



**SECTION III** Tell us about your active duty

1. Enter complete information for all periods of service. If more space is needed use Item 29 "Remarks".

2. Attach your original DD214 or a certified copy to this form. (We will return original documents to you.)

The VA has a registry of veterans who served in the Gulf War. This area has also been called the "Persian Gulf." If you served there, we will include your name in the registry. If you want your medical information included, you must check "Yes" in Item 16b. For more information about the registry, see page 4 of the General Instructions for VA Form 21-526.

<b>14a.</b> I entered active service the <b>first</b> time. . .  _____ mo day yr	<b>14b.</b> Place:	<b>14c.</b> My service number was . . .	
<b>14d.</b> I left this active service. . .  _____ mo day yr	<b>14e.</b> Place:	<b>14f.</b> Branch of Service	<b>14g.</b> Grade, rank, or rating
<b>14h.</b> I entered my <b>second</b> period of active service. . .  _____ mo day yr	<b>14i.</b> Place:	<b>14j.</b> My service number was . . .	
<b>14k.</b> I left this active service. . .  _____ mo day yr	<b>14l.</b> Place:	<b>14m.</b> Branch of Service	<b>14n.</b> Grade, rank, or rating
<b>15a.</b> Did you serve in Vietnam?  <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," answer Item 15b also)		<b>15b.</b> When were you in Vietnam? from _____ to _____ mo day yr                      mo day yr	
<b>16a.</b> Were you stationed in the Gulf after August 1, 1990?  <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," answer Item 16b also)		<b>16b.</b> Do you want to have medical and other information about you included in the "Gulf War Veterans' Health Registry?"  <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>17a.</b> Have you ever been a prisoner of war?  <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," answer Items 17b, 17c, and 17d also)		<b>17b.</b> What country or government imprisoned you?	
<b>17c.</b> When were you confined? from _____ to _____ mo day yr                      mo day yr		<b>17d.</b> What was the name of the camp or sector and what are the names of the city and country near its location	

**SECTION IV** Tell us about your reserve duty

<b>18a.</b> Are you currently assigned to an active reserve unit?  <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," answer Item 18b also)	<b>18b.</b> What is the name, mailing address, and telephone number of your current unit?
<b>18c.</b> Were you previously assigned to an active reserve unit within the last 2 years?  <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," answer Item 18d also)	<b>18d.</b> What is the name, mailing address, and telephone number of that unit?

<p><b>SECTION (Continued)</b> <b>IV Tell us about your reserve duty</b></p>	<p><b>18e.</b> Do you have an inactive reserve obligation? (You perform no active duty, but you could be activated if there was a national emergency)</p> <p><input type="checkbox"/> Yes   <input type="checkbox"/> No   <input type="checkbox"/> Don't know</p> <p>(If "Yes," answer Item 18f also)</p>	<p><b>18f.</b> What is your reserve obligation termination date?</p> <p>_____</p> <p>mo   day   yr</p>
<p><b>Instructions 18g-18k</b></p> <p>If you are currently or have ever been a full time reservist for operational or support duty,</p> <ol style="list-style-type: none"> <li>1. Complete 18g-18k for that service only.</li> <li>2. Attach proof of reserve service</li> </ol>	<p><b>18g.</b> I entered reserve service. . .</p> <p>_____ Place: _____</p> <p>mo   day   yr</p> <p><b>18h.</b> My service number was . . .</p>	
<p><b>Instructions 18l-18p</b></p> <p>If your disability occurred or was aggravated during any period of reserve duty,</p> <ol style="list-style-type: none"> <li>1. Complete 18l-18p for the period when your disability occurred.</li> <li>2. Attach proof that your disability occurred during reserve service.</li> </ol>	<p><b>18i.</b> I left reserve service. . .</p> <p>_____ Place: _____</p> <p>mo   day   yr</p> <p><b>18j.</b> Branch of service   <b>18k.</b> Grade, rank, or rating</p>	
<p><b>SECTION V Tell us about your National Guard duty</b></p>	<p><b>19a.</b> Are you currently a member of the National Guard?</p> <p><input type="checkbox"/> Yes   <input type="checkbox"/> No   <input type="checkbox"/> Not assigned yet</p> <p>(If "Yes," answer Item 19b also)</p>	<p><b>19b.</b> What is the name, mailing address, and telephone number of your current unit?</p>
	<p><b>19c.</b> Were you previously assigned to a guard unit within the last 2 years?</p> <p><input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>(If "Yes," answer Item 19d also)</p>	<p><b>19d.</b> What is the name, mailing address, and telephone number of that unit?</p>
<p><b>Instructions 19e-19i</b></p> <p>If you were activated to Federal Active Duty under the Authority of Title 10, United States Code,</p> <ol style="list-style-type: none"> <li>1. Complete 19e-19i for that service only</li> <li>2. Attach proof of this Federal Active Duty.</li> </ol>	<p><b>19e.</b> I entered Federal Active Duty. . .</p> <p>_____ Place: _____</p> <p>mo   day   yr</p> <p><b>19f.</b> My service number was . . .</p>	
<p><b>Instructions 19j-19n</b></p> <p>If your disability occurred or was aggravated during any period of guard duty,</p> <ol style="list-style-type: none"> <li>1. Complete 19j-19n for the period when your disability occurred</li> <li>2. Attach proof that your disability occurred during National Guard Service.</li> </ol>	<p><b>19g.</b> I left Federal Active Duty. . .</p> <p>_____ Place: _____</p> <p>mo   day   yr</p> <p><b>19h.</b> Branch of service   <b>19i.</b> Grade, rank, or rating</p>	
	<p><b>19j.</b> I entered National Guard. . .</p> <p>_____ Place: _____</p> <p>mo   day   yr</p> <p><b>19k.</b> My service number was . . .</p> <p><b>19l.</b> I left National Guard. . .</p> <p>_____ Place: _____</p> <p>mo   day   yr</p> <p><b>19m.</b> Branch of service   <b>19n.</b> Grade, rank, or rating</p>	

<b>SECTION VI</b> <b>Tell us about your travel status</b>	<b>20a.</b> Were you injured while traveling to or from your military assignment?  (If "Yes," answer Items 20b thru 20e and Section I of Part B: Compensation)	<b>20b.</b> When did your injury happen?  _____ mo    day    yr	<b>20c.</b> Where did your injury happen? (City, State, Country)	<b>20d.</b> Where were you treated? (Provide name and address of Doctor's office, hospital, etc.)	<b>20e.</b> What agency did you file an accident report with?
	<input type="checkbox"/> Yes <input type="checkbox"/> No				

<b>SECTION VII</b> <b>Tell us about your military benefits</b>  When you file this application, you are telling us that you want to get VA compensation instead of military retired pay. If you currently receive military retired pay, you should be aware that we will reduce your retired pay by the amount of any compensation that you are awarded. VA will notify the Military Retired Pay Center of all benefit changes.  <b>You must sign 21e if you want to keep getting military retired pay instead of VA compensation.</b>  Please see page 4 of the General Instructions for VA Form 21-526.  If you have gotten both military retired pay and VA compensation, some of the amount you get may be recouped by VA, or in the case of VSI, by the Department of Defense	<b>21a.</b> Are you receiving or will you receive retired or retainer pay that is based on your military service?  <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," answer Items 21b thru 21f. If "No," skip to Item 22)	<b>21b.</b> What branch of service is paying or will pay your retired or retainer pay?	<b>21c.</b> What is the monthly amount?  \$ _____ . _____													
	<b>21d.</b> What is your retirement based on? <input type="checkbox"/> Length of service <input type="checkbox"/> Disability <input type="checkbox"/> TDRL (Temporary Disability Retired List)															
	<b>21e.</b> Sign here if you want to receive military retired pay <i>instead of</i> VA compensation  _____															
<b>21f.</b> Have you received or will you receive any of the following military benefits? (Please check the appropriate boxes and tell us the amount)																
<table border="1"> <thead> <tr> <th style="text-align: left;"><i>Benefit</i></th> <th style="text-align: right;"><i>Amount</i></th> </tr> </thead> <tbody> <tr> <td>(1) <input type="checkbox"/> Lump Sum Readjustment Pay</td> <td style="text-align: right;">\$ _____ . _____</td> </tr> <tr> <td>(2) <input type="checkbox"/> Separation pay under 10 USC 1174</td> <td style="text-align: right;">\$ _____ . _____</td> </tr> <tr> <td>(3) <input type="checkbox"/> Special Separation Benefit (SSB)</td> <td style="text-align: right;">\$ _____ . _____</td> </tr> <tr> <td>(4) <input type="checkbox"/> Voluntary Separation Incentive (VSI)</td> <td style="text-align: right;">\$ _____ . _____</td> </tr> <tr> <td>(5) <input type="checkbox"/> Disability Severance Pay (name of disability _____)</td> <td style="text-align: right;">\$ _____ . _____</td> </tr> <tr> <td>(6) <input type="checkbox"/> Other (tell us the type of benefit _____)</td> <td style="text-align: right;">\$ _____ . _____</td> </tr> </tbody> </table>			<i>Benefit</i>	<i>Amount</i>	(1) <input type="checkbox"/> Lump Sum Readjustment Pay	\$ _____ . _____	(2) <input type="checkbox"/> Separation pay under 10 USC 1174	\$ _____ . _____	(3) <input type="checkbox"/> Special Separation Benefit (SSB)	\$ _____ . _____	(4) <input type="checkbox"/> Voluntary Separation Incentive (VSI)	\$ _____ . _____	(5) <input type="checkbox"/> Disability Severance Pay (name of disability _____)	\$ _____ . _____	(6) <input type="checkbox"/> Other (tell us the type of benefit _____)	\$ _____ . _____
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(6) <input type="checkbox"/> Other (tell us the type of benefit _____)	\$ _____ . _____															

<b>SECTION VIII</b> <b>Give us direct deposit information</b>  <b>If benefits are awarded</b> we will need more information in order to process any payments to you. Please read the paragraph starting with, " <i>All federal payments...</i> " and then either:  1. Attach a voided check, or  2. Answer questions 22-24 to the right.	All federal payments beginning January 2, 1999, must be made by electronic funds transfer (EFT) also called Direct Deposit. Please attach a voided personal check or deposit slip or provide the information requested below in Items 22, 23 and 24 to enroll in Direct Deposit. If you do not have a bank account we will give you a waiver from Direct Deposit, just check the box below in Item 22. The Treasury Department is working on making bank accounts available to you. Once these accounts are available, you will be able to decide whether you wish to sign-up for one of the accounts or continue to receive a paper check. You can also request a waiver if you have other circumstances that you feel would cause you a hardship to be enrolled in Direct Deposit. You can write to: Department of Veterans Affairs, 125 S. Main Street Suite B, Muskogee OK 74401-7004, and give us a brief description of why you do not wish to participate in Direct Deposit.
	<b>22.</b> Account number (Please check the appropriate box and provide that account number, if applicable) <input type="checkbox"/> Checking <input type="checkbox"/> I certify that I <b>do not</b> have an account with a financial institution or certified payment agent <input type="checkbox"/> Savings Account number _____
	<b>23.</b> Name of financial institution _____
	<b>24.</b> Routing or transit number _____

**SECTION IX Give us your signature**

1. Read the box that starts, "I certify and authorize the release of information:"
2. Sign the box that says, "Your signature."
3. If you sign with an "X," then you must have 2 people you know witness you as you sign. They must then sign the form and print their names and addresses also.

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.

<b>25.</b> Your signature	<b>26.</b> Today's date  _____ / _____ / _____ mo day yr
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<b>27a.</b> Signature of witness (If claimant signed above using an "X")	<b>27b.</b> Printed name and address of witness
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<b>28c.</b> Signature of witness (If claimant signed above using an "X")	<b>28b.</b> Printed name and address of witness
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**SECTION X**

**Remarks—Use this space for any additional statements that you would like to make concerning your application for Compensation and/or Pension**

**IMPORTANT**  
 Penalty: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false, or for the fraudulent acceptance of any payment which you are not entitled to.

**29. Remarks** (If you need more space to answer a question or have a comment about a specific item number on this form, please identify your answer or statement by the part and item number). (See page 5 "Tips For Filling Out Your VA Form 21-526.")



**SECTION II** Tell us about any previous marriages

NOTE: You should provide copies of divorce decrees or death certificates

In the table below, tell us about:

- Your previous marriages, and
- Your spouse's previous marriages

**Your previous marriages**

13a. How many times have you been married before? \_\_\_\_\_

13b. When were you married?	13c. Where were you married? (city/state or country)	13d. Who were you married to? (first, middle initial, last)	13e. When did your marriage end? _____	13f. Why did your marriage end? (death, divorce)	13g. Where did your marriage end? (city/state or country)
_____			_____		
mo day yr			mo day yr		
_____			_____		
mo day yr			mo day yr		

**Your spouse's previous marriages**

14a. How many times has your current spouse been married before? \_\_\_\_\_

14b. When was your spouse married?	14c. Where was your spouse married? (city/state or country)	14d. Who was your spouse married to? (first, middle initial, last)	14e. When did your spouse's marriage end? _____	14f. Why did your spouse's marriage end? (death, divorce)	14g. Where did your spouse's marriage end? (city/state or country)
_____			_____		
mo day yr			mo day yr		
_____			_____		
mo day yr			mo day yr		

**SECTION III** Tell us about your other dependents

In this section we want to know whether your parents are financially dependent on you (Question 15) and more about your **dependent children**. VA may recognize a veteran's biological children, adopted children, and stepchildren as dependent. These children must be unmarried and:

- be under the age of 18, **or**
- be at least 18 but under 23 and pursuing an approved course of education, **or**
- have become permanently unable to support themselves before reaching the age of 18.

You should provide: a copy of the public record of birth for each child or a copy of the court record of adoption for each adopted child.

15. Are your parents financially dependent on you?  
 Yes  No (If "Yes," we will request additional information from you later.)

16. Do you have dependent children?  
 Yes (If "No," Skip Items 17-21f.) Go to the bottom of page 3 and write your name and Social Security number.)  
 No

17. How many dependent children do you have?  
 \_\_\_\_\_  
 Give us more information about these children in the tables on the next page (Items 18 through 21f).

**SECTION III Tell us about your dependents (continued)**

18a. What is the name of your unmarried child(ren)? (first, middle initial, last)	18b. Date and place of birth (city/state or country)	18c. Social Security Number	19a. Biological	19b. Adopted	19c. Stepchild	20a. 18-23 yrs. old and in school	20b. Seriously disabled before age 18	20c. Child previously married
	_____ mo day yr Place:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	_____ mo day yr Place:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	_____ mo day yr Place:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	_____ mo day yr Place:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Tell us about your dependents listed above who *don't live with you***

**21a.** Do all the children listed above live with you?  
 Yes (If "Yes," skip Items 21b thru 21f and write your name and Social Security number below.)  
 No (If "No," complete Item 21b and the table below (Items 21c -21f) and write your name and Social Security number below.)

**21b.** How many of the children do not live with you?  
 \_\_\_\_\_

21c. What is the name of your child? (first, middle initial, last)	21d. What is your child's complete address?	21e. What is the name of the person your child lives with (If applicable)? (first, middle initial, last)	21f. How much do you contribute each month to the support of your child?
			\$ .
			\$ .
			\$ .
			\$ .

<b>Your name</b>	<b>Your Social Security Number</b>
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# Department of Veterans Affairs

## VA Form 21-526, Part D: Pension

Use this form to apply for pension. Remember that you must also fill out a VA Form 21-526, Part A: General Information, for your application to be processed. Be sure to write your name and Social Security number in the space provided on page 4.

### SECTION I Tell us about your disability and background

Complete this section if you are claiming pension because of permanent and total disability not caused by your military service.

Attach current medical evidence showing that you are permanently and totally disabled.

Note: If you are a veteran who is age 65 or older or determined to be disabled by the Social Security Administration, you **DO NOT** have to submit medical evidence with your application.

1a. What disability(ies) prevent you from working?

1b. When did the disability(ies) begin?

\_\_\_\_\_ day yr

2. Are you claiming a special monthly pension because you need the regular assistance of another person, are blind, nearly blind, or having severe visual problems, or are housebound?

Yes  No

3a. Are you now, or have you recently been hospitalized or given outpatient or home-based care?

Yes  No  
(If "Yes," answer Items 3b and 3c also)

3b. Tell us the dates of the recent hospitalization or care

Began \_\_\_\_\_ day yr

Ended \_\_\_\_\_ day yr

3c. What is the name and complete mailing address of the facility or doctor?

4a. Are you now employed?

Yes  No

(If "No," answer Item 4b also)

4b. When did you last work?

\_\_\_\_\_ day yr

4c. Were you self-employed before becoming totally disabled?

Yes  No

(If "Yes," answer Item 4d and 4e also)

4d. What kind of work did you do?

4e. Are you still self-employed?

Yes  No

(If "Yes," answer Item 4f also)

4f. What kind of work do you do now?

4g. Have you claimed or are you receiving disability benefits from the Social Security Administration (SSA)?

Yes  No

4h. Circle the highest year of education you completed:

**Grade school**  
1 2 3 4 5 6 7 8 9 10 11 12  
**College**  
1 2 3 4 over 4

4i. List the other training or experience you have and any certificates that you hold.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SECTION II** Tell us your work history

In the table below, tell us about all of your employment, including self-employment, for one year before you became disabled to the present.

5a. What was the name and address of your employer?	5b. What was your job title?	5c. When did your work begin?	5d. When did your work end?	5e. How many days were lost due to disability?	5f. What were your total annual earnings?
		_____ mo day yr	_____ mo day yr		\$ .
		_____ mo day yr	_____ mo day yr		\$ .
		_____ mo day yr	_____ mo day yr		\$ .

**SECTION III** Tell us if you are in a nursing home

In this section, tell us if you are in a nursing home. If you are in a nursing home, give us more information about the nursing home.

<p>To get your claim processed faster, provide a statement by an official of the nursing home that tells us that you are a patient in the nursing home because of a physical or mental disability and tells us the daily charge for your care.</p>	<p><b>6a.</b> Are you now in a nursing home?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(If "yes," answer Item 6b also)</p>	<p><b>6b.</b> What is the name and complete mailing address of the facility or doctor?</p>
	<p><b>6c.</b> Does Medicaid cover all or part of your nursing home costs?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(If "no," answer Item 6d also)</p>	<p><b>6d.</b> Have you applied for Medicaid?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

**SECTION IV** Tell us the net worth of you and your dependents

In this section, we ask you to give us specific information about your net worth and the net worth of your dependents. You will need to enter this information in the tables on page 3.

You must include all assets in your net worth except those items you use everyday (See definition of net worth below.)  
 You should subtract from the market value of your real estate any amounts that you owe on it (such as mortgages, liens, etc.)  
 You can subtract mortgages on any property, and the value of the house or part of a building that you live in as your primary residence.  
 You can report farms or buildings that you or a dependent own by reporting its value as "real property."

Definitions:  
 Net worth is the market value of all interest and rights in any kind of property less any mortgages or other claims against the property. However, net worth does not include the house you live in or a reasonable area of land it sits on. Net worth also does not include the value of personal things you use everyday like your vehicle, clothing, and furniture.

VA cannot pay you pension if your net worth is sizeable.

Go to Page 3 and fill out the table.

**SECTION IV Tell us about your net worth and your dependents' net worth.**

**IV  
(Continued)**

**For items 7a-h: provide the amounts. If none, write "0" or "None"**

Source	Veteran	Spouse	Child(ren)		
			I. Name: (first, middle initial, last)	II. Name: (first, middle initial, last)	III. Name: (first, middle initial, last)
7a. Cash, non-interest bearing bank accounts					
7b. Interest bearing bank accounts, certificates of deposit (CDs)					
7c. IRAs, Keogh Plans, etc.					
7d. Stocks and bonds					
7e. Mutual funds					
7f. Value of business assets					
7g. Real property (not your home)					
7h. All other property					

**SECTION V Tell us about the income you have received and you expect to receive**

In this section, we ask you to give us specific information about the income you have received and the income you expect to receive from all sources. You will need to enter this information in the tables on Page 4. In these tables,

Report the total amounts before you take out deductions for taxes, insurance, etc. Do not report the same information in both tables.

If you expect to receive a payment, but you don't know how much it will be, write "Unknown" in the space.

If you do not receive any payments from one of the sources that we list, write "0" or "None" in the space.

If you are receiving monthly benefits, give us a copy of your most recent award letter. This will help us determine the amount of benefits you should be paid.

Payments from any source will be counted, unless the law says that they don't need to be counted. VA will determine any amount that does not count.

**8. Will you receive any income from rental property or from operation of a business within 12 months of the day you sign this form?**

Yes  No

**9. Will you receive any income from the operation of a farm within 12 months of the day you sign this form?**

Yes  No

**10. Do you expect to receive money from a civilian agency, corporation, or individual, because of personal injury or death within 12 months of the day you sign this form?**

Yes  No

**SECTION V (Continued) Monthly Income –Tell us the income you and your dependents receive every month.**

For Items 11a-12f if none write "0" or "None"

Sources of recurring monthly income	Veteran	Spouse	Child(ren)		
			I. Name:	II. Name:	III. Name:
			(first, middle initial, last)	(first, middle initial, last)	(first, middle initial, last)
11a. Social Security					
11b. U.S. Civil Service					
11c. U.S. Railroad Retirement					
11d. Military Retired Pay					
11e. Black Lung Benefits					
11f. Supplemental Security (SSI)/Public Assistance					
11g. Other income received monthly (Please write in the source below:)					

**Next 12 months –Tell us about other income for you and your dependents**

Sources of income for the next 12 months	Veteran	Spouse	Child(ren)		
			I. Name:	II. Name:	III. Name:
			(first, middle initial, last)	(first, middle initial, last)	(first, middle initial, last)
12a. Gross wages and salary					
12b. Total interest and dividends					
12c. Worker's compensation for injury					
12d. Unemployment compensation					
12e. Other military benefit (Please write in the source below:)					
12f. Other one-time benefit (Please write in the source below:)					

<p><b>SECTION VI</b></p> <p>IMPORTANT– Items 13A through 13E should be completed only if you are applying for nonservice-connected pension.</p>	<p><b>Tell us any information concerning, Medical, Legal or Other Expenses–</b> Family medical expenses actually paid by you may be deductible from your income. Show the amount of unreimbursed medical expenses you paid for yourself or relatives you are under an obligation to support. Also, show medical, legal or other expenses you paid because of a disability for which civilian disability benefits have been awarded. When determining your income, we may be able to deduct them from the disability benefits for the year in which the expenses are paid. <b>Do not</b> include any expenses for which you were reimbursed. Show the Medicare deduction in line 1. If more space is needed attach a separate sheet.</p>				
	13A. AMOUNT PAID BY YOU	13B. DATE PAID	13C. PURPOSE <i>(Doctor's fees, hospital charges, Attorney fees, etc)</i>	13D. PAID TO <i>(Name of doctor, hospital, pharmacy, Attorney, etc.)</i>	13E. DISABILITY OR RELATIONSHIP OF PERSON FOR WHOM EXPENSES PAID

<b>Your name</b>	<b>Your Social Security Number</b>
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