OMB Approved No. 2900-0091
Estimated Burden Avg. 20 min

Department of Veterans Affairs

APPLICATION FOR HEALTH BENEFITS

SECTION I - GENERAL INFORMATION

1A. TYPE OF BENEFIT(S) APPLIED FOR *(You may check more than one)*

☐ HEALTH SERVICES ☐ NURSING HOME ☐ DOMICILIARY ☐ DENTAL ☐ ENROLLMENT

1B. IF APPLYING FOR HEALTH SERVICES, WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER

2. VETERAN'S NAME *(Last, First, MI)*	3. OTHER NAMES USED	4. GENDER *(Check one)* ☐ M ☐ F

5. SOCIAL SECURITY NUMBER	6. CLAIM NUMBER	7. DATE OF BIRTH *(mm/dd/yyyy)*	8. RELIGION

9A. CURRENT MAILING ADDRESS *(Street)*	9B. CITY	9C. STATE	9D. ZIP

9E. COUNTY	10. HOME TELEPHONE NUMBER	11. WORK TELEPHONE NUMBER
	( )	( )

12. CURRENT MARITAL STATUS *(Check one)* ☐ MARRIED ☐ NEVER MARRIED ☐ SEPARATED ☐ WIDOWED ☐ DIVORCED ☐ UNKNOWN

13A. LAST BRANCH OF SERVICE	13B. LAST ENTRY DATE	13C. LAST DISCHARGE DATE	13D. DISCHARGE TYPE	13E. MILITARY SERVICE NUMBER

14. CIRCLE YES OR NO

A. ARE YOU A FORMER PRISONER OF WAR	YES	NO	H. DO YOU HAVE A MILITARY DENTAL INJURY	YES	NO
B. DO YOU HAVE A VA SERVICE-CONNECTED RATING	YES	NO	I. DO YOU HAVE A SPINAL CORD INJURY	YES	NO
B1. IF YES, WHAT IS YOUR RATED PERCENTAGE	%		J. ARE YOU ELIGIBLE FOR MEDICAID	YES	NO
C. ARE YOU RECEIVING A VA PENSION	YES	NO	K. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A	YES	NO
D. ARE YOU RETIRED FROM THE MILITARY	YES	NO	K1. EFFECTIVE DATE		
D1. WAS YOUR RETIREMENT THE RESULT OF A DISABILITY	YES	NO	L. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART B	YES	NO
D2. WERE YOU REGULARLY RETIRED - (20 - yrs.)	YES	NO	L1. EFFECTIVE DATE		
E. WERE YOU EXPOSED TO TOXINS IN THE GULF WAR	YES	NO	M. MEDICARE CLAIM NUMBER		
F. WERE YOU EXPOSED TO AGENT ORANGE	YES	NO	N. NAME EXACTLY AS IT APPEARS ON YOUR MEDICARE CARD		
G. WERE YOU EXPOSED TO RADIATION	YES	NO			

15A. VETERAN'S EMPLOYMENT STATUS *(check one)*	15B. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER
☐ NOT EMPLOYED ☐ EMPLOYED ☐ RETIRED *If employed or retired, complete item 15B* / / *Date of retirement*	

16A. SPOUSE'S EMPLOYMENT STATUS *(check one)*	16B. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER
☐ NOT EMPLOYED ☐ EMPLOYED ☐ RETIRED *If employed or retired, complete item 16B* / / *Date of retirement*	

17A. VETERAN'S HEALTH INSURANCE COMPANY	18A. SPOUSE'S HEALTH INSURANCE COMPANY

17B. NAME OF POLICY HOLDER	18B. NAME OF POLICY HOLDER

17C. POLICY NUMBER	17D. GROUP CODE	18C. POLICY NUMBER	18D. GROUP CODE

19A. NAME, ADDRESS AND RELATIONSHIP OF NEXT OF KIN	19B. NEXT OF KIN'S HOME TELEPHONE NUMBER ( )
	19C. NEXT OF KIN'S WORK TELEPHONE NUMBER ( )

20A. NAME, ADDRESS AND RELATIONSHIP OF EMERGENCY CONTACT	20B. EMERGENCY CONTACT'S HOME TELEPHONE NUMBER ( )
	20C. EMERGENCY CONTACT'S WORK TELEPHONE NUMBER ( )

21. I DESIGNATE THE FOLLOWING INDIVIDUAL TO RECEIVE POSSESSION OF ALL MY PERSONAL PROPERTY LEFT ON PREMISES UNDER VA CONTROL AFTER MY DEPARTURE OR AT THE TIME OF MY DEATH. *(Check one)* ***(This does not constitute a will or transfer of title.)***

☐ EMERGENCY CONTACT ☐ NEXT OF KIN

22A. IS NEED FOR CARE DUE TO ON THE JOB INJURY *(Check one)*	22B. IS NEED FOR CARE DUE TO ACCIDENT *(Check one)*
☐ YES ☐ NO	☐ YES ☐ NO