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Department of Veterans Affairs

# Camp Lejeune Family Member Program Information Update Form

**Department of Veterans Affairs, Financial Services Center**
PO Box 149200, Austin TX 78714-9200
Customer Service Center: 1-866-372-1144 FAX: 512-460-5536

## Family Member

| Last Name | First Name | MI | Social Security Number |
|---|---|---|---|
| | | | |

| Street Address (current address) | City | State | Zip Code |
|---|---|---|---|
| | | | |

☐ Check this box if this is a change of address.

☐ Check this box if this is a permanent address.

☐ Check this box if this is a temporary address. From _____ To _____

| Email Address | Please indicate if you would like to receive correspondence via ☐ email ☐ regular mail |
|---|---|
| | |

☐ Check this box if this is a phone number change.

| Phone Number (include area code) | Alternate Phone Number (include area code) |
|---|---|
| | |

## Health Care Coverage Update

Is this an update to your previous health care coverage? ☐ Yes ☐ No

Has your previous health care coverage ended? ☐ Yes ☐ No

If **Yes,** please complete the following**.** If **No,** Please continue with next section**.**

| Name of prior health care coverage: | Effective Date (MMDDYYYY) | End Date (MMDDYYYY) |
|---|---|---|
| | | |
| Other health care coverage: | Effective Date (MMDDYYYY) | End Date (MMDDYYYY) |
| | | |

Do you have health care coverage? ☐ Yes, please complete the following ☐ No, continue with next section

**Note: This includes coverage you may have through an employer, spouse, significant other or federal/state health care benefit plan.**

**Please complete the following (check all that apply and provide the effective date(s).)**

☐ Medicare Part A Effective Date (MMDDYYYY) _____

☐ Medicare Part B Effective Date (MMDDYYYY) _____

☐ Medicare Advantage Effective Date (MMDDYYYY) _____

☐ Medicare Part D Effective Date (MMDDYYYY) _____

☐ Medicaid/State Assistance Effective Date (MMDDYYYY) _____

☐ TRICARE Effective Date (MMDDYYYY) _____

☐ CHAMPVA Effective Date (MMDDYYYY) _____

Please complete the following if you have other health care coverage not identified above.

| Name of Primary Insurance: | Effective Date (MMDDYYYY) |
|---|---|
| | |
| Name of Secondary Insurance: | Effective Date (MMDDYYYY) |
| | |

Does your health care coverage provide Pharmacy benefits? Yes ☐ No ☐

## Certification

I give permission for my personal information to be used by appropriate Federal Government agencies and Federal Government contractors.

By my signature I attest that I have answered the questions truthfully and that I understand the following: Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud to gain enrollment in the Camp Lejeune Family Member Program to which that person is not entitled is subject to civil and/or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

*I certify that the above information is correct and true to the best of my knowledge and belief. (Sign and date below.)*

| Signature | Date |
|---|---|
| | |

*If certification is signed by a person other than an applicant, complete the following:*

| Last Name | First Name |
|---|---|
| | |

| Mailing Address | | | |
|---|---|---|---|
| City | State | Zip Code | Telephone Number (include area code) |
| | | | |

**This form may be faxed to 512-460-5536 or mailed to:**
Department of Veterans Affairs
Financial Services Center
PO Box 149200
Austin, TX 78714-9200

**NOTE:** This form is to be used for updating your address, phone and/or health care coverage.

Directions for Camp Lejeune Family Member, representative or POA: please complete all fields that require updating.

**The Paperwork Reduction Act:** This information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. Public reporting burden for this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. The purpose of this data collection is to determine eligibility for benefits.

**Privacy Act Information:** The authority for collection of the requested information on this form is 38 USC 1787. The purpose of collecting this information is to determine your eligibility for reimbursement of health care related to conditions determined to result from contaminated water while you resided at Camp Lejeune, North Carolina, for a period of at least 30 days. The information you provide may be verified by computer matching programs with authoritative sources such as the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), Department of Defense (DoD), Defense Enrollment Eligibility Reporting System (DEERS), Centers for Medicare & Medicaid Services (CMS) or any other applicable authoritative source at any time. You are requested to provide your social security number as your VA record is filed and retrieved by this number. You do not have to provide the requested information on this form but if any or all of the requested information is not provided, given the form's purpose of establishing eligibility for the Camp Lejeune Family Member Program, it may delay or result in denial of your request for Camp Lejeune Family Member Program benefits. Failure to furnish the requested information will have no adverse impact on any other VA benefit to which you may be entitled. The responses you submit are considered private confidential and may be disclosed outside VA only if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records number 23VA16. For example, information including your social security number may be disclosed to the Department of Defense, contractors, trading partners, health care providers and other suppliers of health care services to determine your eligibility for medical benefits and payment for services.