

Department of Veterans Affairs		<h2 style="margin: 0;">APPLICATION FOR HEALTH BENEFITS</h2>			
SECTION I - GENERAL INFORMATION					
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)					
1. VETERAN'S NAME <i>(Last, First, Middle Name)</i>		2. OTHER NAMES USED	3. MOTHER'S MAIDEN NAME	4. GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
5. ARE YOU SPANISH, HISPANIC, OR LATINO? <input type="checkbox"/> YES <input type="checkbox"/> NO	6. 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				
7. SOCIAL SECURITY NUMBER	8. VA CLAIM NUMBER		9. DATE OF BIRTH <i>(mm/dd/yyyy)</i>		
9A. PLACE OF BIRTH <i>(City and State)</i>			10. RELIGION		
11. PERMANENT ADDRESS <i>(Street)</i>		11A. CITY	11B. STATE	11C. ZIP CODE	
11D. COUNTY	11E. HOME TELEPHONE NUMBER <i>(Include area code)</i>		11F. E-MAIL ADDRESS		
11G. CELLULAR TELEPHONE NUMBER <i>(Include area code)</i>		12. TYPE OF BENEFIT(S) APPLYING FOR <i>(You may check more than one)</i> <input type="checkbox"/> ENROLLMENT/HEALTH SERVICES <input type="checkbox"/> DENTAL			
13. WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER? <i>(for listing of facilities visit www.va.gov/directory)</i>		14. DO YOU WANT AN APPOINTMENT WITH A VA DOCTOR OR PROVIDER AS SOON AS ONE BECOMES AVAILABLE? <input type="checkbox"/> YES <input type="checkbox"/> NO I am only enrolling in case I need care in the future.			
15. CURRENT MARITAL STATUS <i>(Check one)</i> <input type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> UNKNOWN					
16. NAME, ADDRESS AND RELATIONSHIP OF NEXT OF KIN			16A. NEXT OF KIN'S HOME TELEPHONE NUMBER <i>(Include area code)</i>		
			16B. NEXT OF KIN'S WORK TELEPHONE NUMBER <i>(Include area code)</i>		
17. NAME, ADDRESS AND RELATIONSHIP OF EMERGENCY CONTACT <i>(if different than 16)</i>			17A. EMERGENCY CONTACT'S HOME TELEPHONE NUMBER <i>(Include area code)</i>		
			17B. EMERGENCY CONTACT'S WORK TELEPHONE NUMBER <i>(Include area code)</i>		
SECTION II - INSURANCE INFORMATION <i>(Use a separate sheet for additional information)</i>					
1. ENTER 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	5A. EFFECTIVE DATE <i>(mm/dd/yyyy)</i>	
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>		
7. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART B? <input type="checkbox"/> YES <input type="checkbox"/> NO			7A. EFFECTIVE DATE <i>(mm/dd/yyyy)</i>		
8. NAME EXACTLY AS IT APPEARS ON YOUR MEDICARE CARD			9. MEDICARE CLAIM NUMBER		

APPLICATION FOR HEALTH BENEFITS, Continued		VETERAN'S NAME (<i>Last, First, Middle</i>)		SOCIAL SECURITY NUMBER	
SECTION III - EMPLOYMENT INFORMATION					
1. VETERAN'S EMPLOYMENT STATUS (<i>Check one</i>) If employed or retired, complete item 1A <input type="checkbox"/> FULL TIME <input type="checkbox"/> NOT EMPLOYED <input type="checkbox"/> PART TIME <input type="checkbox"/> RETIRED <div style="text-align: right;"><i>Date of retirement (mm/dd/yyyy)</i></div>			1A. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER		
2. SPOUSE'S EMPLOYMENT STATUS (<i>Check one</i>) If employed or retired, complete item 2A <input type="checkbox"/> FULL TIME <input type="checkbox"/> NOT EMPLOYED <input type="checkbox"/> PART TIME <input type="checkbox"/> RETIRED <div style="text-align: right;"><i>Date of retirement (mm/dd/yyyy)</i></div>			2A. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER		
SECTION IV - MILITARY SERVICE INFORMATION					
1. LAST BRANCH OF SERVICE		1A. LAST ENTRY DATE	1B. LAST DISCHARGE DATE	1C. DISCHARGE TYPE	1D. MILITARY SERVICE NUMBER
2. CHECK YES OR NO		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?	
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?	
C. DID YOU SERVE IN COMBAT AFTER 11/11/1998?		<input type="checkbox"/>	<input type="checkbox"/>	G. WERE YOU EXPOSED TO RADIATION WHILE IN THE MILITARY?	
D. WAS YOUR DISCHARGE FROM MILITARY FOR A DISABILITY INCURRED OR AGGRAVATED IN THE LINE OF DUTY?		<input type="checkbox"/>	<input type="checkbox"/>	H. DID YOU RECEIVE NOSE AND THROAT RADIUM TREATMENTS WHILE IN THE MILITARY?	
D1. ARE YOU RECEIVING DISABILITY RETIREMENT PAY INSTEAD OF VA COMPENSATION?		<input type="checkbox"/>	<input type="checkbox"/>	I. DO YOU HAVE A SPINAL CORD INJURY?	
<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SECTION V - FINANCIAL DISCLOSURE					
<p>Disclosure allows VA to accurately determine whether certain Veterans will be charged copays for care and medications, their eligibility for other services and enrollment priority. Veterans are not required to disclose their financial information; however, VA is not currently enrolling <u>new</u> applicants who decline to provide their financial information unless they have other qualifying eligibility factors. Recent Combat Veterans are eligible for enrollment without disclosing their financial information but like other Veterans may provide it to establish their eligibility for travel assistance, cost-free medication and/or medical care for services unrelated to military experience.</p> <p><input type="checkbox"/> No, I do not wish to provide financial information in Sections VI through IX. I understand that VA is not enrolling <u>new</u> applicants who do not provide this information and who do not have other qualifying eligibility factors [i.e., a former Prisoner of War; in receipt of a Purple Heart; a recently discharged Combat Veteran (e.g., OEF/OIF/OND who were discharged within the past 5 years); discharged for a disability incurred or aggravated in the line of duty; receiving VA service-connected disability compensation; receiving VA pension; or in receipt of Medicaid benefits.] <i>Sign and date the form in Section XII.</i></p> <p><input type="checkbox"/> Yes, I will provide my household financial information for last calendar year. Complete applicable sections VI through IX. <i>Sign and date the form in Section XII.</i></p>					
SECTION VI - DEPENDENT INFORMATION (Use a separate sheet for additional dependents)					
1. SPOUSE'S NAME (<i>Last, First, Middle Name</i>)			2. CHILD'S NAME (<i>Last, First, Middle Name</i>)		
1A. SPOUSE'S MAIDEN NAME OR OTHER NAMES USED			2A. 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		
1B. SPOUSE'S SOCIAL SECURITY NUMBER		2B. CHILD'S SOCIAL SECURITY NUMBER		2C. DATE CHILD BECAME YOUR DEPENDENT (mm/dd/yyyy)	
1C. SPOUSE'S DATE OF BIRTH (mm/dd/yyyy)		1D. DATE OF MARRIAGE (mm/dd/yyyy)		2D. CHILD'S DATE OF BIRTH (mm/dd/yyyy)	
1E. 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? <div style="text-align: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</div>		
3. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR, DID YOU PROVIDE SUPPORT? <div style="text-align: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</div>			2F. IF CHILD IS BETWEEN 18 AND 23 YEARS OF AGE, DID CHILD ATTEND SCHOOL LAST CALENDAR YEAR? <div style="text-align: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</div>		
			2G. EXPENSES PAID BY YOUR DEPENDENT CHILD FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING (e.g., tuition, books, materials) <div style="text-align: right;">\$</div>		

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SECTION VII - 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>eg., Social Security, compensation, pension interest, dividends</i>). EXCLUDING WELFARE.	\$	\$	\$
SECTION VIII - 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 IX - PREVIOUS CALENDAR YEAR NET WORTH (Use a separate sheet for additional dependents)			
	VETERAN	SPOUSE	CHILD 1
1. CASH AMOUNT IN BANK ACCOUNTS (<i>e.g., checking, savings accounts, certificates of deposit, individual retirement accounts, stocks and bonds</i>)	\$	\$	\$
2. MARKET VALUE OF LAND AND BUILDINGS MINUS MORTGAGES AND LIENS. (<i>e.g., second home and non-incoming producing property. Do not count your primary home.</i>)	\$	\$	\$
3. VALUE OF OTHER PROPERTY OR ASSETS (<i>e.g., art, rare coins, collectables</i>) MINUS THE AMOUNT YOU OWE ON THESE ITEMS. INCLUDE VALUE OF FARM, RANCH OR BUSINESS ASSETS. <i>Exclude household effects and family vehicles.</i>	\$	\$	\$
SECTION X - PAPERWORK REDUCTION ACT AND PRIVACY ACT INFORMATION			
<p>The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of Section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 45 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.</p> <p>Privacy Act Information: VA is asking you to provide the information on this form under 38 U.S.C. Sections 1705, 1710, 1712, and 1722 in order for VA to determine your eligibility for medical benefits. Information you supply may be verified through a computer-matching program. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices and in accordance with the VHA Notice of Privacy Practices. Providing the requested information is voluntary, but if any or all of the requested information is not provided, it may delay or result in denial of your request for health care benefits. Failure to furnish the information will not have any effect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify Veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.</p>			
SECTION XI - CONSENT TO COPAYS			
By signing this application you are agreeing to pay the applicable VA copays for treatment or services of your NSC conditions as required by law.			
SECTION XII - 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