



Department of Veterans Affairs

HEALTH BENEFITS RENEWAL FORM

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. GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		4. SOCIAL SECURITY NUMBER		5. DATE OF BIRTH (<i>mm/dd/yyyy</i>)
6. PERMANENT ADDRESS (<i>Street</i>)		6A. CITY	6B. STATE	6C. ZIP
6D. COUNTY		6E. HOME TELEPHONE NUMBER (<i>Include area code</i>)		
6F. E-MAIL ADDRESS		6G. CELLULAR TELEPHONE NUMBER (<i>Include area code</i>)		
7. 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				
8. NAME, ADDRESS AND RELATIONSHIP OF NEXT OF KIN			8A. NEXT OF KIN'S HOME TELEPHONE NUMBER (<i>Include area code</i>)	
			8B. NEXT OF KIN'S WORK TELEPHONE NUMBER (<i>Include area code</i>)	
9. NAME, ADDRESS AND RELATIONSHIP OF EMERGENCY CONTACT (<i>if different than 8</i>)			9A. EMERGENCY CONTACT'S HOME TELEPHONE NUMBER (<i>Include area code</i>)	
			9B. EMERGENCY CONTACT'S WORK TELEPHONE NUMBER (<i>Include area code</i>)	

SECTION II - INSURANCE INFORMATION (Use a separate sheet for additional information)

1. ARE YOU COVERED BY HEALTH INSURANCE, INCLUDING COVERAGE THROUGH A SPOUSE OR ANOTHER PERSON? <input type="checkbox"/> YES <input type="checkbox"/> NO		2. HEALTH INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER	
3. NAME OF POLICY HOLDER			
4. POLICY NUMBER	5. GROUP CODE	6. ARE YOU ELIGIBLE FOR MEDICAID? <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 A? <input type="checkbox"/> YES <input type="checkbox"/> NO		7A. EFFECTIVE DATE (<i>mm/dd/yyyy</i>)	
8. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART B? <input type="checkbox"/> YES <input type="checkbox"/> NO		8A. EFFECTIVE DATE (<i>mm/dd/yyyy</i>)	
9. NAME EXACTLY AS IT APPEARS ON YOUR MEDICARE CARD		10. MEDICARE CLAIM NUMBER	

SECTION III - EMPLOYMENT INFORMATION

1. VETERAN'S EMPLOYMENT STATUS (<i>check one</i>) <input type="checkbox"/> FULL TIME <input type="checkbox"/> NOT EMPLOYED <i>If employed or retired, complete item 1A</i> <input type="checkbox"/> PART TIME <input type="checkbox"/> RETIRED <i>Date of retirement (mm/dd/yyyy)</i>		1A. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER
2. SPOUSE'S EMPLOYMENT STATUS (<i>check one</i>) <input type="checkbox"/> FULL TIME <input type="checkbox"/> NOT EMPLOYED <i>If employed or retired, complete item 2A</i> <input type="checkbox"/> PART TIME <input type="checkbox"/> RETIRED <i>Date of retirement (mm/dd/yyyy)</i>		2A. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER

SECTION IV - FINANCIAL DISCLOSURE

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. **Recent Combat Veterans (e.g., OEF/OIF/OND)** like other Veterans may answer YES in Section IV and complete Sections V-VIII to have their priority for enrollment and financial eligibility for travel assistance, cost-free medications and/or medical care for services unrelated to military experience.

- ☐ **No, I do not wish to provide financial information in Sections V through VIII.** If I am enrolled, I agree to pay applicable VA copayments. *Sign and date the form in Section XI.*
- ☐ **Yes, I will provide my household financial information for last calendar year.** Complete applicable Sections V through VIII. *Sign and date the form in Section XI.*

Department of Veterans Affairs		VETERAN'S NAME (<i>Last, First, Middle</i>)		SOCIAL SECURITY NUMBER	
SECTION V - 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			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 (<i>mm/dd/yyyy</i>)	
1C. SPOUSE'S DATE OF BIRTH (<i>mm/dd/yyyy</i>)	1D. DATE OF MARRIAGE (<i>mm/dd/yyyy</i>)		2D. CHILD'S DATE OF BIRTH (<i>mm/dd/yyyy</i>)		
1E. SPOUSE'S ADDRESS AND TELEPHONE NUMBER (<i>Street, City, State, ZIP</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 VI - PREVIOUS CALENDAR YEAR GROSS ANNUAL INCOME OF VETERAN, SPOUSE AND DEPENDENT CHILDREN (Use a separate sheet for additional dependents)					
	VETERAN		SPOUSE		CHILD 1
1. GROSS ANNUAL INCOME FROM EMPLOYMENT (<i>eg., 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 VII - PREVIOUS CALENDAR YEAR DEDUCTIBLE EXPENSES					
1. TOTAL NON-REIMBURSED MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE LAST CALENDAR YEAR (<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 V.</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 VIII - PREVIOUS CALENDAR YEAR NET WORTH OF VETERAN, SPOUSE AND DEPENDENT CHILDREN (Use a separate sheet for additional dependents)					
	VETERAN		SPOUSE		CHILD 1
1. CASH AMOUNT IN BANK ACCOUNTS (<i>e.g., checking and 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 homes 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 IX - 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 24 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 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 X --CONSENT TO COPAYMENTS					
By signing this application you are agreeing to pay the applicable VA copays for treatment or services for your NSC conditions as required by law.					
SECTION XI - 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 ON WHO CAN SIGN ON BEHALF OF THE VETERAN.					
SIGNATURE OF APPLICANT					DATE (<i>mm/dd/yyyy</i>)