



800 Mickelson Dr.  
Rapid City, SD 57703  
605-718-2410  
605-394-5116 – Fax

## Veteran Change of Benefit Declaration

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

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

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

Benefits Change starting Semester (Check One):  Fall  Spring  Summer \_\_\_\_\_ (Academic Year)

**Please select the Benefit Program you will be changing to 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 |
|--|--|---|---|---|

\*Student must include new Certificate of Eligibility and Notice of Basic Eligibility.

\*\*Student must include new Certificate of Eligibility with Change of Benefit Declaration.

\*\*\*Student will need to have his or her VA Vocational Rehabilitation Counselor submit the authorization of benefits.

**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 revoke use of my currently declared benefit starting the effective semester and that I intend to utilize the newly declared benefit for all remaining semesters for my program of study. By signing I also verify all the above information is correct. If I choose to stop benefits, I will notify the Registrar's Office in writing.

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

\_\_\_\_\_  
Date

School Certifying Official Use Only

Student certified for newly declared benefit \_\_\_\_\_ (initials) \_\_\_\_\_ (date)