OMB Approved No. 2900-0091
Estimated Burden Avg. 24 min.

Department of Veterans Affairs

HEALTH BENEFITS RENEWAL FORM

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. GENDER ☐ MALE ☐ FEMALE
4. SOCIAL SECURITY NUMBER
5. DATE OF BIRTH *(mm/dd/yyyy)*
6. PERMANENT ADDRESS *(Street)*
6A. CITY
6B. STATE
6C. ZIP
6D. COUNTY
6E. HOME TELEPHONE NUMBER *(Include area code)*
6F. E-MAIL ADDRESS
6G. CELLULAR TELEPHONE NUMBER *(Include area code)*
6H. PAGER NUMBER *(Include area code)*
7. CURRENT MARITAL STATUS *(Check one)* ☐ MARRIED ☐ NEVER MARRIED ☐ SEPARATED ☐ WIDOWED ☐ DIVORCED ☐ UNKNOWN
8. NAME, ADDRESS AND RELATIONSHIP OF NEXT OF KIN
8A. NEXT OF KIN'S HOME TELEPHONE NUMBER *(Include area code)*
8B. NEXT OF KIN'S WORK TELEPHONE NUMBER *(Include area code)*
9. NAME, ADDRESS AND RELATIONSHIP OF EMERGENCY CONTACT
9A. EMERGENCY CONTACT'S HOME TELEPHONE NUMBER *(Include area code)*
9B. EMERGENCY CONTACT'S WORK TELEPHONE NUMBER *(Include area code)*
10. INDIVIDUAL TO RECEIVE POSSESSION OF YOUR PERSONAL PROPERTY LEFT ON PREMISES UNDER VA CONTROL AFTER YOUR DEPARTURE OR AT THE TIME OF DEATH.
Note: This does not constitute a will or transfer of title. *(Check one)* ☐ EMERGENCY CONTACT ☐ NEXT OF KIN

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

1. ARE YOU COVERED BY HEALTH INSURANCE, INCLUDING COVERAGE THROUGH A SPOUSE OR ANOTHER PERSON? ☐ YES ☐ NO
2. HEALTH INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER
3. NAME OF POLICY HOLDER
4. POLICY NUMBER
5. GROUP CODE
6. ARE YOU ELIGIBLE FOR MEDICAID? ☐ YES ☐ NO
7. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A? ☐ YES ☐ NO
7A. EFFECTIVE DATE *(mm/dd/yyyy)*
8. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART B? ☐ YES ☐ NO
8A. EFFECTIVE DATE *(mm/dd/yyyy)*
9. NAME EXACTLY AS IT APPEARS ON YOUR MEDICARE CARD
10. MEDICARE CLAIM 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 - 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 24 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 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.

Department of Veterans Affairs

VETERAN'S NAME *(Last, First, Middle)*	SOCIAL SECURITY NUMBER

SECTION V - FINANCIAL DISCLOSURE

Disclosure allows VA to accurately determine whether certain veterans will be charged copayments for care and medications, their eligibility for other services and enrollment priority. Veterans are not required to disclose their financial information. **Recent combat veterans (e.g., OEF/OIF)** like other veterans may answer YES in Section V and complete Sections VI-IX to have their priority for enrollment and financial eligibility for cost-free medical care, medications, long-term care and beneficiary travel for treatment of nonservice-connected conditions assessed.

☐ **No, I do not wish to provide financial information in Sections VI through IX.** If I am enrolled, I agree to pay applicable VA copayments. *Sign and date the form in Section XI.*

☐ **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 XI.*

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	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)*	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)* $

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

	VETERAN	SPOUSE	CHILD 1
1. GROSS ANNUAL INCOME FROM EMPLOYMENT *(eg., 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 *(e.g., 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 LAST CALENDAR YEAR *(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 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 and 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 homes and non-income producing property.)* DO NOT INCLUDE 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 - CONSENT TO COPAYMENTS

If you are a 0% SC veteran and do not receive VA monetary benefits or a NSC veteran (and you are not a Former POW, Purple Heart Recipient or VA pensioner) and your household income (or combined income and net worth) exceeds the established threshold, this application will be considered for enrollment, but only if you agree to pay VA copays for treatment of your NSC conditions. **If you are such a veteran by signing this application you are agreeing to pay the applicable VA copays as required by law.**

SECTION XI - 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 ON WHO CAN SIGN ON BEHALF OF THE VETERAN.

SIGNATURE OF APPLICANT	DATE *(mm/dd/yyyy)*