VETERAN AND MILITARY FAMILY SERVICES OFFICE

EDUCATIONAL BENEFIT FORM

UNIVERSITY of ROCHESTER

Please complete Part 1 if you are new to the University of Rochester.

*Returning students may skip to Part 2 **unless** something in Part 1 needs to be updated.*

Name: ______________________________ UR ID: ______________________________

PART 1

Mailing Address: ____
Number and Street Apt. #

____
City or Town State Zip

Email Address: ______________________________ Phone Number: ______________________________

Branch of Service (check one):

- ☐ Air Force
- ☐ Army
- ☐ Coast Guard
- ☐ Marines
- ☐ Navy
- ☐ Transferred Benefits D/S

Chapter of Benefit (check one):

- ☐ 30 (MGIB)
- ☐ 31 (Vet Readiness)
- ☐ 35 (DEA)
- ☐ 1606 (SR)
- ☐ 33 (Post-9/11, 100%)
- ☐ 33 (Post-9/11, other ___%)

Remaining months of eligibility:

__________ months

School: ______________________________ ☐ Graduate ☐ Undergraduate

Program/Major: ______________________________ ☐ Part time ☐ Full time

Anticipated Degree: ______________________________ ☐ Matriculated ☐ Non-matriculated

Anticipated Grad Date (month & year): ______________________________

Were you awarded a scholarship? ☐ No ☐ Yes (Amount per semester or percentage: ________________)

Do you have employee tuition benefits? ☐ No ☐ Yes (Percentage: __________)

PART 2

Semester/quarter: ______________________________ Beginning and end dates of term: ______________________________

Number of credits: ______________________________ ☐ On campus ☐ Online

Read and initial beside each statement below, then sign at the bottom:

______ I understand that I am responsible for submitting this form for each semester or quarter I plan to receive veteran educational benefits.

______ I understand that I am responsible for reporting any status changes (including add/drop; withdrawals; incomplete or failing grades; change of address; change of college, department, or major; or any other changes that may affect my entitlement to G.I. Bill Benefits) to the Veteran and Military Family Services Office immediately.

______ I understand that I am responsible for any underpayments or overpayments due to changes that may affect my entitlement to G.I. Bill Benefits as described above.

I, the undersigned, certify that the above statements are true to the best of my knowledge. I have read and understand my responsibilities as outlined above.

Signature: ______________________________ Date: ______________________________