

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)
 NOT EMPLOYED
 EMPLOYED / /
If employed or retired, complete item 15B
 RETIRED Date of retirement

15B. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER _____

16A. SPOUSE'S EMPLOYMENT STATUS (check one)
 NOT EMPLOYED
 EMPLOYED / /
If employed or retired, complete item 16B
 RETIRED Date of retirement

16B. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER _____

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

17B. NAME OF POLICY HOLDER _____ 17B. NAME OF POLICY HOLDER _____

17C. POLICY NUMBER _____ 17D. GROUP CODE _____ 17C. POLICY NUMBER _____ 17D. 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)
 YES NO

22B. IS NEED FOR CARE DUE TO ACCIDENT (Check one)
 YES NO