



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)

1A. VETERAN'S NAME (Last, First, Middle Name)			1B. PREFERRED NAME		2. MOTHER'S MAIDEN NAME	
3A. BIRTH SEX  <input type="checkbox"/> MALE  <input type="checkbox"/> FEMALE	3B. SELF-IDENTIFIED GENDER IDENTITY  <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? (You may check more than one. Information is required for statistical purposes only.)  <input type="checkbox"/> ASIAN <input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> WHITE <input type="checkbox"/> NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER			6. SOCIAL SECURITY NO.
7. VA CLAIM NUMBER		8A. DATE OF BIRTH (mm/dd/yyyy)	8B. PLACE OF BIRTH (City and State)			9. RELIGION
10A. PERMANENT ADDRESS (Street)		10B. CITY		10C. STATE	10D. ZIP CODE	10E. COUNTY
10F. HOME TELEPHONE NO. (Include area code)		10G. MOBILE TELEPHONE NO. (Include area code)		10H. E-MAIL ADDRESS		
11A. RESIDENTIAL ADDRESS (Street)		11B. CITY		11C. STATE	11D. ZIP CODE	11E. COUNTY
12. TYPE OF BENEFIT(S) APPLYING FOR (You may check more than one)  <input type="checkbox"/> ENROLLMENT/HEALTH SERVICES <input type="checkbox"/> DENTAL		13. CURRENT MARTIAL STATUS  <input type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED				
14A. NEXT OF KIN NAME		14B. NEXT OF KIN ADDRESS			14C. NEXT OF KIN RELATIONSHIP	
14D. NEXT OF KIN TELEPHONE NO. (Include Area Code)		14E. NEXT OF KIN WORK TELEPHONE NO. (Include Area Code)		15. DESIGNEE - 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)		
16. I AM ENROLLING TO OBTAIN MINIMUM ESSENTIAL COVERAGE UNDER THE AFFORDABLE CARE ACT  <input type="checkbox"/> YES <input type="checkbox"/> NO		17. WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER? (for listing of facilities visit <a href="http://www.va.gov/directory">www.va.gov/directory</a> )			18. 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

1A. LAST BRANCH OF SERVICE		1B. LAST ENTRY DATE		1C. FUTURE DISCHARGE DATE		1D. LAST DISCHARGE DATE	
1E. DISCHARGE TYPE						1F. MILITARY SERVICE NUMBER	
2. MILITARY HISTORY (Check yes or no)				YES	NO	YES	NO
A. ARE YOU A PURPLE HEART AWARD RECIPIENT?				<input type="checkbox"/>	<input type="checkbox"/>	G. DO YOU HAVE A VA SERVICE-CONNECTED RATING?	
B. ARE YOU A FORMER PRISONER OF WAR?				<input type="checkbox"/>	<input type="checkbox"/>	IF "YES", WHAT IS YOUR RATED PERCENTAGE _____ %	
C. DID YOU SERVE IN A COMBAT THEATER OF OPERATIONS AFTER 11/11/1998?				<input type="checkbox"/>	<input type="checkbox"/>	H. DID YOU SERVE IN VIETNAM BETWEEN JANUARY 9, 1962 AND MAY 7, 1975?	
D. WERE YOU DISCHARGED OR RETIRED FROM MILITARY FOR A DISABILITY INCURRED IN THE LINE OF DUTY?				<input type="checkbox"/>	<input type="checkbox"/>	I. WERE YOU EXPOSED TO RADIATION WHILE IN THE MILITARY?	
E. ARE YOU RECEIVING DISABILITY RETIREMENT PAY INSTEAD OF VA COMPENSATION?				<input type="checkbox"/>	<input type="checkbox"/>	J. DID YOU RECEIVE NOSE AND THROAT RADIUM TREATMENTS WHILE IN THE MILITARY?	
F. DID YOU SERVE IN SW ASIA DURING THE GULF WAR BETWEEN AUGUST 2, 1990 AND NOVEMBER 11, 1998?				<input type="checkbox"/>	<input type="checkbox"/>	K. DID YOU SERVE ON ACTIVE DUTY AT LEAST 30 DAYS AT CAMP LEJEUNE FROM AUGUST 1, 1953 THROUGH DECEMBER 31, 1987?	

<b>APPLICATION FOR HEALTH BENEFITS</b> <i>Continued</i>		VETERAN'S NAME <i>(Last, First, Middle)</i>		SOCIAL SECURITY NUMBER	
<b>SECTION III - INSURANCE INFORMATION</b> <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	6A. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A?  <input type="checkbox"/> YES <input type="checkbox"/> NO  6B. EFFECTIVE DATE <i>(mm/dd/yyyy)</i>	
<b>SECTION IV - DEPENDENT INFORMATION</b> <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 NO.	
1B. SPOUSE'S DATE OF BIRTH <i>(mm/dd/yyyy)</i>	1C. SPOUSE SELF-IDENTIFIED GENDER IDENTITY <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		2C. DATE CHILD BECAME YOUR DEPENDENT <i>(mm/dd/yyyy)</i>		
1D. 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		
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?  <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>		
<b>SECTION V - EMPLOYMENT INFORMATION</b>					
1A. VETERAN'S EMPLOYMENT STATUS <i>(Check one)</i> .  <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> NOT EMPLOYED <input type="checkbox"/> RETIRED				1B. DATE OF RETIREMENT	
1C. COMPANY NAME. <i>(Complete if employed or retired)</i>		1D. COMPANY ADDRESS <i>(Complete if employed or retired -Street, City, State, ZIP )</i>		1E. COMPANY PHONE NUMBER <i>(Complete if employed or retired) (Include area code)</i>	
<b>SECTION VI - PREVIOUS CALENDAR YEAR GROSS ANNUAL INCOME OF VETERAN, SPOUSE AND DEPENDENT CHILDREN</b> <i>(Use a separate sheet for additional dependents)</i>					
1. GROSS ANNUAL INCOME FROM EMPLOYMENT <i>(wages, bonuses, tips, etc.)</i> EXCLUDING INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	VETERAN	SPOUSE	CHILD 1		
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.	\$ _____	\$ _____	\$ _____		
<b>SECTION VII - PREVIOUS CALENDAR YEAR DEDUCTIBLE EXPENSES</b>					
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.	\$ _____				