OMB Control No. 2900-0219
Respondent Burden: 10 Minutes
Expiration Date: 10/31/2024

Department of Veterans Affairs

APPLICATION FOR CHAMPVA BENEFITS

Champ VA Program Office, Office of Integrated Veteran Care, CHAMPVA Eligibility, PO Box 469028, Denver CO 80246-9028
Customer Service Center: 1-800-733-8387 | FAX: 303-331-7809

ATTENTION: Please refer to the information on the following pages for assistance completing this form in its entirety (print or type only). Return the form and any additional, requested information to the address shown above. If applicants indicate in Section II that they have Medicare or other health insurance, each applicant must submit VA Form 10-7959c, *CHAMPVA Other Health Insurance (OHI) Certification*. If additional space is needed, complete another VA Form 10-10d in its entirety, sign and submit.

SECTION I - SPONSOR INFORMATION

VETERAN'S LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NUMBER	VA FILE NUMBER *(Claim Number)*
Surname	Veteran	B	222554444	123456789

STREET ADDRESS	CITY	STATE	ZIP CODE
1 First Ln	Place	AL	12345

PHONE NUMBER *(Include Area Code)*	DATE OF BIRTH *(MM/DD/YYYY)*	DATE OF MARRIAGE *(MM/DD/YYYY)*
9876543213	1987-02-02	2005-04-06

IS THE VETERAN DECEASED?		DATE OF DEATH *(MM/DD/YYYY)*	DID THE VETERAN DIE WHILE ON ACTIVE MILITARY SERVICE?
☐ YES ☒ NO	*IF "YES," CONTINUE IF "NO," GO TO SECTION II*	2021-01-08	☐ YES ☒ NO

SECTION II - APPLICANT INFORMATION

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NUMBER	DATE OF BIRTH *(MM/DD/YYYY)*
Onceler	Applicant	C	123456644	1978-03-04

STREET ADDRESS	CITY	STATE	ZIP CODE
2 Second St	Town	LA	16542

EMAIL ADDRESS	PHONE NUMBER *(Include Area Code)*	GENDER
email@address.com	6543219877	☐ MALE ☒ FEMALE

☒ ENROLLED IN MEDICARE *If checked, complete VA Form 10-7959c and attach a copy of Medicare Card*	☒ HAS OTHER HEALTH INSURANCE *If checked, complete VA Form 10-7959c and attach a copy of insurance card*	RELATIONSHIP TO VETERAN *(i.e., spouse, child)*
		Relative - Other

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NUMBER	DATE OF BIRTH *(MM/DD/YYYY)*
Twos	Appy	D	123664444	1985-03-10

STREET ADDRESS	CITY	STATE	ZIP CODE
3 Third Ave	Ville	AR	65478

EMAIL ADDRESS	PHONE NUMBER *(Include Area Code)*	GENDER
mailme@domain.com	2345698777	☐ MALE ☒ FEMALE

☒ ENROLLED IN MEDICARE *If checked, complete VA Form 10-7959c and attach a copy of Medicare Card*	☒ HAS OTHER HEALTH INSURANCE *If checked, complete VA Form 10-7959c and attach a copy of insurance card*	RELATIONSHIP TO VETERAN *(i.e., spouse, child)*
		Relative - Other

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NUMBER	DATE OF BIRTH *(MM/DD/YYYY)*
Simpson	Homer	D	123664444	1985-03-10

STREET ADDRESS	CITY	STATE	ZIP CODE
4 Third Ave	Mark	AR	65478

EMAIL ADDRESS	PHONE NUMBER *(Include Area Code)*	GENDER
mailme@homer.com	2345698777	☐ MALE ☒ FEMALE

☒ ENROLLED IN MEDICARE *If checked, complete VA Form 10-7959c and attach a copy of Medicare Card*	☒ HAS OTHER HEALTH INSURANCE *If checked, complete VA Form 10-7959c and attach a copy of insurance card*	RELATIONSHIP TO VETERAN *(i.e., spouse, child)*
		Relative - Other

SECTION III - CERTIFICATION

I declare under penalty of perjury that the foregoing is true and accurate to the best of my knowledge. I understand that any materially false, fictitious, or fraudulent statement or representation, made knowingly, is punishable by a fine and/or imprisonment pursuant to title 18, United States Code, Sections 287 and 1001. *(Sign and date below.)*

SIGNATURE:	DATE *(MM/DD/YYYY)*
GI Joe	2021-01-08

If certification is signed by a person other than an applicant, complete the following:

LAST NAME	FIRST NAME	MI	RELATIONSHIP TO APPLICANT(S)
Joe	GI	Canc	Agent

STREET ADDRESS	CITY	STATE	ZIP CODE	PHONE NUMBER *(Include Area Code)*
Hasbro	Burbank	CA	90041	2345698777