OMB Control No. 2900-0065 Respondent Burden: 15 minutes Expiration Date: 09/30/2020

|  |  |   |                   |                   | CE CTAMB                    |  |  |  |
|--|--|---|-------------------|-------------------|-----------------------------|--|--|--|
| Department of Veterans Aff   | airs   |   |                   |                   | FE STAMP<br>E IN THIS SPACE |  |  |  |
|  |  |   |                   |                   |                             |  |  |  |
| REQUEST FOR EMPLOYMENT IN  |  |   |                   |                   |                             |  |  |  |
| DIS  | SABILITY BENEFIT   | S   |                   |                   |                             |  |  |  |
| 1. NAME AND ADDRESS OF EMPLOYER OF VETERA  | N (Complete)   | . ADDRESS (Complete)                            |                   |                   |                             |  |  |  |
| T. NAME AND ADDITESS OF LIMITED TERROR VETERA  | (Complete)   | ABBITEOU (Compiete)                             |                   |                   |                             |  |  |  |
|  |  |   |                   |                   |                             |  |  |  |
|  | RETURN   |   |                   |                   |                             |  |  |  |
|  | ТО   |   |                   |                   |                             |  |  |  |
|  |  |   |                   |                   |                             |  |  |  |
|  |  |   |                   |                   |                             |  |  |  |
| INSTRUCTIONS: The veteran named in Item 3 ha   | s filed a claim for veterans   | disability benefits and has stated th           | nat he/she was re | cently employed   | by you. In order to         |  |  |  |
| arrive at a fair decision in this case, we need the in                                       | formation requested below  | . Please complete Sections II, III a            | nd IV and return  | to this office at | the address below.          |  |  |  |
| Please be sure to sign and date this form in Iter  |  | e help in completing this form,                 | call VA toll-free | e at 1-800-827-1  | 000. If you use a           |  |  |  |
| Telecommunications Device for the Deaf (TDD), the  | Federal number is 711.   |   |                   |                   |                             |  |  |  |
|  |  | FICATION INFORMATION                            |                   |                   |                             |  |  |  |
| <b>NOTE:</b> You can <i>either</i> complete the form onlin                                   | e or by hand. Please pri   | nt the information requested in                 | ink, neatly and   | legibly to help   | process the form.           |  |  |  |
| 3. VETERAN/BENEFICARY'S NAME (First, Middle Inition  | ıl, Last)  |   |                   |                   |                             |  |  |  |
|  |  |   |                   |                   |                             |  |  |  |
| 4. SOCIAL SECURITY NUMBER  | SOCIAL SECURITY NUMBER 5. VA FILE NUMBER (If applicable) 6. DATE OF BIRT |   |                   |                   |                             |  |  |  |
|  |  | (3 11   | Month             | Day               | Year                        |  |  |  |
|  |  |   | _                 | _                 |                             |  |  |  |
| SECTION  | III EMDI OVMENT INE  | ORMATION (To be completed by                    | amployan)         |                   |                             |  |  |  |
| 7. BEGINNING DATE OF EMPLOYMENT (MM/DD/YYY   |  | ` 1   | 1 2 /             | EREORMED          |                             |  |  |  |
| Month Day Year   | Month Da   |   | TE OF WORKTE      | IN ONWED          |                             |  |  |  |
|  | _  | _   |                   |                   |                             |  |  |  |
|  |  |   |                   |                   |                             |  |  |  |
| <ol> <li>AMOUNT EARNED DURING 12 MONTHS PRECEI<br/>EMPLOYMENT (BEFORE DEDUCTIONS)</li> </ol> | DING LAST DATE OF  | 11. TIME LOST DURING 12 MON (DUE TO DISABILITY) | THS PRECEDIN      | G LAST DATE OF    | EMPLOYMENT                  |  |  |  |
| Ф.   |  |   |                   |                   |                             |  |  |  |
| 12A. NUMBER OF HOURS WORKED (Daily)  | ZED (WLL.)   |   |                   |                   |                             |  |  |  |
| 12A. NOWIDER OF FIGURE WORKED (Duty)   | 12B. NUMBER OF HOURS WORK  | NED (Wеекіу)                                    |                   |                   |                             |  |  |  |
| 13. CONCESSIONS (if any) MADE TO EMPLOYEE BY   | REASON OF AGE OR DISA  | <br>ABILITY                                     |                   |                   |                             |  |  |  |
| .o. oo. oo   |  | .5.2  |                   |                   |                             |  |  |  |
|  |  |   |                   |                   |                             |  |  |  |
|  |  |   |                   |                   |                             |  |  |  |
|  |  |   |                   |                   |                             |  |  |  |
| 14A. IF VETERAN IS NOT WORKING. STATE THE RE   | ASON FOR TERMINATION   | OF EMPLOYMENT:                                  | TAAD DATE LAC     | T WORKED          |                             |  |  |  |
| (IF RETIRED ON DISABILITY, PLEASE SPECIFY)   | 14B. DATE LAS  | I WORKED  |                   |                   |                             |  |  |  |
|  |  |   | Month             | Day               | Year                        |  |  |  |
|  |  |   | _                 | _                 |                             |  |  |  |
| 15A. DATE OF LAST PAYMENT  | 5B. GROSS AMOUNT OF  | 16A. WAS LUMP SUM PAYMENT                       | 16B. DATE PAIL    | <u> </u>          |                             |  |  |  |
|  | LAST PAYMENT   | MADE?   |                   |                   |                             |  |  |  |
| Month Day Year   |  | YES NO  | Month             | Dov               | Veer                        |  |  |  |
|  | •  | GROSS AMOUNT PAID                               | Month             | Day<br>—          | Year                        |  |  |  |
|  | \$   | \$  |                   |                   |                             |  |  |  |
|  |  | NATIONAL GUARD DUTY STA                         |                   |                   |                             |  |  |  |
| Only con<br>17A. WHAT IS THE VETERAN'S CURRENT DUTY STA                                      | 1 0  | ly serving in the Reserve or Nationa            | u Guara)          |                   |                             |  |  |  |
| ITA. WHAT IS THE VETERANS CURRENT DUTY STA   | 1100!  |   |                   |                   |                             |  |  |  |
|  |  |   |                   |                   |                             |  |  |  |
|  |  |   |                   |                   |                             |  |  |  |
| 17B. DOES THE VETERAN HAVE ANY DISABILITIES  | THAT PREVENT THEM ED   | OM PERFORMING THEIR MII ITAD                    | Y DUTIES?         |                   |                             |  |  |  |
|  |  |   |                   |                   |                             |  |  |  |
| YES NO   |  |   |                   |                   |                             |  |  |  |

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| SECTION IV - INFORMATION ON BENEFIT ENTITLEMENT AND/OR PAYMENTS (To be completed by employer)  |                             |                            |                   |                                 |  |  |  |  |
|--|-----------------------------|----------------------------|-------------------|---------------------------------|--|--|--|--|
| 18. IS VETERAN RECEIVING OR ENTITLED TO RECEIVE, AS A RESULT OF HIS/HER EMPLOYMENT WITH YOU, SICK, RETIREMENT OR OTHER BENEFITS?   |                             |                            |                   |                                 |  |  |  |  |
| YES NO   | (If "Yes," complete Items 1 | 9 through 21C)             |                   |                                 |  |  |  |  |
| 19. TYPE OF BENEFI   | Т                           |                            |                   |                                 |  |  |  |  |
|  |                             |                            |                   |                                 |  |  |  |  |
|  |                             |                            |                   |                                 |  |  |  |  |
|  |                             |                            |                   |                                 |  |  |  |  |
|  |                             |                            |                   |                                 |  |  |  |  |
| 20. GROSS MONTHL   | Y AMOUNT OF BENEFIT         |                            |                   |                                 |  |  |  |  |
| \$   |                             |                            |                   |                                 |  |  |  |  |
| 21A. DATE BENEFIT I  | BEGAN (MM/DD/YYYY)          | 21B. DATE FIRST PAYMENT IS | SUED (MM/DD/YYYY) | 21C. DATE BENEF<br>(MM/DD/YYYY) | DATE BENEFIT WILL STOP (If known) I/DD/YYYY) |  |  |  |
| Month Da   | ay Year                     | Month Day                  | Year              | Month                           | Day Year                                     |  |  |  |
| _  | _                           |                            |                   | _                               | -  |  |  |  |
| 22. REMARKS  |                             | I                          |                   | 1                               |  |  |  |  |
|  |                             |                            |                   |                                 |  |  |  |  |
|  |                             |                            |                   |                                 |  |  |  |  |
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| I CEPTIEV THAT do not an ability of the Community of the Lord Community of the Lord Community of the Communi |                             |                            |                   |                                 |  |  |  |  |
| I CERTIFY THAT the statements made in this form are true and complete to the best of my knowledge  |                             |                            |                   |                                 | IGNED (MM/DD/YYYY)                           |  |  |  |
| 23A. SIGNATURE OF EMPLOYER OR SUPERVISOR (If claimant is serving in the Reserves or National Guard, then signature of unit commander or designee is required.) (Sign in ink)   |                             |                            |                   | u, 230. DATE S                  | IGNED (MIM/DD/1111)                          |  |  |  |
|  |                             |                            |                   |                                 |  |  |  |  |
|  |                             |                            |                   |                                 |  |  |  |  |
| DENIAL TEXT TEL 1  |                             | 1:1:116                    | 1 1 0             | 1 1101 1 1                      |  |  |  |  |

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

**PRIVACY ACT NOTICE**: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary. The requested information is considered relevant and necessary to determine maximum benefits under the law. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

**RESPONDENT BURDEN**: We need this information to determine eligibility for disability benefits based on unemployability (38 U.S.C. 1521). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 15 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at <a href="www.reginfo.gov/public/do/PRAMain">www.reginfo.gov/public/do/PRAMain</a>. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

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