



Department of Veterans Affairs

APPLICATION FOR HEALTH BENEFITS

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 (Last, First, Middle Name)		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? (You may check more than one.) (Information is required for statistical purposes only.) <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	9. DATE OF BIRTH (mm/dd/yyyy)		10. RELIGION	
8. CLAIM NUMBER	9A. PLACE OF BIRTH (City and State)			
11. PERMANENT ADDRESS (Street)		11A. CITY	11B. STATE	11C. ZIP CODE
11D. COUNTY	11E. HOME TELEPHONE NUMBER (Include area code)		11F. E-MAIL ADDRESS	
11G. CELLULAR TELEPHONE NUMBER (Include area code)		11H. PAGER NUMBER (Include area code)		
12. TYPE OF BENEFIT(S) APPLIED FOR (You may check more than one) <input type="checkbox"/> HEALTH SERVICES <input type="checkbox"/> NURSING HOME <input type="checkbox"/> DOMICILIARY <input type="checkbox"/> DENTAL				
13. IF APPLYING FOR HEALTH SERVICES OR ENROLLMENT, WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER?				
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. HAVE YOU BEEN SEEN AT A VA HEALTH CARE FACILITY? <input type="checkbox"/> YES, LOCATION: <input type="checkbox"/> NO		
16. CURRENT MARITAL STATUS (Check one) <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				
17. NAME, ADDRESS AND RELATIONSHIP OF NEXT OF KIN		17A. NEXT OF KIN'S HOME TELEPHONE NUMBER (Include area code)		
		17B. NEXT OF KIN'S WORK TELEPHONE NUMBER (Include area code)		
18. NAME, ADDRESS AND RELATIONSHIP OF EMERGENCY CONTACT		18A. EMERGENCY CONTACT'S HOME TELEPHONE NUMBER (Include area code)		
		18B. EMERGENCY CONTACT'S WORK TELEPHONE NUMBER (Include area code)		
19. INDIVIDUAL TO RECEIVE POSSESSION OF YOUR PERSONAL PROPERTY LEFT ON PREMISES UNDER VA CONTROL AFTER YOUR DEPARTURE OR AT THE TIME OF DEATH. NOTE: THIS DOES NOT CONSTITUTE A WILL OR TRANSFER OF TITLE (Check one) <input type="checkbox"/> EMERGENCY CONTACT <input type="checkbox"/> NEXT OF KIN				

APPLICATION FOR HEALTH BENEFITS, Continued	VETERAN'S NAME (<i>Last, First, Middle</i>)	SOCIAL SECURITY NUMBER
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SECTION II - INSURANCE INFORMATION (Use a separate sheet for additional information)

1. ARE YOU COVERED BY HEALTH INSURANCE? (<i>Including coverage through a spouse or another person</i>) <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	YES	NO	
6. ARE YOU ELIGIBLE FOR MEDICAID?	<input type="checkbox"/>	<input type="checkbox"/>		
7. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A?	<input type="checkbox"/>	<input type="checkbox"/>	7A. EFFECTIVE DATE (<i>mm/dd/yyyy</i>)	
8. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART B?	<input type="checkbox"/>	<input type="checkbox"/>	8A. EFFECTIVE DATE (<i>mm/dd/yyyy</i>)	
9. NAME EXACTLY AS IT APPEARS ON YOUR MEDICARE CARD			10. MEDICARE CLAIM NUMBER	
11. IS NEED FOR CARE DUE TO ON THE JOB INJURY? (<i>Check one</i>) <input type="checkbox"/> YES <input type="checkbox"/> NO			12. IS NEED FOR CARE DUE TO ACCIDENT? (<i>Check One</i>) <input type="checkbox"/> YES <input type="checkbox"/> NO	

SECTION III - EMPLOYMENT INFORMATION

1. VETERAN'S EMPLOYMENT STATUS (<i>Check one</i>) <input type="checkbox"/> FULL TIME <input type="checkbox"/> NOT EMPLOYED If employed or retired, complete item 1A <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 If employed or retired, complete item 2A <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 - 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		YES NO
A. ARE YOU A PURPLE HEART AWARD RECIPIENT?	<input type="checkbox"/>	<input type="checkbox"/>	E1. ARE YOU RECEIVING DISABILITY RETIREMENT PAY INSTEAD OF VA COMPENSATION?	<input type="checkbox"/> <input type="checkbox"/>
B. ARE YOU A FORMER PRISONER OF WAR?	<input type="checkbox"/>	<input type="checkbox"/>	F. WERE YOU EXPOSED TO ENVIRONMENTAL CONTAMINANTS WHILE SERVING IN SW ASIA DURING THE GULF WAR?	<input type="checkbox"/> <input type="checkbox"/>
C. DO YOU HAVE A VA SERVICE-CONNECTED RATING?	<input type="checkbox"/>	<input type="checkbox"/>	G. WERE YOU EXPOSED TO AGENT ORANGE WHILE SERVING IN VIETNAM?	<input type="checkbox"/> <input type="checkbox"/>
C1. IF YES, WHAT IS YOUR RATED PERCENTAGE? %			H. WERE YOU EXPOSED TO RADIATION WHILE IN THE MILITARY?	<input type="checkbox"/> <input type="checkbox"/>
D. DID YOU SERVE IN COMBAT AFTER 11/11/1998?	<input type="checkbox"/>	<input type="checkbox"/>	I. DID YOU RECEIVE NOSE AND THROAT RADIUM TREATMENTS WHILE IN THE MILITARY?	<input type="checkbox"/> <input type="checkbox"/>
E. WAS YOUR DISCHARGE FROM MILITARY FOR A DISABILITY INCURRED OR AGGRAVATED IN THE LINE OF DUTY?	<input type="checkbox"/>	<input type="checkbox"/>	J. DO YOU HAVE A SPINAL CORD INJURY?	<input type="checkbox"/> <input type="checkbox"/>

SECTION V - PAPERWORK REDUCTION ACT AND PRIVACY ACT INFORMATION

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.

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. You do not have to provide the information to VA, but if you don't, VA may be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect 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.

