

Request for Information from Bureau of Veterans Affairs Complete and Return This Page Only

TO BE COMPLETED BY BUREAU OF VETERANS AFFAIRS (Please return to address indicated on page 1.)

Name of Veteran	C or XC No.	Date
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EFFECTIVE DATE	GROSS AMOUNT	PENSION		DIC		COMPENSATION	INSURANCE
		Old Law	Improved Plan	Parents	Widows & Children		

Will improved pension payments for this claimant be capped at \$90? **Yes** **No**

If yes, in what month and year will claimant receive the first \$90 check?

Month	Year (4 digits)
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Has the check been augmented to include the needs of a dependent? **Yes** **No**

If yes, give the amount by which the claimant's check has been augmented for dependent(s):\$ _____

Is full payment being received?..... **Yes** **No**

If no, why? **Recoupment of Overpayment** **Suspension of Benefits** **Other:** _____

Does the check include an adjustment for out-of-pocket medical expenses? **Yes** **No**

If yes, amount of adjustment:\$ _____

Does the check include aid and attendance or housebound benefits? **Yes** **No**

If yes, amount of aid and attendance \$ _____ ; amount of housebound benefits \$ _____

		Telephone No. (include A/C)
Signature—BVA Official	Date	

Return Form To:

HHSC Staff	Telephone No.	Fax No.
Address		