OMB Control No. 2900-0675
Respondent Burden: 15 minutes
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Department of Veterans Affairs

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STATEMENT IN SUPPORT OF CLAIM

INSTRUCTIONS: Read the Privacy Act and Respondent Burden on Page 2 before completing the form. Complete as much of Section I as possible. The information requested will help process your claim for benefits. If you need any additional room, use the second page.

SECTION I. VETERAN/BENEFICIARY'S IDENTIFICATION INFORMATION

NOTE: You will *either* complete the form online or by hand. Please print the information request in ink, neatly, and legibly to help process the form.

1. VETERAN/BENEFICIARY'S NAME *(First, Middle Initial, Last)*

Victor Aviles Aviles

2. VETERAN'S SOCIAL SECURITY NUMBER

[redacted]

3. VA FILE NUMBER *(If applicable)*

4. VETERAN'S DATE OF BIRTH *(MM/DD/YY)*

Month 04 - Day 18 - Year 1947

5. VETERAN'S SERVICE NUMBER *(If applicable)*

6. TELEPHONE NUMBER *(Include Area Code)*

(787) 375-1544

7. E-MAIL ADDRESS *(Optional)*

8. MAILING ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*

No. & Street: Box 4883

Apt./Unit Number:

City: Aibonito

State/Province: PR

Country:

ZIP Code/Postal Code: 00705 -

SECTION II. REMARKS

(The following statement is made in connection with a claim for benefits in the case of the above-named veteran/beneficiary.)

Department of Veterans Affair
Evidence Intake Center
P.O. Box 4444
Janesville WI 53547-4444

Court-19-5969.

Please reply to Court Orders

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