CARE FACILITY <input type="checkbox"/> IN-HOME CARE ATTENDANT</p>	<p>10B(3). IF THIS IS AN IN-HOME CARE PROVIDER WHAT IS THE:</p> <p>Payment Rate (Per Hour) \$ □□□□.00</p> <p>Hours Worked (Per Week) □□□□</p>
<p>10B(4). PROVIDER START AND END DATE <i>(MM/DD/YYYY)</i></p> <p>START: □□/□□/□□□□</p> <p>END: □□/□□/□□□□ <input type="checkbox"/> NO END DATE</p>	<p>10B(5). PAYMENT FREQUENCY</p> <p><input type="checkbox"/> MONTHLY <input type="checkbox"/> ANNUALLY</p>	<p>10B(6). AMOUNT YOU PAY <i>(Based on frequency selected in Item 10B(5))</i></p> <p>\$ □□□□, □□□□. □□□□</p>

VETERAN'S SOCIAL SECURITY NUMBER - -

IN-HOME CARE OR CARE FACILITY <i>(Continued)</i>		
10C(1). WHOSE EXPENSES WERE PAID? <i>(Select one)</i> <input type="checkbox"/> SURVIVING SPOUSE <input type="checkbox"/> OTHER <i>(Specify below)</i>	10C(2). NAME OF PROVIDER AND TYPE OF CARE CHECK ONE: <input type="checkbox"/> CARE FACILITY <input type="checkbox"/> IN-HOME CARE ATTENDANT	10C(3). IF THIS IS AN IN-HOME CARE PROVIDER WHAT IS THE: Payment Rate (Per Hour) \$ <input type="text"/> <input type="text"/> <input type="text"/> .00 Hours Worked (Per Week) <input type="text"/> <input type="text"/> <input type="text"/>
10C(4). PROVIDER START AND END DATE <i>(MM/DD/YYYY)</i> START: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> END: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="checkbox"/> NO END DATE	10C(5). PAYMENT FREQUENCY <input type="checkbox"/> MONTHLY <input type="checkbox"/> ANNUALLY	10C(6). AMOUNT YOU PAY <i>(Based on frequency selected in Item 10C(5))</i> \$ <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>
10D(1). WHOSE EXPENSES WERE PAID? <i>(Select one)</i> <input type="checkbox"/> SURVIVING SPOUSE <input type="checkbox"/> OTHER <i>(Specify below)</i>	10D(2). NAME OF PROVIDER AND TYPE OF CARE CHECK ONE: <input type="checkbox"/> CARE FACILITY <input type="checkbox"/> IN-HOME CARE ATTENDANT	10D(3). IF THIS IS AN IN-HOME CARE PROVIDER WHAT IS THE: Payment Rate (Per Hour) \$ <input type="text"/> <input type="text"/> <input type="text"/> .00 Hours Worked (Per Week) <input type="text"/> <input type="text"/> <input type="text"/>
10D(4). PROVIDER START AND END DATE <i>(MM/DD/YYYY)</i> START: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> END: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="checkbox"/> NO END DATE	10D(5). PAYMENT FREQUENCY <input type="checkbox"/> MONTHLY <input type="checkbox"/> ANNUALLY	10D(6). AMOUNT YOU PAY <i>(Based on frequency selected in Item 10D(5))</i> \$ <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>
OTHER MEDICAL, LAST, AND/OR BURIAL EXPENSES		
10E(1). WHOSE EXPENSES WERE PAID? <i>(Select one)</i> <input type="checkbox"/> SURVIVING SPOUSE <input type="checkbox"/> VETERAN <i>(Last expense/burial)</i> <input type="checkbox"/> CHILD <i>(Specify below)</i>	10E(2). PAID TO <i>(Name of Provider, Insurance company, etc.)</i> AND PURPOSE <i>(Insurance premium, medical supplies, etc.)</i> Provider: Purpose:	
10E(3). DATE COSTS PAID <i>(MM/DD/YYYY)</i> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	10E(4). PAYMENT FREQUENCY <input type="checkbox"/> MONTHLY <input type="checkbox"/> ANNUALLY <input type="checkbox"/> ONE-TIME	10E(5). AMOUNT YOU PAY <i>(Based on frequency selected in Item 10E(4))</i> \$ <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>
10F(1). WHOSE EXPENSES WERE PAID? <i>(Select one)</i> <input type="checkbox"/> SURVIVING SPOUSE <input type="checkbox"/> VETERAN <i>(Last expense/burial)</i> <input type="checkbox"/> CHILD <i>(Specify below)</i>	10F(2). PAID TO <i>(Name of Provider, Insurance company, etc.)</i> AND PURPOSE <i>(Insurance premium, medical supplies, etc.)</i> Provider: Purpose:	
10F(3). DATE COSTS PAID <i>(MM/DD/YYYY)</i> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	10F(4). PAYMENT FREQUENCY <input type="checkbox"/> MONTHLY <input type="checkbox"/> ANNUALLY <input type="checkbox"/> ONE-TIME	10F(5). AMOUNT YOU PAY <i>(Based on frequency selected in Item 10F(4))</i> \$ <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>
10G(1). WHOSE EXPENSES WERE PAID? <i>(Select one)</i> <input type="checkbox"/> SURVIVING SPOUSE <input type="checkbox"/> VETERAN <i>(Last expense/burial)</i> <input type="checkbox"/> CHILD <i>(Specify below)</i>	10G(2). PAID TO <i>(Name of Provider, Insurance company, etc.)</i> AND PURPOSE <i>(Insurance premium, medical supplies, etc.)</i> Provider: Purpose:	
10G(3). DATE COSTS PAID <i>(MM/DD/YYYY)</i> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	10G(4). PAYMENT FREQUENCY <input type="checkbox"/> MONTHLY <input type="checkbox"/> ANNUALLY <input type="checkbox"/> ONE-TIME	10G(5). AMOUNT YOU PAY <i>(Based on frequency selected in Item 10G(4))</i> \$ <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>

OTHER MEDICAL, LAST AN/OR BURIAL EXPENSES (Continued)

10H(1). WHOSE EXPENSES WERE PAID? (Select one) <input type="checkbox"/> SURVIVING SPOUSE <input type="checkbox"/> VETERAN (Last expense/burial) <input type="checkbox"/> CHILD (Specify below)	10H(2). PAID TO (Name of Provider, Insurance company, etc.) AND PURPOSE (Insurance premium, medical supplies, etc.) Provider: Purpose:	
10H(3). DATE COSTS PAID (MM/DD/YYYY) <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	10H(4). PAYMENT FREQUENCY <input type="checkbox"/> MONTHLY <input type="checkbox"/> ANNUALLY <input type="checkbox"/> ONE-TIME	10H(5). AMOUNT YOU PAY (Based on frequency selected in Item 10H(4)) \$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>

10I(1). WHOSE EXPENSES WERE PAID? (Select one) <input type="checkbox"/> SURVIVING SPOUSE <input type="checkbox"/> VETERAN (Last expense/burial) <input type="checkbox"/> CHILD (Specify below)	10I(2). PAID TO (Name of Provider, Insurance company, etc.) AND PURPOSE (Insurance premium, medical supplies, etc.) Provider: Purpose:	
10I(3). DATE COSTS PAID (MM/DD/YYYY) <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	10I(4). PAYMENT FREQUENCY <input type="checkbox"/> MONTHLY <input type="checkbox"/> ANNUALLY <input type="checkbox"/> ONE-TIME	10I(5). AMOUNT YOU PAY (Based on frequency selected in Item 10I(4)) \$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>

10J(1). WHOSE EXPENSES WERE PAID? (Select one) <input type="checkbox"/> SURVIVING SPOUSE <input type="checkbox"/> VETERAN (Last expense/burial) <input type="checkbox"/> CHILD (Specify below)	10J(2). PAID TO (Name of Provider, Insurance company, etc.) AND PURPOSE (Insurance premium, medical supplies, etc.) Provider: Purpose:	
10J(3). DATE COSTS PAID (MM/DD/YYYY) <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	10J(4). PAYMENT FREQUENCY <input type="checkbox"/> MONTHLY <input type="checkbox"/> ANNUALLY <input type="checkbox"/> ONE-TIME	10J(5). AMOUNT YOU PAY (Based on frequency selected in Item 10J(4)) \$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>

SECTION XI: DIRECT DEPOSIT INFORMATION (MUST COMPLETE)

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. 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 questions or concerns you may have.

11A. NAME OF FINANCIAL INSTITUTION (Please provide the name of the bank where you want your direct deposit) <input style="width:100%; height: 20px;" type="text"/> <input style="width:100%; height: 20px;" type="text"/>	11B. ROUTING OR TRANSIT NUMBER (The first nine numbers located at the bottom left of your check) <input style="width:100%; height: 20px;" type="text"/>
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11C. 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.:

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 Survivor of Evidence Necessary to Substantiate a Claim for Dependency Indemnity Compensation, Death Pension, and/or Accrued 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 12A, 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.

12A. 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 paid processing under the FDC Program because I plan to submit further evidence in support of my claim.

WORKSHEET FOR A RESIDENTIAL CARE, ADULT DAYCARE, OR A SIMILAR FACILITY

NOTE: This worksheet is to be completed by an administrator or licensed medical professional from a residential care, adult daycare, or similar facility. To count this medical provider as an expense, they must be claimed on your application for benefits or VA Form 21P-8416, *Medical Expense Report*. In addition, VA Form 21-2680, *Examination for Housebound Status or Permanent Need for Regular Aid and Attendance* may be needed to count these expenses.

1. WHO ARE YOU COMPLETING THIS WORKSHEET FOR? (Name of Care Recipient, either the Claimant or Dependent) (First, Last)

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2. WHO IS COMPLETING THIS WORKSHEET? (Name of Provider, either an Administrator or Licensed Medical Professional) (First, Last)

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3. WHAT ROLE OR POSITION DO YOU PERFORM AT THE FACILITY?

--

4. WHAT IS THE NAME OF THE FACILITY? (As shown on facility license or official website)

--

5. WHAT IS THE FACILITY TELEPHONE NUMBER? International Phone Number (If applicable)

() () ()	-	() () ()	-	() () ()	
-------------	---	-------------	---	-------------	--

6. WHAT IS THE MAILING ADDRESS OF THE FACILITY'S ADMINISTRATIVE OFFICE?

No. & Street

--

Apt./Unit Number

--

 City

--

State/Province

--

 Country

--

 ZIP Code

--

 -

--

7. WHAT IS THE FACILITY'S WEBSITE ADDRESS?

--

8. PLEASE SELECT EACH ACTIVITY OF DAILY LIVING (ADL) THAT THE FACILITY IS PROVIDING TO THE CARE RECIPIENT.

A. EATING B. BATHING/SHOWERING C. TRANSFERRING IN OR OUT OF BED OR CHAIR

D. DRESSING E. USING THE TOILET F. AMBULATING WITHIN HOME OR LIVING AREA

9. FOR EACH STATEMENT BELOW PLEASE CHECK THE BOX IF THIS STATEMENT IS TRUE FOR THE FACILITY:

THE STATE OR COUNTRY **REQUIRES** THIS FACILITY TO BE LICENSED

THE FACILITY IS LICENSED

THE FACILITY IS RESIDENTIAL

THE FACILITY IS STAFFED 24 HOURS

10. DOES THE FACILITY'S STAFF PROVIDE THE CARE RECIPIENT WITH HEALTH CARE OR CUSTODIAL CARE OR BOTH.
(Custodial Care is regular assistance with two or more ADLs (Question 8), or supervision because an individual with a physical, mental, developmental, or cognitive disorder requires care or assistance on a regular basis to protect the individual from hazards or dangers incident to their daily environment.)

YES NO, Care is being provided by a third-party provider. NO, Care is not being provided to this claimant.

If care is provided by a third-party provider, please ensure the claimant has each In-Home provider complete an In-Home Attendant Worksheet.

11. PLEASE PROVIDE THE DATE OF ADMISSION FOR THE CARE RECIPIENT STAYING AT THE FACILITY. (MM/DD/YYYY)

() ()	/	() ()	/	() () () ()
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12. ON WHAT DATE DO YOU EXPECT THIS CARE TO END? (MM/DD/YYYY)
(Select "Indefinite" if the care you provide is not temporary.)

() ()	/	() ()	/	() () () ()	<input type="checkbox"/> INDEFINITE
---------	---	---------	---	-----------------	-------------------------------------

13. PLEASE PROVIDE THE MONTHLY CHARGES THE CARE RECIPIENT STAYING AT THE FACILITY IS RESPONSIBLE FOR PAYING.

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 PER MONTH

FACILITY CERTIFICATION

I CERTIFY that the information stated within this WORKSHEET FOR AN ASSISTED LIVING, ADULT DAYCARE, OR SIMILAR FACILITY is accurate and reflects the current environment of the Care Recipient and the facility.

14. SIGNATURE OF PROVIDER (From question 2)

--

15. DATE SIGNED (MM/DD/YYYY)

() ()	/	() ()	/	() () () ()
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WORKSHEET FOR IN-HOME ATTENDANT EXPENSES

NOTE: This worksheet is to be completed by your in-home care provider -OR- if an agency is providing you in-home care please have an agency administrator complete this form. These expenses must be claimed on your application for benefits or VA Form 21P-8416, *Medical Expense Report*. In addition, VA Form 21-2680, *Examination for Housebound Status or Permanent Need for Regular Aid and Attendance* may be needed to count these expenses.

1. WHO ARE YOU COMPLETING THIS WORKSHEET FOR? (*Name of Care Recipient, either the Claimant or Dependent*) (*First, Last*)

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2. WHO IS COMPLETING THIS WORKSHEET? (*In-Home Care Attendant or Agency Administrator, Provider*) (*First, Last*)

--	--

3. IS THE IN-HOME CARE PROVIDED BY A LICENSED MEDICAL PROFESSIONAL?
(*A licensed health care provider refers to a person licensed to furnish health services by the State or country in which the services are provided.*)

YES NO

4. DO YOU WORK FOR AN AGENCY OR ORGANIZATION?

YES NO (*If "NO," skip to question 7*)

5. WHAT IS THE NAME OF THE AGENCY OR ORGANIZATION?

--

6. WHAT IS THE AGENCY TELEPHONE NUMBER?

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

7. WHAT IS YOUR MAILING ADDRESS OR THAT OF YOUR AGENCY'S ADMINISTRATIVE OFFICE?

No. & Street

--

Apt./Unit Number

--

 City

--

State/Province

--

 Country

--

 ZIP Code

--

 -

--

8. PLEASE SELECT EACH ACTIVITY OF DAILY LIVING (ADL) THAT THE IN-HOME CARE ASSISTANT PROVIDED TO THE CARE RECIPIENT.

A. EATING B. BATHING/SHOWERING C. TRANSFERRING IN OR OUT OF BED OR CHAIR
 D. DRESSING E. USING THE TOILET F. AMBULATING WITHIN HOME OR LIVING AREA

9. PLEASE SELECT EACH INSTRUMENTAL ACTIVITY OF DAILY LIVING (IADL) THAT THE IN-HOME CARE ASSISTANT PROVIDES TO THE CARE RECIPIENT.

A. SHOPPING B. FOOD PREPARATION C. NON-MEDICAL TRANSPORTATION
 D. LAUNDERING E. USING TELEPHONE F. MANAGING FINANCES
 G. HOUSEKEEPING H. HANDLING MEDICATIONS

10. IS THE PRIMARY RESPONSIBILITY OF THE IN-HOME ATTENDANT TO PROVIDE THE CARE RECIPIENT WITH HEALTH CARE OR CUSTODIAL CARE?
(*Custodial Care is regular assistance with two or more ADLs (Question 8), or supervision because an individual with a physical, mental, developmental, or cognitive disorder requires care or assistance on a regular basis to protect the individual from hazards or dangers incident to their daily environment.*)

YES NO

11. PLEASE PROVIDE THE DATE CARE BEGAN FOR THE CARE RECIPIENT.
(*MM/DD/YYYY*)

	/		/	
--	---	--	---	--

12. ON WHAT DATE DO YOU EXPECT THIS CARE TO END? (*MM/DD/YYYY*)
(*Select "Indefinite" if the care you provide is not temporary.*)

	/		/		<input type="checkbox"/> INDEFINITE
--	---	--	---	--	-------------------------------------

13. PLEASE PROVIDE THE HOURLY CHARGES THE CARE RECIPIENT IS RESPONSIBLE FOR PAYING.

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 PER HOUR

14. PLEASE PROVIDE THE TOTAL HOURS PER MONTH THAT YOU PROVIDE CARE TO THE CARE RECIPIENT.

--

 HOURS PER MONTH

CERTIFICATION

I CERTIFY that the information stated within this WORKSHEET FOR IN-HOME ATTENDANT EXPENSES is accurate and reflects the current environment of the care recipient and the care services listed in questions eight and nine (8-9) above.

15. SIGNATURE OF PROVIDER (*From question 2*)

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16. DATE SIGNED (*MM/DD/YYYY*)

	/		/	
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DIRECT DEPOSIT SIGN-UP FORM

DIRECTIONS

- To sign up for Direct Deposit, the payee is to read the back of this form and fill in the information requested in Sections 1 and 2. Then take or mail this form to the financial institution. The financial institution will verify the information in Sections 1 and 2, and will complete Section 3. The Completed form will be returned to the Government agency identified below.
- A separate form must be completed for each type of payment to be sent by Direct Deposit
- The claim number and type of payment are printed on Government checks. (see the sample check on the back of this form.) This information is also stated on beneficiary/annuitant award letters and other documents from the Government agency.
- Payee must keep the Government agency informed of any address changes in order to receive important about benefits and to remain qualified for payments.

SECTION 1 (TO BE COMPLETED BY PAYEE)

A NAME OF PAYEE (<i>last, first, middle initial</i>) ADDRESS (<i>street, route, P.O. Box, APO/FPO</i>) CITY STATE ZIP CODE TELEPHONE NUMBER AREA CODE	D TYPE OF DEPOSITOR ACCOUNT <input type="checkbox"/> CHECKING <input type="checkbox"/> SAVINGS E DEPOSITOR ACCOUNT NUMBER <table style="width: 100%; text-align: center;"> <tr> <td style="width: 20px; height: 20px;"> </td> </tr> </table>																				
B NAME OF PERSON(S) ENTITLED TO PAYMENT C CLAIM OR PAYROLL ID NUMBER Prefix Suffix	F TYPE OF PAYMENT (<i>Check only one</i>) <input type="checkbox"/> Social Security <input type="checkbox"/> Fed. Salary/Mil. Civilian Pay <input type="checkbox"/> Supplemental Security Income <input type="checkbox"/> Mil. Active _____ <input type="checkbox"/> Railroad Retirement <input type="checkbox"/> Mil. Retire. _____ <input type="checkbox"/> Civil Service Retirement (<i>OPM</i>) <input type="checkbox"/> Mil. Survivor _____ <input type="checkbox"/> VA Compensation or Pension <input type="checkbox"/> Other _____ <i>(specify)</i>																				
PAYEE/JOINT PAYEE CERTIFICATION I certify that I am entitled to the payment identified above, and that I have read and understood the back of this form. In signing this form, I authorize my payment to be sent to the financial institution named below to be deposited to the designated account.	G THIS BOX FOR ALLOTMENT OF PAYMENT ONLY (<i>if applicable</i>) <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%; border-bottom: 1px solid black;">TYPE</td> <td style="width: 30%; border-bottom: 1px solid black;">AMOUNT</td> </tr> <tr> <td style="height: 20px;"> </td> <td> </td> </tr> </table>	TYPE	AMOUNT																		
TYPE	AMOUNT																				
SIGNATURE DATE SIGNATURE DATE	JOINT ACCOUNT HOLDERS' CERTIFICATION (<i>optional</i>) I certify that I have read and understood the back of this form, including the SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS. SIGNATURE DATE SIGNATURE DATE																				

SECTION 2 (TO BE COMPLETED BY PAYEE OR FINANCIAL INSTITUTION)

GOVERNMENT AGENCY NAME	GOVERNMENT AGENCY ADDRESS
------------------------	---------------------------

SECTION 3 (TO BE COMPLETED BY FINANCIAL INSTITUTION)

NAME AND ADDRESS OF FINANCIAL INSTITUTION	ROUTING NUMBER CHECK DIGIT <table style="width: 100%; text-align: center;"> <tr> <td style="width: 20px; height: 20px;"> </td> </tr> </table>											
DEPOSITOR ACCOUNT TITLE												
FINANCIAL INSTITUTION CERTIFICATION I confirm the identity of the above-named payee(s) and the account number and title. AS representative of the above-named financial institution, I certify that the financial institution agrees to receive and deposit the payment identified above in accordance with 31 CFR Parts 240, 209, and 210.												
PRINT OR TYPE REPRESENTATIVE'S NAME	SIGNATURE OF REPRESENTATIVE	TELEPHONE NUMBER	DATE									

Financial institution should refer to the GREEN BOOK for further instructions.

THE FINANCIAL INSTITUTION SHOULD MAIL THE COMPLETED FORM TO THE GOVERNMENT AGENCY IDENTIFIED ABOVE.

BURDEN ESTIMATE STATEMENT

The estimated average burden associated with this collection of information is 10 minutes per respondent or recordkeeper, depending on individual circumstances. Comments concerning the accuracy of this burden estimate and suggestions for reducing this burden should be directed to the Financial Management Services, Facilities Management Division, Property & Supply Section, Room B-101, 3700 East-West highway, Hyattsville, MD 20782 or the Office of Management and Budget, Paperwork Reduction Project (1510-0007), Washington, D.C. 20503

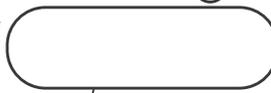
PLEASE READ THIS CAREFULLY

All information on this form, including the individual claim number, is required under 31 USC 3322, 31 CFR 209 and/or 210. The information is confidential and is needed to prove entitlement to payments. The information will be used to process payment data from the Federal agency to the financial institution and/ or its agent. Failure to provide the requested information may affect the processing of this form and may delay or prevent the receipt of payments through the Direct Deposit/Electronic Funds Transfer Program.

INFORMATION FOUND ON CHECKS

Most of the information needed to complete boxes A, C, and F in Section 1 is printed on your government check:

- (A) Be sure that payee's name is written exactly as it appears on the check. Be sure current address is shown.
- (C) claim numbers and suffixes are printed here on checks beneath the date for the type of payment shown here. Check the Green Book for the location of prefixes and suffixes for other types of payments.
- (F) Type of payment is printed to the left of the amount.

United States Treasury		15-51 000
	Month Day Year 08 31 84	AUSTIN, TEXAS
29-693-775	00	Check No. 0000 415785
Pay to the order of	28 28	DOLLARS CTS
	VA COMP	\$****100 00
(A)	(F)	
NOT NEGOTIABLE		
:00000518: 041571926"		

SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS

Joint account holders should immediately advise both the Government agency and the financial institution of the death of a beneficiary. funds deposited after the date of death or in eligibility, except for salary payments, are to be returned to the Government agency. The Government agency will then make a determination regarding survivor rights, calculate survivor benefits payments, if any, and begin payments.

CANCELLATION

The agreement represented by this authorization remains in effect until cancelled by the recipient by notice to the Federal agency or by the death or legal incapacity of the recipient. Upon cancellation by the recipient, the recipient should notify the receiving financial institution that he/she is doing so.

The agreement represented by this authorization may be cancelled by the financial institution by providing the recipient a written notice 30 days in advance of the cancellation date. The recipient must immediately advise the Federal agency if the authorization is cancelled by the financial institution. The financial institution cannot cancel the authorization by advice to the Government agency.

CHANGING RECEIVING FINANCIAL INSTITUTIONS

The payee's Direct Deposit will continue to be received by selected financial institution until the Government agency is notified by the payee that the payee wishes to change the financial institution receiving the Direct Deposit. To effect this change, the payee will complete a new SF 1199A at the newly selected financial institution. It is recommended that the payee maintain accounts at both financial institutions until the transition is complete, i.e. after the new financial institution receives the payee's direct Deposit payment.

FALSE STATEMENTS OR FRAUDULENT CLAIMS

Federal law provides a fine of not more than \$10,000 or imprisonment for not more than five (5) years or both for presenting a false statement or making a fraudulent claim.

Appendix E - Form W4-P, Withholding Certificate for Periodic Pension or Annuity
Payments (정기 연금 / 연금지급 원천징수 증명서)

Withholding Certificate for Periodic Pension or Annuity Payments

Department of the Treasury
Internal Revenue Service

Give Form W-4P to the payer of your pension or annuity payments.

2025

Step 1:
Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		
City or town, state, and ZIP code		
(c) <input type="checkbox"/> Single or Married filing separately		
<input type="checkbox"/> Married filing jointly or Qualifying surviving spouse		
<input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		

TIP: Consider using the estimator at www.irs.gov/W4App to determine the most accurate withholding for the rest of the year if: you are completing this form after the beginning of the year; expect to receive your payments only part of the year; or have changes during the year in your marital status, number of pensions/jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs or pension/annuity payments), deductions, or credits. Have your most recent payment statements/pay stubs from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See pages 2 and 3 for more information on each step, when to use the estimator at www.irs.gov/W4App, and how to elect to have no federal income tax withheld (if permitted).

Step 2:
Income From a Job and/or Multiple Pensions/Annuities (Including a Spouse's Job/Pension/Annuity)

Complete this step if you (1) have income from a job or more than one pension/annuity, or (2) are married filing jointly and your spouse receives income from a job or a pension/annuity. **See page 2 for examples on how to complete Step 2.**
Do **only one** of the following.

(a) Use the estimator at www.irs.gov/W4App for the most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(b) Complete the items below.

(i) If you (and/or your spouse) have one or more jobs, then enter the total taxable annual pay from all jobs, plus any income entered on Form W-4, Step 4(a), for the jobs less the deductions entered on Form W-4, Step 4(b), for the jobs. Otherwise, enter “-0-” . . . \$ _____

(ii) If you (and/or your spouse) have any other pensions/annuities that pay less annually than this pension/annuity, then enter the total annual taxable payments from all lower-paying pensions/annuities. Otherwise, enter “-0-” . . . \$ _____

(iii) Add the amounts from items (i) and (ii) and enter the **total** here . . . \$ _____

TIP: To be accurate, submit a new Form W-4P for all other pensions/annuities if you haven't updated your withholding since 2021 or this is a new pension/annuity that pays less than the other(s). Submit a new Form W-4 for your job(s) if you have not updated your withholding since 2019.

Complete Steps 3–4(b) on this form only if (b)(i) is blank **and** this pension/annuity pays the most annually. Otherwise, do not complete Steps 3–4(b) on this form.

Step 3:
Claim Dependent and Other Credits

If your total income will be \$200,000 or less (\$400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by \$2,000	\$ _____	
Multiply the number of other dependents by \$500	\$ _____	
Add other credits, such as foreign tax credit and education tax credits	\$ _____	
Add the amounts for qualifying children, other dependents, and other credits and enter the total here		3 \$ _____

Step 4 (optional):
Other Adjustments

(a) **Other income (not from jobs or pension/annuity payments).** If you want tax withheld on other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, taxable social security, and dividends . . . **4(a)** \$ _____

(b) **Deductions.** If you expect to claim deductions other than the basic standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here **4(b)** \$ _____

(c) **Extra withholding.** Enter any additional tax you want withheld from **each payment** . . . **4(c)** \$ _____

Step 5:
Sign Here

Your signature (This form is not valid unless you sign it.) _____
Date

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about any future developments related to Form W-4P, such as legislation enacted after it was published, go to www.irs.gov/FormW4P.

Purpose of form. Complete Form W-4P to have payers withhold the correct amount of federal income tax from your periodic pension, annuity (including commercial annuities), profit-sharing and stock bonus plan, or IRA payments. Federal income tax withholding applies to the taxable part of these payments. Periodic payments are made in installments at regular intervals (for example, annually, quarterly, or monthly) over a period of more than 1 year. Don't use Form W-4P for a nonperiodic payment (note that distributions from an IRA that are payable on demand are treated as nonperiodic payments) or an eligible rollover distribution (including a lump-sum pension payment). Instead, use Form W-4R, Withholding Certificate for Nonperiodic Payments and Eligible Rollover Distributions, for these payments/distributions. For more information on withholding, see Pub. 505, Tax Withholding and Estimated Tax.

Choosing not to have income tax withheld. You can choose not to have federal income tax withheld from your payments by writing "No Withholding" on Form W-4P in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Generally, if you are a U.S. citizen or a resident alien, you are not permitted to elect not to have federal income tax withheld on payments to be delivered outside the United States and its territories.

Caution: If you have too little tax withheld, you will generally owe tax when you file your tax return and may owe a penalty unless you make timely payments of estimated tax. If too much tax is withheld, you will generally be due a refund when you file your tax return. If your tax situation changes, or you choose not to have federal income tax withheld and you now want withholding, you should submit a new Form W-4P.

When to use the estimator. Consider using the estimator at www.irs.gov/W4App if you:

1. Are submitting this form after the beginning of the year;
2. Have social security, dividend, capital gain, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax;
3. Receive these payments or pension and annuity payments for only part of the year; or
4. Have changes during the year in your marital status, number of pensions/jobs for you (and/or your spouse if married filing jointly), number of dependents, or changes in your deductions or credits.

TIP: Have your most recent payment statements/pay stubs from this year available when using the estimator to account for federal income tax that has already been withheld this year. At the beginning of next year, use the estimator again to recheck your withholding.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you (or you and your spouse) receive. If you do not have a job and want to pay these taxes through withholding from your payments, use the estimator at www.irs.gov/W4App to figure the amount to have withheld.

Payments to nonresident aliens and foreign estates. Do not use Form W-4P. See Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Entities, and Pub. 519, U.S. Tax Guide for Aliens, for more information.

Tax relief for victims of terrorist attacks. If your disability payments for injuries incurred as a direct result of a terrorist attack are not taxable, write "No Withholding" in the space below Step 4(c). See Pub. 3920, Tax Relief for Victims of Terrorist Attacks, for more details.

Specific Instructions

Submit a **separate Form W-4P** for each pension, annuity, or other periodic payments you receive.

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you have at least one of the following: income from a job, income from more than one pension/annuity, and/or a spouse (if married filing jointly) that receives income from a job/pension/annuity. The following examples will assist you in completing Step 2(b).

Example 1. Taylor, a single filer, is completing Form W-4P for a pension that pays \$50,000 a year. Taylor also has a job that pays \$25,000 a year. Taylor has no other pensions or annuities. Taylor will enter \$25,000 in Step 2(b)(i) and in Step 2(b)(iii).

If Taylor also has \$1,000 of interest income, which they entered on Form W-4, Step 4(a), then they will instead enter \$26,000 in Step 2(b)(i) and in Step 2(b)(iii). They will make no entries in Step 4(a) on this Form W-4P.

Example 2. Casey, a single filer, is completing Form W-4P for a pension that pays \$50,000 a year. Casey does not have a job, but receives another pension for \$25,000 a year (which pays less annually than the \$50,000 pension). Casey will enter \$25,000 in Step 2(b)(ii) and in Step 2(b)(iii).

If Casey also has \$1,000 of interest income, then they will enter \$1,000 in Step 4(a) of this Form W-4P.

Example 3. Sam, a single filer, is completing Form W-4P for a pension that pays \$50,000 a year. Sam does not have a job, but receives another pension for \$75,000 a year (which pays more annually than the \$50,000 pension). Sam will not enter any amounts in Step 2.

If Sam also has \$1,000 of interest income, they won't enter that amount on this Form W-4P because they entered the \$1,000 on the Form W-4P for the higher paying \$75,000 pension.

Example 4. Alex, a single filer, is completing Form W-4P for a pension that pays \$50,000 a year. Alex also has a job that pays \$25,000 a year and another pension that pays \$20,000 a year. Alex will enter \$25,000 in Step 2(b)(i), \$20,000 in Step 2(b)(ii), and \$45,000 in Step 2(b)(iii).

If Alex also has \$1,000 of interest income, which they entered on Form W-4, Step 4(a), they will instead enter \$26,000 in Step 2(b)(i), leave Step 2(b)(ii) unchanged, and enter \$46,000 in Step 2(b)(iii). They will make no entries in Step 4(a) of this Form W-4P.

If you are married filing jointly, the entries described above do not change if your spouse is the one who has the job or the other pension/annuity instead of you.



Multiple sources of pensions/annuities or jobs. If you (or if married filing jointly, you and/or your spouse) have a job(s), do NOT complete Steps 3 through 4(b) on Form W-4P. Instead, complete Steps 3 through 4(b) on the Form W-4 for the job. If you (or if married filing jointly, you and your spouse) do not have a job, complete Steps 3 through 4(b) on Form W-4P for **only** the pension/annuity that pays the most annually. Leave those steps blank for the other pensions/annuities.

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible

Specific Instructions *(continued)*

in this step, such as the foreign tax credit and the education tax credits. Including these credits will increase your payments and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include amounts from any job(s) or pension/annuity payments. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your pension, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 6, if you expect to claim deductions other than

the basic standard deduction on your 2025 tax return and want to reduce your withholding to account for these deductions. This includes itemized deductions, the additional standard deduction for those 65 and over, and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from **each payment**. Entering an amount here will reduce your payments and will either increase your refund or reduce any amount of tax that you owe.

Note: If you don't give Form W-4P to your payer, you don't provide an SSN, or the IRS notifies the payer that you gave an incorrect SSN, then the payer will withhold tax from your payments as if your filing status is single with no adjustments in Steps 2 through 4. For payments that began before 2025, your current withholding election (or your default rate) remains in effect unless you submit a new Form W-4P.

Step 4(b)—Deductions Worksheet *(Keep for your records.)*



1	Enter an estimate of your 2025 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$10,000), and medical expenses in excess of 7.5% of your income	1	\$ _____			
2	Enter: <table style="display: inline-table; vertical-align: middle;"> <tr> <td style="font-size: 3em; vertical-align: middle;">{</td> <td style="padding: 0 10px;"> <ul style="list-style-type: none"> • \$30,000 if you're married filing jointly or a qualifying surviving spouse • \$22,500 if you're head of household • \$15,000 if you're single or married filing separately </td> <td style="font-size: 3em; vertical-align: middle;">}</td> </tr> </table>	{	<ul style="list-style-type: none"> • \$30,000 if you're married filing jointly or a qualifying surviving spouse • \$22,500 if you're head of household • \$15,000 if you're single or married filing separately 	}	2	\$ _____
{	<ul style="list-style-type: none"> • \$30,000 if you're married filing jointly or a qualifying surviving spouse • \$22,500 if you're head of household • \$15,000 if you're single or married filing separately 	}				
3	If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-"	3	\$ _____			
4	If line 3 equals zero, and you (or your spouse) are 65 or older, enter: <ul style="list-style-type: none"> • \$2,000 if you're single or head of household. • \$1,600 if you're married filing separately. • \$1,600 if you're a qualifying surviving spouse or you're married filing jointly and one of you is under age 65. • \$3,200 if you're married filing jointly and both of you are age 65 or older. Otherwise, enter "-0-". See Pub. 505 for more information	4	\$ _____			
5	Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information	5	\$ _____			
6	Add lines 3 through 5. Enter the result here and in Step 4(b) on Form W-4P	6	\$ _____			

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. You are required to provide this information only if you want to (a) request federal income tax withholding from pension or annuity payments based on your filing status and adjustments; (b) request additional federal income tax withholding from your pension or annuity payments; (c) choose not to have federal income tax withheld, when permitted; or (d) change a previous Form W-4P. To do any of the aforementioned, you are required by sections 3405(e) and 6109 and their regulations to provide the information requested on this form. Failure to provide this information may result in inaccurate withholding on your payment(s). Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties.

Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, and to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their tax laws. We may

also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.