



800 Mickelson Dr.  
Rapid City, SD 57703  
605-718-2400  
605-348-2204 – Fax

## Veteran Benefit Declaration

Student's Name: \_\_\_\_\_ Student ID#: \_\_\_\_\_

Current Mailing Address: \_\_\_\_\_  
Street City, State Zip

Phone Number: \_\_\_\_\_ Program: \_\_\_\_\_

**Please select the Benefit Program you will be using for your Program:**

- |   |  |  |   |   |
|---|--|--|---|---|
| <input type="checkbox"/> Chapter 1606<br>Selected Reserve | <input type="checkbox"/> Chapter 30<br>Montgomery Bill | <input type="checkbox"/> Chapter 31<br>VA Voc. Rehab | <input type="checkbox"/> Chapter 33<br>Post 9/11 Bill | <input type="checkbox"/> Chapter 35<br>Survivor/Dependent |
|---|--|--|---|---|

**Please check area of service related to the Veteran Benefits you are receiving:**

- |  |   |
|--|---|
| <input type="checkbox"/> Veteran of _____  | <input type="checkbox"/> Reserves                                   |
| <input type="checkbox"/> Active Duty with _____  | <input type="checkbox"/> National Guard (State _____)               |
| <input type="checkbox"/> Spouse or Dependent of Veteran who is deceased  | <input type="checkbox"/> Spouse or Dependent of Veteran/Active Duty |
| <input type="checkbox"/> Veteran/Active Duty or Spouse/Dependent of Veteran/Active Duty who has suffered service related injury/illness. |   |

**\*If Taking Corporate Education Class:**

Course: \_\_\_\_\_

Class Dates: \_\_\_\_\_

By signing below, I verify that the above information is correct and that I intend to utilize the declared benefit for all semesters pursuing my program of study. If I choose to stop benefits, I will notify the Registrar's Office in writing.

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

School Certifying Official Use Only

Student activated for certifications in VAOnce (Initial Certification Processed) \_\_\_\_\_ (initials) \_\_\_\_\_ (date)