

Department of Veterans Affairs		<h2 style="margin: 0;">APPLICATION FOR HEALTH BENEFITS</h2>			
SECTION I - GENERAL INFORMATION					
<p>Federal law provides criminal penalties, including a fine and/or imprisonment for up to 5 years, for concealing a material fact or making a materially false statement. (See 18 U.S.C. 1001)</p>					
1. VETERAN'S NAME <i>(Last, First, Middle Name)</i>			2. MOTHER'S MAIDEN NAME		3. GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
4. ARE YOU SPANISH, HISPANIC, OR LATINO? <input type="checkbox"/> YES <input type="checkbox"/> NO		5. WHAT IS YOUR RACE? <i>(You may check more than one. Information is required for statistical purposes only.)</i> <input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> ASIAN <input type="checkbox"/> WHITE <input type="checkbox"/> NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER			
6. SOCIAL SECURITY NUMBER		7. DATE OF BIRTH <i>(mm/dd/yyyy)</i>		7A. PLACE OF BIRTH <i>(City and State)</i>	
8. PERMANENT ADDRESS <i>(Street)</i>			8A. CITY		8B. STATE
					8C. ZIP CODE
8D. COUNTY		8E. HOME TELEPHONE NUMBER <i>(Include area code)</i>		8F. MOBILE TELEPHONE NUMBER <i>(Include area code)</i>	
8G. E-MAIL ADDRESS		9. CURRENT MARTIAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			
10. I AM ENROLLING TO OBTAIN MINIMUM ESSENTIAL COVERAGE UNDER THE AFFORDABLE CARE ACT <input type="checkbox"/> YES <input type="checkbox"/> NO		11. WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER? <i>(for listing of facilities visit www.va.gov/directory)</i>			12. WOULD YOU LIKE FOR VA TO CONTACT YOU TO SCHEDULE YOUR FIRST APPOINTMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO
SECTION II - MILITARY SERVICE INFORMATION					
1. LAST BRANCH OF SERVICE		1A. LAST ENTRY DATE		1B. LAST DISCHARGE DATE	
				1C. DISCHARGE TYPE	
2. MILITARY HISTORY <i>(Check yes or no)</i>		YES	NO		
A. ARE YOU A PURPLE HEART AWARD RECIPIENT?		<input type="checkbox"/>	<input type="checkbox"/>	E. DID YOU SERVE IN SW ASIA DURING THE GULF WAR BETWEEN AUGUST 2, 1990 AND NOVEMBER 11, 1998? <input type="checkbox"/> YES <input type="checkbox"/> NO	
B. ARE YOU A FORMER PRISONER OF WAR?		<input type="checkbox"/>	<input type="checkbox"/>	F. DID YOU SERVE IN VIETNAM BETWEEN JANUARY 9, 1962 AND MAY 7, 1975? <input type="checkbox"/> YES <input type="checkbox"/> NO	
C. DID YOU SERVE IN A COMBAT THEATER OF OPERATIONS AFTER 11/11/1998?		<input type="checkbox"/>	<input type="checkbox"/>	G. WERE YOU EXPOSED TO RADIATION WHILE IN THE MILITARY? <input type="checkbox"/> YES <input type="checkbox"/> NO	
D. WERE YOU DISCHARGED OR RETIRED FROM MILITARY FOR A DISABILITY INCURRED IN THE LINE OF DUTY?		<input type="checkbox"/>	<input type="checkbox"/>	H. DID YOU RECEIVE NOSE AND THROAT RADIUM TREATMENTS WHILE IN THE MILITARY? <input type="checkbox"/> YES <input type="checkbox"/> NO	
				I. DID YOU SERVE ON ACTIVE DUTY AT LEAST 30 DAYS AT CAMP LEJEUNE FROM AUGUST 1, 1953 THROUGH DECEMBER 31, 1987? <input type="checkbox"/> YES <input type="checkbox"/> NO	
SECTION III - INSURANCE INFORMATION <i>(Use a separate sheet for additional information)</i>					
1. ENTER YOUR HEALTH INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER <i>(include coverage through spouse or other person)</i>					
2. NAME OF POLICY HOLDER	3. POLICY NUMBER	4. GROUP CODE	5. ARE YOU ELIGIBLE FOR MEDICAID? <input type="checkbox"/> YES <input type="checkbox"/> NO		6. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A? <input type="checkbox"/> YES <input type="checkbox"/> NO
					6A. EFFECTIVE DATE <i>(mm/dd/yyyy)</i>

APPLICATION FOR HEALTH BENEFITS, Continued		VETERAN'S NAME (<i>Last, First, Middle</i>)		SOCIAL SECURITY NUMBER	
SECTION IV - DEPENDENT INFORMATION (<i>Use a separate sheet for additional dependents</i>)					
1. SPOUSE'S NAME (<i>Last, First, Middle Name</i>)		2. CHILD'S NAME (<i>Last, First, Middle Name</i>)			
1A. SPOUSE'S SOCIAL SECURITY NUMBER		2A. CHILD'S DATE OF BIRTH (<i>mm/dd/yyyy</i>)		2B. CHILD'S SOCIAL SECURITY NUMBER	
1B. SPOUSE'S DATE OF BIRTH (<i>mm/dd/yyyy</i>)		2C. DATE CHILD BECAME YOUR DEPENDENT (<i>mm/dd/yyyy</i>)			
1C. DATE OF MARRIAGE (<i>mm/dd/yyyy</i>)		2D. CHILD'S RELATIONSHIP TO YOU (<i>Check one</i>) <input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER <input type="checkbox"/> STEPSON <input type="checkbox"/> STEPDAUGHTER			
1D. SPOUSE'S ADDRESS AND TELEPHONE NUMBER (<i>Street, City, State, ZIP - if different from Veteran's</i>)		2E. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18? <input type="checkbox"/> YES <input type="checkbox"/> NO			
		2F. IF CHILD IS BETWEEN 18 AND 23 YEARS OF AGE, DID CHILD ATTEND SCHOOL LAST CALENDAR YEAR? <input type="checkbox"/> YES <input type="checkbox"/> NO			
3. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR, DID YOU PROVIDE SUPPORT? <input type="checkbox"/> YES <input type="checkbox"/> NO		2G. EXPENSES PAID BY YOUR DEPENDENT CHILD FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING (<i>e.g., tuition, books, materials</i>)			
SECTION V - PREVIOUS CALENDAR YEAR GROSS ANNUAL INCOME OF VETERAN, SPOUSE AND DEPENDENT CHILDREN (<i>Use a separate sheet for additional dependents</i>)					
	VETERAN	SPOUSE	CHILD 1		
1. GROSS ANNUAL INCOME FROM EMPLOYMENT (<i>wages, bonuses, tips, etc.</i>) EXCLUDING INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	\$ _____	\$ _____	\$ _____		
2. NET INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	\$ _____	\$ _____	\$ _____		
3. LIST OTHER INCOME AMOUNTS (<i>e.g., Social Security, compensation, pension interest, dividends</i>) EXCLUDING WELFARE.	\$ _____	\$ _____	\$ _____		
SECTION VI - PREVIOUS CALENDAR YEAR DEDUCTIBLE EXPENSES					
1. TOTAL NON-REIMBURSED MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE (<i>e.g., payments for doctors, dentists, medications, Medicare, health insurance, hospital and nursing home</i>) VA will calculate a deductible and the net medical expenses you may claim.			\$ _____		
2. AMOUNT YOU PAID LAST CALENDAR YEAR FOR FUNERAL AND BURIAL EXPENSES (INCLUDING PREPAID BURIAL EXPENSES) FOR YOUR DECEASED SPOUSE OR DEPENDENT CHILD (<i>Also enter spouse or child's information in Section VI.</i>)			\$ _____		
3. AMOUNT YOU PAID LAST CALENDAR YEAR FOR YOUR COLLEGE OR VOCATIONAL EDUCATIONAL EXPENSES (<i>e.g., tuition, books, fees, materials</i>) DO NOT LIST YOUR DEPENDENTS' EDUCATIONAL EXPENSES.			\$ _____		
SECTION VII - CONSENT TO COPAYS AND TO RECEIVE COMMUNICATIONS					
By submitting this application you are agreeing to pay the applicable VA copays for treatment or services of your NSC conditions as required by law. You also agree to receive communications from VA to your supplied email or mobile number.					
ASSIGNMENT OF BENEFITS					
<p>I understand that pursuant to 38 U.S.C. Section 1729 and 42 U.S.C. 2651, the Department of Veterans Affairs (VA) is authorized to recover or collect from my health plan (HP) or any other legally responsible third party for the reasonable charges of nonservice-connected VA medical care or services furnished or provided to me. I hereby authorize payment directly to VA from any HP under which I am covered (including coverage provided under my spouse's HP) that is responsible for payment of the charges for my medical care, including benefits otherwise payable to me or my spouse. Furthermore, I hereby assign to the VA any claim I may have against any person or entity who is or may be legally responsible for the payment of the cost of medical services provided to me by the VA. I understand that this assignment shall not limit or prejudice my right to recover for my own benefit any amount in excess of the cost of medical services provided to me by the VA or any other amount to which I may be entitled. I hereby appoint the Attorney General of the United States and the Secretary of Veterans' Affairs and their designees as my Attorneys-in-fact to take all necessary and appropriate actions in order to recover and receive all or part of the amount herein assigned. I hereby authorize the VA to disclose, to my attorney and to any third party or administrative agency who may be responsible for payment of the cost of medical services provided to me, information from my medical records as necessary to verify my claim. Further, I hereby authorize any such third party or administrative agency to disclose to the VA any information regarding my claim.</p>					
ALL APPLICANTS MUST SIGN AND DATE THIS FORM. REFER TO INSTRUCTIONS WHICH DEFINE WHO CAN SIGN ON BEHALF OF THE VETERAN.					
SIGNATURE OF APPLICANT _____			DATE _____		