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
	N/A		☐ MALE ☐ FEMALE

5. ARE YOU SPANISH, HISPANIC, OR LATINO?	6. WHAT IS YOUR RACE? *(You may check more than one.) (Information is required for statistical purposes only.)*
☐ YES ☐ NO	☐ 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 *(9 digits)*
		CO	

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?
Durango, CO CBOC	☑ 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?	5A. EFFECTIVE DATE *(mm/dd/yyyy)*
			☐ YES ☐ NO	

6 ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A?	6A. EFFECTIVE DATE *(mm/dd/yyyy)*
☐ YES ☐ NO	

7. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART B?	7A. EFFECTIVE DATE *(mm/dd/yyyy)*
☐ YES ☐ NO	

8. NAME EXACTLY AS IT APPEARS ON YOUR MEDICARE CARD	9. MEDICARE CLAIM NUMBER
	-A

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*) ☐ FULL TIME ☐ NOT EMPLOYED ☐ PART TIME ☐ RETIRED ***If employed or retired, complete item 1A*** *Date of retirement (mm/dd/yyyy)*	1A. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER
2. SPOUSE'S EMPLOYMENT STATUS *(Check one)* ☐ FULL TIME ☐ NOT EMPLOYED ☐ PART TIME ☐ RETIRED ***If employed or retired, complete item 2A*** *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. DO YOU NEED CARE OF CONDITIONS POTENTIALLY RELATED TO SERVICE IN SW ASIA DURING THE GULF WAR?	☐	☐
B. ARE YOU A FORMER PRISONER OF WAR?	☐	☐	F. WERE YOU EXPOSED TO AGENT ORANGE WHILE SERVING IN VIETNAM?	☐	☐
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 who were discharged within the past 5 years or were discharged more than 5 years ago and applying for enrollment by Jan. 27, 2011)**; 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)* same as veteran		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 ENTER THE AMOUNT YOU CONTRIBUTED TO THEIR SUPPORT. SPOUSE $ CHILD $		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 be verified 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, VA is authorized to recover or collect from my health plan (HP) 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.

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

PLEASE RETURN APPLICATION TO THE
NM VA Health Care System
Benefits Section (04E)
1501 San Pedro SE
Albuquerque, NM 87108

PLEASE COMPLETE THE FOLLOWING:

1. **FILL OUT** the 10-10EZ application **COMPLETELY**.
2. Complete the questions on this sheet and return it with your 10-10EZ application.
3. Send a copy of your discharge papers from the service, preferably your DD 214, with your application. Whatever form you turn in must show dates of ACTIVE DUTY and discharge status (type of discharge i.e. Honorable etc.)
4. If you have insurance and/or Medicare please include this information and a copy of your insurance and/or Medicare card(s).

The financial information on page 2 of the 10-10EZ is the information for the previous year. Example = year 2003 will require 2002 income information.

YOUR NAME AND LAST FOUR (4) OF YOUR SOCIAL SECURITY NUMBER:

_____

YOUR OCCUPATION: _____

SPOUSES OCCUPATION: _____
If retired, please state so.

VETERANS PLACE OF BIRTH: City/State _____

WERE YOU IN COMBAT? If yes, give location and dates.

FATHERS NAME: Last, First _____

MOTHERS NAME: Last, First _____

MOTHERS MAIDEN NAME: _____

ANY MEDICAL EXPENSES: List your expenses, your spouse and any dependent children that you paid for out of pocket for the last year (include emergency room visits, Dr.'s office visits, prescriptions, dental, ophthalmology and hearing aids for the entire dependent family and health insurance payments.)

Please allow about seven (7) days for processing. *I have enclosed the following*:

- ☑ 10-10EZ application
- ☐ Copy of award letter
- ☑ Copy of discharge papers/*do not submit if this application if only for updating means test*
- ☑ I have completed this sheet
- ☐ Copy of insurance and/or Medicare card

Submitted by:
Raymond Taylor, CVSO Pagosa Springs, Colorado
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