

APPLICATION FOR HEALTH BENEFITS, Continued	VETERAN'S NAME <i>(Last, First, Middle)</i>	SOCIAL SECURITY NUMBER
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SECTION II - INSURANCE INFORMATION <i>(Use a separate sheet for additional information)</i>			
1. ARE YOU COVERED BY HEALTH INSURANCE? <i>(Including coverage through a spouse or another person)</i>		2. HEALTH INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER	
<input type="checkbox"/> YES <input type="checkbox"/> NO			
3. NAME OF POLICY HOLDER			
4. POLICY NUMBER	5. GROUP CODE		
		YES	NO
6. ARE YOU ELIGIBLE FOR MEDICAID?		<input type="checkbox"/>	<input type="checkbox"/>
7. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A?		<input type="checkbox"/>	<input type="checkbox"/>
		7A. EFFECTIVE DATE <i>(mm/dd/yyyy)</i>	
8. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART B?		<input type="checkbox"/>	<input type="checkbox"/>
		8A. EFFECTIVE DATE <i>(mm/dd/yyyy)</i>	
9. NAME EXACTLY AS IT APPEARS ON YOUR MEDICARE CARD		10. MEDICARE CLAIM NUMBER	
11. IS NEED FOR CARE DUE TO ON THE JOB INJURY? <i>(Check one)</i>		12. IS NEED FOR CARE DUE TO ACCIDENT? <i>(Check One)</i>	
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	

SECTION III - EMPLOYMENT INFORMATION	
1. VETERAN'S EMPLOYMENT STATUS <i>(Check one)</i>	1A. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER
<input type="checkbox"/> FULL TIME <input type="checkbox"/> NOT EMPLOYED	
<i>If employed or retired, complete item 1A</i>	
<input type="checkbox"/> PART TIME <input type="checkbox"/> RETIRED	
<i>Date of retirement (mm/dd/yyyy)</i>	
2. SPOUSE'S EMPLOYMENT STATUS <i>(Check one)</i>	2A. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER
<input type="checkbox"/> FULL TIME <input type="checkbox"/> NOT EMPLOYED	
<i>If employed or retired, complete item 2A</i>	
<input type="checkbox"/> PART TIME <input type="checkbox"/> RETIRED	
<i>Date of retirement (mm/dd/yyyy)</i>	

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?	<input type="checkbox"/>	<input type="checkbox"/>	E1. ARE YOU RECEIVING DISABILITY RETIREMENT PAY INSTEAD OF VA COMPENSATION?	<input type="checkbox"/>
				<input type="checkbox"/>
B. ARE YOU A FORMER PRISONER OF WAR?	<input type="checkbox"/>	<input type="checkbox"/>	F. DO YOU NEED CARE OF CONDITIONS POTENTIALLY RELATED TO SERVICE IN SW ASIA DURING THE GULF WAR?	<input type="checkbox"/>
				<input type="checkbox"/>
C. DO YOU HAVE A VA SERVICE-CONNECTED RATING?	<input type="checkbox"/>	<input type="checkbox"/>	G. WERE YOU EXPOSED TO AGENT ORANGE WHILE SERVING IN VIETNAM?	<input type="checkbox"/>
				<input type="checkbox"/>
C1. IF YES, WHAT IS YOUR RATED PERCENTAGE?	%		H. WERE YOU EXPOSED TO RADIATION WHILE IN THE MILITARY?	<input type="checkbox"/>
				<input type="checkbox"/>
D. DID YOU SERVE IN COMBAT AFTER 11/11/1998?	<input type="checkbox"/>	<input type="checkbox"/>	I. DID YOU RECEIVE NOSE AND THROAT RADIUM TREATMENTS WHILE IN THE MILITARY?	<input type="checkbox"/>
				<input type="checkbox"/>
E. WAS YOUR DISCHARGE FROM MILITARY FOR A DISABILITY INCURRED OR AGGRAVATED IN THE LINE OF DUTY?	<input type="checkbox"/>	<input type="checkbox"/>	J. DO YOU HAVE A SPINAL CORD INJURY?	<input type="checkbox"/>
				<input type="checkbox"/>

SECTION V - 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.