

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. The information provided on this form will be used by VA to determine your eligibility for medical benefits and on average will take 30 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).
- Go to www.va.gov/health-care for information about VA health benefits.
- 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.
- **COMPENSABLE:** A VA determination that a service-connected disability is severe enough to warrant monetary compensation.
- **NONCOMPENSABLE:** A VA determination that a service-connected disability is not 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 - III.**Directions for Sections I - III:**

Section I - General Information: Answer all questions.

Section II - 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.

Section III - 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.

Directions for Sections IV-VI:

Financial Disclosure: ONLY NSC AND 0% NONCOMPENSABLE SC VETERANS MUST COMPLETE THIS SECTION TO DETERMINE ELIGIBILITY FOR VA HEALTH CARE ENROLLMENT AND/OR CARE OR SERVICES.

Financial Disclosure Requirements Do Not Apply To:

- a former Prisoner of War; or
- those in receipt of a Purple Heart; or
- a recently discharged Combat Veteran; or
- those discharged for a disability incurred or aggravated in the line of duty; or
- those receiving VA SC disability compensation; or
- those receiving VA pension; or
- those in receipt of Medicaid benefits; or
- those who served in Vietnam between January 9, 1962 and May 7, 1975; or
- those who served in SW Asia during the Gulf War between August 2, 1990 and November 11, 1998; or
- those who served at least 30 days at Camp Lejeune between August 1, 1953 and December 31, 1987.

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. However, if a financial assessment is used to determine your eligibility for cost-free medication, travel assistance or waiver of the travel deductible, and you do not disclose your financial information, you will not be eligible for these benefits.

Section IV - 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.

Continued ...

Section V - Employment Information:

- Veterans Employment Status
- Date of Retirement
- Company Name
- Company Address
- Company Phone Number

Section VI - 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.

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 payments; 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 VII - 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 last illness and burial expenses, e.g., prepaid burial, paid by the Veteran for spouse or dependent(s).

Section VIII - Consent to Copays and to Receive Communications

By submitting this application, you are agreeing to pay the applicable VA copayments for care or services (including urgent care) as required by law. You also agree to receive communications from VA to your supplied email, home phone number, or mobile number. However, providing your email, home phone number, or mobile number is voluntary.

Submitting Your Application

1. 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.
2. Attach any continuation sheets, a copy of supporting materials and your Power of Attorney documents to your application.

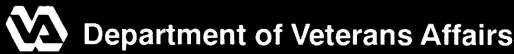
Where do I send my application?

Mail the original application and supporting materials to the Health Eligibility Center, 2957 Clairmont Road, Suite 200, Atlanta, GA 30329.

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 30 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 from initial submission forward 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.



VA DATE STAMP
(For VHA Use Only)

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)

TYPE OF BENEFIT(S) APPLYING FOR:

- ENROLLMENT** - VA Medical Benefits Package (Veteran meets and agrees to the enrollment eligibility criteria specified at 38 CFR 17.36)
 REGISTRATION - VA Health Services (Veterans meets the "Enrollment not required" eligibility criteria specified at 38 CFR 17.37)

1A. VETERAN'S NAME <i>(Last, First, Middle Name)</i>	1B. PREFERRED NAME	2. MOTHER'S MAIDEN NAME
------------------------------------------------------	--------------------	-------------------------

3A. BIRTH SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	3B. SELF-IDENTIFIED GENDER IDENTITY <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> TRANSMALE/TRANSMAN/FEMALE-TO-MALE <input type="checkbox"/> TRANSFEMALE/TRANSWOMAN/MALE-TO-FEMALE <input type="checkbox"/> CHOOSE NOT TO ANSWER	4. ARE YOU SPANISH, HISPANIC, OR LATINO? <input type="checkbox"/> YES <input type="checkbox"/> NO	5. WHAT IS YOUR RACE? <i>(You may check more than one. Information is required for statistical purposes only.)</i> <input type="checkbox"/> ASIAN <input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> WHITE <input type="checkbox"/> NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER <input type="checkbox"/> CHOOSE NOT TO ANSWER
-----------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

6. SOCIAL SECURITY NO.	7A. DATE OF BIRTH <i>(mm/dd/yyyy)</i>	7B. PLACE OF BIRTH <i>(City and State)</i>	8. RELIGION
------------------------	---------------------------------------	--------------------------------------------	-------------

9A. MAILING ADDRESS <i>(Street)</i>	9B. CITY	9C. STATE	9D. ZIP CODE	9E. COUNTY
-------------------------------------	----------	-----------	--------------	------------

9F. HOME TELEPHONE NO. <i>(optional)</i> <i>(Include Area Code)</i>	9G. MOBILE TELEPHONE NO. <i>(optional)</i> <i>(Include Area Code)</i>	9H. E-MAIL ADDRESS <i>(optional)</i>
------------------------------------------------------------------------	--------------------------------------------------------------------------	--------------------------------------

10A. HOME ADDRESS <i>(Street)</i>	10B. CITY	10C. STATE	10D. ZIP CODE	10E. COUNTY
-----------------------------------	-----------	------------	---------------	-------------

11. CURRENT MARTIAL STATUS
 MARRIED NEVER MARRIED SEPARATED WIDOWED DIVORCED

12A. NEXT OF KIN NAME	12B. NEXT OF KIN ADDRESS	12C. NEXT OF KIN RELATIONSHIP
-----------------------	--------------------------	-------------------------------

12D. NEXT OF KIN TELEPHONE NO. <i>(Include Area Code)</i>	12E. NEXT OF KIN WORK TELEPHONE NO. <i>(Include Area Code)</i>	13. DESIGNEE - INDIVIDUAL TO RECEIVE POSSESSION OF YOUR PERSONAL PROPERTY LEFT ON PREMISES UNDER VA CONTROL AFTER YOUR DEPARTURE OR AT THE TIME OF DEATH <i>(Note: This does not constitute a will or transfer of title)</i>
--------------------------------------------------------------	-------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

14. WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER? <i>(for listing of facilities visit www.va.gov/find-locations)</i>	15. WOULD YOU LIKE FOR VA TO CONTACT YOU TO SCHEDULE YOUR FIRST APPOINTMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------

SECTION II - MILITARY SERVICE INFORMATION

1A. LAST BRANCH OF SERVICE	1B. LAST ENTRY DATE	1C. FUTURE DISCHARGE DATE	1D. LAST DISCHARGE DATE
----------------------------	---------------------	---------------------------	-------------------------

1E. DISCHARGE TYPE	1F. MILITARY SERVICE NUMBER
--------------------	-----------------------------

2. MILITARY HISTORY <i>(Check yes or no)</i>	YES	NO		YES	NO
A. ARE YOU A PURPLE HEART AWARD RECIPIENT?	<input type="checkbox"/>	<input type="checkbox"/>	G. DO YOU HAVE A VA SERVICE-CONNECTED RATING?	<input type="checkbox"/>	<input type="checkbox"/>
B. ARE YOU A FORMER PRISONER OF WAR?	<input type="checkbox"/>	<input type="checkbox"/>	IF "YES", WHAT IS YOUR RATED PERCENTAGE _____ %		
C. DID YOU SERVE IN A COMBAT THEATER OF OPERATIONS AFTER 11/11/1998?	<input type="checkbox"/>	<input type="checkbox"/>	H. DID YOU SERVE IN VIETNAM BETWEEN JANUARY 9, 1962 AND MAY 7, 1975?	<input type="checkbox"/>	<input type="checkbox"/>
D. WERE YOU DISCHARGED OR RETIRED FROM MILITARY FOR A DISABILITY INCURRED IN THE LINE OF DUTY?	<input type="checkbox"/>	<input type="checkbox"/>	I. WERE YOU EXPOSED TO RADIATION WHILE IN THE MILITARY?	<input type="checkbox"/>	<input type="checkbox"/>
E. ARE YOU RECEIVING DISABILITY RETIREMENT PAY INSTEAD OF VA COMPENSATION?	<input type="checkbox"/>	<input type="checkbox"/>	J. DID YOU RECEIVE NOSE AND THROAT RADIUM TREATMENTS WHILE IN THE MILITARY?	<input type="checkbox"/>	<input type="checkbox"/>
F. DID YOU SERVE IN SW ASIA DURING THE GULF WAR BETWEEN AUGUST 2, 1990 AND NOVEMBER 11, 1998?	<input type="checkbox"/>	<input type="checkbox"/>	K. DID YOU SERVE ON ACTIVE DUTY AT LEAST 30 DAYS AT CAMP LEJEUNE FROM AUGUST 1, 1953 THROUGH DECEMBER 31, 1987?	<input type="checkbox"/>	<input type="checkbox"/>

APPLICATION FOR HEALTH BENEFITS <i>Continued</i>		VETERAN'S NAME <i>(Last, First, Middle)</i>		SOCIAL SECURITY NUMBER	
SECTION III - INSURANCE INFORMATION (Use a separate sheet for additional information)					
1. ENTER YOUR HEALTH INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER <i>(include coverage through spouse or other person)</i>					
2. NAME OF POLICY HOLDER			3. POLICY NUMBER		4. GROUP CODE
5. ARE YOU ELIGIBLE FOR MEDICAID? <i>(Federal health insurance for low income adults)</i> <input type="checkbox"/> YES <input type="checkbox"/> NO			6A. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A? <input type="checkbox"/> YES <input type="checkbox"/> NO		
			6B. EFFECTIVE DATE <i>(mm/dd/yyyy)</i> _____		
SECTION IV - DEPENDENT INFORMATION (Use a separate sheet for additional dependents)					
1. SPOUSE'S NAME <i>(Last, First, Middle Name)</i>			2. CHILD'S NAME <i>(Last, First, Middle Name)</i>		
1A. SPOUSE'S SOCIAL SECURITY NUMBER			2A. CHILD'S DATE OF BIRTH <i>(mm/dd/yyyy)</i>		2B. CHILD'S SOCIAL SECURITY NO.
1B. SPOUSE'S DATE OF BIRTH <i>(mm/dd/yyyy)</i>	1C. SELF-IDENTIFIED GENDER IDENTITY <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> TRANSMALE/TRANSMAN/FEMALE-TO-MALE <input type="checkbox"/> TRANSFEMALE/TRANSWOMAN/MALE-TO-FEMALE <input type="checkbox"/> CHOOSE NOT TO ANSWER		2C. DATE CHILD BECAME YOUR DEPENDENT <i>(mm/dd/yyyy)</i>		
			2D. CHILD'S RELATIONSHIP TO YOU <i>(Check one)</i> <input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER <input type="checkbox"/> STEPSON <input type="checkbox"/> STEPDAUGHTER		
1D. DATE OF MARRIAGE <i>(mm/dd/yyyy)</i>			2E. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18? <input type="checkbox"/> YES <input type="checkbox"/> NO		
1E. SPOUSE'S ADDRESS AND TELEPHONE NUMBER <i>(Street, City, State, ZIP if different from Veteran's)</i>			2F. IF CHILD IS BETWEEN 18 AND 23 YEARS OF AGE, DID CHILD ATTEND SCHOOL LAST CALENDAR YEAR? <input type="checkbox"/> YES <input type="checkbox"/> NO		
			2G. EXPENSES PAID BY YOUR DEPENDENT CHILD FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING <i>(e.g., tuition, books, materials)</i>		
3. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR, DID YOU PROVIDE SUPPORT? <input type="checkbox"/> YES <input type="checkbox"/> NO					
SECTION V - EMPLOYMENT INFORMATION					
1A. VETERAN'S EMPLOYMENT STATUS <i>(Check one)</i> . <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> NOT EMPLOYED <input type="checkbox"/> RETIRED				1B. DATE OF RETIREMENT	
1C. COMPANY NAME. <i>(Complete if employed or retired)</i>		1D. COMPANY ADDRESS <i>(Complete if employed or retired - Street, City, State, ZIP)</i>		1E. COMPANY PHONE NUMBER <i>(Complete if employed or retired)</i> <i>(Include area code)</i>	
SECTION VI - PREVIOUS CALENDAR YEAR GROSS ANNUAL INCOME OF VETERAN, SPOUSE AND DEPENDENT CHILDREN (Use a separate sheet for additional dependents)					
1. GROSS ANNUAL INCOME FROM EMPLOYMENT <i>(wages, bonuses, tips, etc.)</i> EXCLUDING INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	\$	VETERAN	\$	SPOUSE	CHILD 1
2. NET INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	\$		\$		
3. LIST OTHER INCOME AMOUNTS <i>(e.g., Social Security, compensation, pension, interest, dividends)</i> EXCLUDING WELFARE.	\$		\$		
SECTION VII - PREVIOUS CALENDAR YEAR DEDUCTIBLE EXPENSES					
1. TOTAL NON-REIMBURSED MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE <i>(e.g., payments for doctors, dentists, medications, Medicare, health insurance, hospital and nursing home)</i> 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 <i>(Also enter spouse or child's information in Section VI.)</i>				\$ _____	
3. AMOUNT YOU PAID LAST CALENDAR YEAR FOR YOUR COLLEGE OR VOCATIONAL EDUCATIONAL EXPENSES <i>(e.g., tuition, books, fees, materials)</i> DO NOT LIST YOUR DEPENDENTS' EDUCATIONAL EXPENSES.				\$ _____	

APPLICATION FOR HEALTH BENEFITSVETERAN'S NAME *(Last, First, Middle)*

SOCIAL SECURITY NUMBER

*Continued***SECTION VIII - CONSENT TO COPAYS AND TO RECEIVE COMMUNICATIONS**

By submitting this application, you are agreeing to pay the applicable VA copayments for care or services (including urgent care) as required by law. You also agree to receive communications from VA to your supplied email, home phone number, or mobile number. However, providing your email, home phone number, or mobile number is voluntary.

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*(Sign in ink)***DATE**