Department of Veterans Affairs

INSTRUCTIONS FOR COMPLETING APPLICATION FOR HEALTH BENEFITS

Please Read Before You Start . . . What is VA Form 10-10EZ used for?

For Veterans to apply for enrollment in the VA health care system, or dental benefits. The information provided on this form will be used by VA to determine your eligibility for medical benefits and on average will take 45 minutes to complete. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

Where can I get help filling out the form and if I have questions?

You may use ANY of the following to request assistance:

- Ask VA to help you fill out the form by calling us at 1-877-222-VETS (8387).
- Access VA's website at http://www.va.gov and select "Contact the VA."
- Contact the Enrollment Coordinator at your local VA health care facility.
- Contact a National or State Veterans Service Organization.

Definitions of terms used on this form

SERVICE-CONNECTED (SC): A VA determination that an illness or injury was incurred or aggravated in the line of duty, in the active military, naval or air service.

NONCOMPENSABLE: A VA determination that a service-connected disability is not severe enough to warrant monetary compensation.

COMPENSABLE: A VA determination that a service-connected disability is severe enough to warrant monetary compensation.

NONSERVICE-CONNECTED (NSC): A Veteran who does not have a VA determined service-related condition.

Getting Started:

ALL VETERANS MUST COMPLETE SECTIONS I - IV.

Directions for Sections I - IV:

Section I - General Information: Answer all questions. **Note:** *Veterans determined by a VA clinician to be Catastrophically Disabled are enrolled in Priority Group 4, unless eligible for a higher Priority Group, and are exempt from inpatient, outpatient and prescription copays. However, these Veterans may still be subject to copayments for extended care (long-term) services*.

Section II - Insurance Information: Include information for all health insurance companies that cover you, this includes coverage provided through a spouse or significant other. Bring your insurance cards, Medicare and/or Medicaid card with you to each health care appointment.

Section III - Employment Information: If you are employed or retired, answer all questions.

Section IV - Military Service Information: If you are not currently receiving benefits from VA, you may attach a copy of your discharge or separation papers from the military (such as DD-214 or, for WWII Veterans, a "WD" Form), with your signed application to expedite processing of your application. If you are currently receiving benefits from VA, we will cross-reference your information with VA data.

Directions for Sections V - IX:

Section V - Financial Disclosure: ONLY NSC and 0% NONCOMPENSABLE SERVICE-CONNECTED VETERANS WHO ARE NOT**:**

- a former Prisoner of War or;
- in receipt of a Purple Heart or;
- a recently discharged Combat Veteran or;
- discharged for a disability incurred or aggravated in the line of duty or;
- receiving VA service-connected disability compensation or;
- receiving VA pension or;
- in receipt of Medicaid benefits or;
- determined by VA to be Catastrophically Disabled

MUST COMPLETE THIS SECTION TO DETERMINE ELIGIBILITY AND COPAY RESPONSIBILITY FOR VA health care enrollment and/or care or services. *Failure to provide financial information, if required to do so, may result in denial of VA health care enrollment.*

Continued ...

Section VI - Dependent Information: Your spouse and dependent social security number(s) are required so we can verify their financial and insurance information through a computer-matching program.

Section VII - Previous Calendar Year Gross Annual Income of Veteran, Spouse and Dependent Children: Answer applicable questions

Section VIII - Previous Calendar Year Deductible Expenses: Answer applicable questions

Section IX - Previous Calendar Year Net Worth: Answer applicable questions

NOTE: All other Veterans may wish to provide this financial assessment to determine, **as applicable**, their eligibility for cost-free medication for their NSC conditions, beneficiary travel eligibility and/or waiver of the beneficiary travel deductible requirement.

Additional Information for Completing your application ...

Answer all questions in the appropriate sections. If you need more space to answer a question, attach a sheet of paper to the form containing your name and Social Security Number. If you need more room to respond to a question, write "Continuation of Item" and write the section and question number.

Section II - Insurance Information.

Include information for all health insurance policies that cover you, this includes coverage that is provided through a spouse or significant other. If you have more than one health insurer, provide this information on a separate sheet of paper and attach to the application. If you have access to a copier, attach a copy of your insurance cards, Medicare card and/or Medicaid card (Medicaid is a federal/state health insurance program for certain low-income people). Bring these cards with you to each health care appointment.

Section IV - Military Service Information.

If you are not currently receiving benefits from VA, you may attach a copy of your discharge or separation papers from the military (such as DD-214 or, for WWII veterans, a "WD" Form), with your signed application to expedite processing of your application.

If you indicate that you received a Purple Heart Medal, we will check our records for confirmation of your status. If we are unable to confirm your Purple Heart status, we will ask you to provide VA a copy of your DD-214 or other military service records or orders indicating your award. To reduce processing time, you may submit a copy of this documentation with your application.

Section V - Financial Disclosure.

You are not required to disclose your financial information; however, VA is not currently enrolling new applicants who decline to provide their financial information unless they have other qualifying eligibility factors. If a financial assessment is not used to determine your priority for enrollment you may choose not to disclose your information and agree to make co-payments for treatment of your NSC conditions. If a financial assessment is used to determine your eligibility for cost-free medication, travel assistance or waiver of deductible, and you do not disclose your financial information, you may not be eligible for these benefits.

Section VI - Dependent Information - Include the following:

- Your spouse even if you did not live together, as long as you contributed support last calendar year.
- Your biological children, adopted children, and stepchildren who are unmarried and under the age of 18, or at least 18 but under 23 and attending high school, college or vocational school (full or part-time), or became permanently unable to support themselves before age 18.
- Child support contributions. Contributions can include tuition or clothing payments or payments of medical bills.

Section VII - Previous Calendar Year Gross Annual Income of Veteran, Spouse and Dependent Children.

Report:

- Gross annual income from employment, except for income from your farm, ranch, property or business. Include your wages, bonuses, tips, severance pay and other accrued benefits and your child's income information if it could have been used to pay your household expenses.
- Net income from your farm, ranch, property, or business.
- Other income amounts, including retirement and pension income, Social Security Retirement and Social Security Disability income, compensation benefits such as VA disability, unemployment, Workers and black lung, cash gifts, interest and dividends, including tax exempt earnings and distributions from Individual Retirement Accounts (IRAs) or annuities.

Continued ...

Do Not Report:

Donations from public or private relief, welfare or charitable organizations; Supplemental Security Income (SSI)and need-based payments from a government agency; profit from the occasional sale of property; income tax refunds, reinvested interest on Individual Retirement Accounts (IRAs); scholarships and grants for school attendance; disaster relief payment; reimbursement for casualty loss; loans; Radiation Compensation Exposure Act payments; Agent Orange settlement payments; Alaska Native Claims Settlement Acts Income, payments to foster parent; amounts in joint accounts in banks and similar institutions acquired by reason of death of the other joint owner; Japanese ancestry restitution under Public Law 100-383; cash surrender value of life insurance; lump-sum proceeds of life insurance policy on a Veteran; and payments received under the Medicare transitional assistance program.

Section VIII - Previous Calendar Year Deductible Expenses.

Report non-reimbursed medical expenses paid by you or your spouse. Include expenses for medical and dental care, drugs, eyeglasses, Medicare, medical insurance premiums and other health care expenses paid by you for dependents and persons for whom you have a legal or moral obligation to support. Do not list expenses if you expect to receive reimbursement from insurance or other sources. Report expenses of last illness and burial expenses, e.g., prepaid burial, paid by the veteran for spouse or dependent(s).

Section IX - Previous Calendar Net Worth.

Your net worth is the market value of all the interest and rights you have in any kind of property. However net worth does not include your single-family residence and a reasonable lot area surrounding it. It also does not include the personal things you use every day like your vehicle, clothing and furniture.

Submitting your application.

1. Read Section X, Paperwork Reduction and Privacy Act Information , Section XI Consent to Copays and Section XII, Assignment of Benefits.
2. In Section XII, you or an individual to whom you have delegated your Power of Attorney must sign and date the form. If you sign with an "X", 2 people you know must witness you as you sign. They must sign the form and print their names. If the form is not signed and dated appropriately, VA will return it for you to complete.
3. Attach any continuation sheets, a copy of supporting materials and your Power of Attorney documents to your application.

Where do I send my application?

Mail the original application and supporting materials to your local VA health care facility. You can find the address by calling VA at 1-877-222-VETS (8387), or on the Internet at http://www.va.gov.

OMB Approved No. 2900-0091
Estimated Burden Avg. 45 min.

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 ☐ MALE ☐ FEMALE

5. ARE YOU SPANISH, HISPANIC, OR LATINO? ☐ YES ☐ NO	6. WHAT IS YOUR RACE? *(You may check more than one.) (Information is required for statistical purposes only.)* ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ BLACK OR AFRICAN AMERICAN ☐ ASIAN ☐ WHITE ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER

7. SOCIAL SECURITY NUMBER	8. VA CLAIM NUMBER	9. DATE OF BIRTH *(mm/dd/yyyy)*

9A. PLACE OF BIRTH *(City and State)*	10. RELIGION

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)*	12. TYPE OF BENEFIT(S) APPLYING FOR *(You may check more than one)* ☐ ENROLLMENT/HEALTH SERVICES ☐ DENTAL

13. WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER? *(for listing of facilities visit www.va.gov/directory)*	14. DO YOU WANT AN APPOINTMENT WITH A VA DOCTOR OR PROVIDER AS SOON AS ONE BECOMES AVAILABLE? ☐ YES ☐ NO I am only enrolling in case I need care in the future.

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

16. NAME, ADDRESS AND RELATIONSHIP OF NEXT OF KIN	16A. NEXT OF KIN'S HOME TELEPHONE NUMBER *(Include area code)*
	16B. NEXT OF KIN'S WORK TELEPHONE NUMBER *(Include area code)*

17. NAME, ADDRESS AND RELATIONSHIP OF EMERGENCY CONTACT *(if different than 16)*	17A. EMERGENCY CONTACT'S HOME TELEPHONE NUMBER *(Include area code)*
	17B. EMERGENCY CONTACT'S WORK TELEPHONE NUMBER *(Include area code)*

SECTION II - INSURANCE INFORMATION *(Use a separate sheet for additional information)*

1. ENTER HEALTH INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER *(include coverage through spouse or other person)*

2. NAME OF POLICY HOLDER	3. POLICY NUMBER	4. GROUP CODE	5. ARE YOU ELIGIBLE FOR MEDICAID? ☐ YES ☐ NO	5A. EFFECTIVE DATE *(mm/dd/yyyy)*

6 ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A? ☐ YES ☐ NO	6A. EFFECTIVE DATE *(mm/dd/yyyy)*
7. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART B? ☐ YES ☐ NO	7A. EFFECTIVE DATE *(mm/dd/yyyy)*
8. NAME EXACTLY AS IT APPEARS ON YOUR MEDICARE CARD	9. MEDICARE CLAIM NUMBER

APPLICATION FOR HEALTH BENEFITS, Continued	VETERAN'S NAME *(Last, First, Middle)*	SOCIAL SECURITY NUMBER

SECTION III - EMPLOYMENT INFORMATION

1. VETERAN'S EMPLOYMENT STATUS (*Check one*) ***If employed or retired, complete item 1A*** ☐ FULL TIME ☐ NOT EMPLOYED ☐ PART TIME ☐ RETIRED *Date of retirement (mm/dd/yyyy)*	1A. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER
2. SPOUSE'S EMPLOYMENT STATUS *(Check one)* ***If employed or retired, complete item 2A*** ☐ FULL TIME ☐ NOT EMPLOYED ☐ PART TIME ☐ RETIRED *Date of retirement (mm/dd/yyyy)*	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?	☐	☐	E. DID YOU SERVE IN SW ASIA DURING THE GULF WAR BETWEEN AUGUST 2, 1990 AND NOVEMBER 11, 1998?	☐	☐
B. ARE YOU A FORMER PRISONER OF WAR?	☐	☐	F. DID YOU SERVE IN VIETNAM BETWEEN JANUARY 9, 1962 AND MAY 7, 1975?	☐	☐
C. DID YOU SERVE IN COMBAT AFTER 11/11/1998?	☐	☐	G. WERE YOU EXPOSED TO RADIATION WHILE IN THE MILITARY?	☐	☐
D. WAS YOUR DISCHARGE FROM MILITARY FOR A DISABILITY INCURRED OR AGGRAVATED IN THE LINE OF DUTY?	☐	☐	H. DID YOU RECEIVE NOSE AND THROAT RADIUM TREATMENTS WHILE IN THE MILITARY?	☐	☐
D1. ARE YOU RECEIVING DISABILITY RETIREMENT PAY INSTEAD OF VA COMPENSATION?	☐	☐	I. DO YOU HAVE A SPINAL CORD INJURY?	☐	☐

SECTION V - FINANCIAL DISCLOSURE

Disclosure allows VA to accurately determine whether certain Veterans will be charged copays for care and medications, their eligibility for other services and enrollment priority. Veterans are not required to disclose their financial information; however, VA is not currently enrolling new applicants who decline to provide their financial information unless they have other qualifying eligibility factors. **Recent Combat Veterans are eligible for enrollment without disclosing their financial information** but like other Veterans may provide it to establish their eligibility for travel assistance, cost-free medication and/or medical care for services unrelated to military experience.

☐ **No, I do not wish to provide financial information in Sections VI through IX.** I understand that VA is not enrolling new applicants who do not provide this information and who do not have other qualifying eligibility factors [i.e., a former Prisoner of War; in receipt of a Purple Heart; a recently discharged Combat Veteran **(e.g., OEF/OIF/OND who were discharged within the past 5 years)**; discharged for a disability incurred or aggravated in the line of duty; receiving VA service-connected disability compensation; receiving VA pension; or in receipt of Medicaid benefits.] *Sign and date the form in Section XII.*

☐ **Yes, I will provide my household financial information for last calendar year.** Complete applicable sections VI through IX. *Sign and date the form in Section XII.*

SECTION VI - DEPENDENT INFORMATION *(Use a separate sheet for additional dependents)*

1. SPOUSE'S NAME *(Last, First, Middle Name)*		2. CHILD'S NAME *(Last, First, Middle Name)*	
1A. SPOUSE'S MAIDEN NAME OR OTHER NAMES USED		2A. CHILD'S RELATIONSHIP TO YOU *(Check one)* ☐ *Son* ☐ *Daughter* ☐ *Stepson* ☐ *Stepdaughter*	
1B. SPOUSE'S SOCIAL SECURITY NUMBER		2B. CHILD'S SOCIAL SECURITY NUMBER	2C. DATE CHILD BECAME YOUR DEPENDENT *(mm/dd/yyyy)*
1C. SPOUSE'S DATE OF BIRTH *(mm/dd/yyyy)*	1D. DATE OF MARRIAGE *(mm/dd/yyyy)*	2D. CHILD'S DATE OF BIRTH *(mm/dd/yyyy)*	
1E. SPOUSE'S ADDRESS AND TELEPHONE NUMBER *(Street, City, State, ZIP - if different from Veteran's)*		2E. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18? ☐ YES ☐ NO 2F. IF CHILD IS BETWEEN 18 AND 23 YEARS OF AGE, DID CHILD ATTEND SCHOOL LAST CALENDAR YEAR? ☐ YES ☐ NO	
3. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR, DID YOU PROVIDE SUPPORT? ☐ YES ☐ NO		2G. EXPENSES PAID BY YOUR DEPENDENT CHILD FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING *(e.g., tuition, books, materials)* $	

APPLICATION FOR HEALTH BENEFITS, Continued	VETERAN'S NAME *(Last, First, Middle)*	SOCIAL SECURITY NUMBER

SECTION VII - PREVIOUS CALENDAR YEAR GROSS ANNUAL INCOME OF VETERAN, SPOUSE AND DEPENDENT CHILDREN
(Use a separate sheet for additional dependents)

	VETERAN	SPOUSE	CHILD 1
1. GROSS ANNUAL INCOME FROM EMPLOYMENT *(wages, bonuses, tips, etc.)* EXCLUDING INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	$	$	$
2. NET INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	$	$	$
3. LIST OTHER INCOME AMOUNTS *(eg., Social Security, compensation, pension interest, dividends).* EXCLUDING WELFARE.	$	$	$

SECTION VIII - PREVIOUS CALENDAR YEAR DEDUCTIBLE EXPENSES

1. TOTAL NON-REIMBURSED MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE *(e.g., payments for doctors, dentists, medications, Medicare, health insurance, hospital and nursing home) 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 *(Also enter spouse or child's information in Section VI.)*	$
3. AMOUNT YOU PAID LAST CALENDAR YEAR FOR YOUR COLLEGE OR VOCATIONAL EDUCATIONAL EXPENSES *(e.g., tuition, books, fees, materials) DO NOT LIST YOUR DEPENDENTS' EDUCATIONAL EXPENSES.*	$

SECTION IX - PREVIOUS CALENDAR YEAR NET WORTH *(Use a separate sheet for additional dependents)*

	VETERAN	SPOUSE	CHILD 1
1. CASH AMOUNT IN BANK ACCOUNTS *(e.g., checking, savings accounts, certificates of deposit, individual retirement accounts, stocks and bonds)*	$	$	$
2. MARKET VALUE OF LAND AND BUILDINGS MINUS MORTGAGES AND LIENS. *(e.g., second home and non-incoming producing property. Do not count your primary home.)*	$	$	$
3. VALUE OF OTHER PROPERTY OR ASSETS *(e.g., art, rare coins, collectables)* MINUS THE AMOUNT YOU OWE ON THESE ITEMS. INCLUDE VALUE OF FARM, RANCH OR BUSINESS ASSETS. *Exclude household effects and family vehicles.*	$	$	$

SECTION X - 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 beverified 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. Providing the requested information is voluntary, but if any or all of the requested information is not provided, it may delay or result in denial of your request for health care benefits. Failure to furnish the information will not have any effect 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.

SECTION XI - CONSENT TO COPAYS

By signing this application you are agreeing to pay the applicable VA copays for treatment or services of your NSC conditions as required by law.

SECTION XII - ASSIGNMENT OF BENEFITS

I understand that pursuant to 38 U.S.C. Section 1729 and 42 U.S.C. 2651, the Department of Veterans Affairs (VA) is authorized to recover or collect from my health plan (HP) or any other legally responsible third party for the reasonable charges of nonservice-connected VA medical care or services furnished or provided to me. I hereby authorize payment directly to VA from any HP under which I am covered (including coverage provided under my spouse's HP) that is responsible for payment of the charges for my medical care, including benefits otherwise payable to me or my spouse. Furthermore, I hereby assign to the VA any claim I may have against any person or entity who is or may be legally responsible for the payment of the cost of medical services provided to me by the VA. I understand that this assignment shall not limit or prejudice my right to recover for my own benefit any amount in excess of the cost of medical services provided to me by the VA or any other amount to which I may be entitled. I hereby appoint the Attorney General of the United States and the Secretary of Veterans' Affairs and their designees as my Attorneys-in-fact to take all necessary and appropriate actions in order to recover and receive all or part of the amount herein assigned. I hereby authorize the VA to disclose, to my attorney and to any third party or administrative agency who may be responsible for payment of the cost of medical services provided to me, information from my medical records as necessary to verify my claim. Further, I hereby authorize any such third party or administrative agency to disclose to the VA any information regarding my claim.

ALL APPLICANTS MUST SIGN AND DATE THIS FORM. REFER TO INSTRUCTIONS WHICH DEFINE WHO CAN SIGN ON BEHALF OF THE VETERAN.

SIGNATURE OF APPLICANT	DATE