§ 58.12 VA Forms 10–10EZ and 10–10EZR—Application for Health Benefits and Renewal Form.
## APPLICATION FOR HEALTH BENEFITS, Continued

<table>
<thead>
<tr>
<th>VETERAN'S NAME (Last, First, Middle)</th>
<th>SOCIAL SECURITY NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

### SECTION II. INSURANCE INFORMATION

<table>
<thead>
<tr>
<th>ARE YOU ELIGIBLE FOR MEDICARE?</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>ARE YOU ENROLLED IN MEDICARE INSURANCE?</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>

### SECTION III. EMPLOYMENT INFORMATION

<table>
<thead>
<tr>
<th>VETERAN'S EMPLOYMENT STATUS (Check one)</th>
<th>FULL TIME</th>
<th>PART TIME</th>
<th>RETIRED</th>
<th>DATE OF RETIREMENT (Month/Year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>RETIRED</td>
<td>75</td>
<td>30</td>
<td>2023</td>
<td></td>
</tr>
</tbody>
</table>

### SECTION IV. MILITARY SERVICE INFORMATION

<table>
<thead>
<tr>
<th>LAST BRANCH OF SERVICE</th>
<th>1A. LAST ENLISTED DATE</th>
<th>1B. LAST DISCHARGE DATE</th>
<th>1C. DISCHARGE TYPE</th>
<th>1D. MILITARY SERVICE NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

### 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.
APPENDIX FOR HEALTH BENEFITS, Continued

SECTION VI: 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; however, VA is not currently enrolling new applicants who decline to provide this financial information unless they have a special eligibility factor. Recent combat veterans (e.g., OIF/OEF/OND) who were discharged within the past 5 years or were discharged more than 5 years ago and applying for enrollment by Jan. 27, 2011 are eligible for enrollment without disclosing their financial information but the other veterans may provide it to establish their eligibility for travel reimbursement, out-of-pocket medication and/or medical care for services unrelated to military experience.

No. I do not wish to provide financial information in Sections VII through XII. I understand that VA is not currently enrolling new applicants who decline to provide this financial information and who do not have a special eligibility factor (e.g., recently discharged combat veterans, compensable service connection, except for VA pension or Medicaid benefits). If I am enrolled, I agree to pay applicable VA copayments. Sign and date the form in Section XII.

Yes. I will provide my household financial information for last calendar year. Complete applicable sections VII through XII. Sign and date the form in Section XII.

SECTION VII: DEPENDENT INFORMATION (Use a separate sheet for additional dependents)

1. APPLICANT'S NAME (Last, First, Middle Name)
2. CHILDREN'S NAME
   - Son
   - Daughter
   - Stepson
   - Stepdaughter
3. APPLICANT'S SOCIAL SECURITY NUMBER
4. CHILD'S SOCIAL SECURITY NUMBER
5. DATE CHILD BECAME YOUR DEPENDENT (month/day/year)
6. ENSURE THAT YOUR SPOUSE OR DEPENDENT CHILD DOES NOT LIVE WITH YOU. If you last year enter the amount you contributed to their support:

   - FOR VETERAN
   - FOR SPOUSE
   - FOR CHILD 1

1. GROSS ANNUAL INCOME FROM EMPLOYMENT (wages, salaries, tips, etc.)
2. GROSS ANNUAL INCOME FROM RENTAL, FARM, BUSINESS, PROPERTY OR BUSINESS
   - FOR VETERAN
   - FOR SPOUSE
   - FOR CHILD 1
3. ANY OTHER INCOME (e.g., Social Security, compensation, pension, interest, dividends) EXCLUDING INCOME FROM RENTAL, FARM, BUSINESS, PROPERTY OR BUSINESS
   - FOR VETERAN
   - FOR SPOUSE
   - FOR CHILD 1

SECTION IX: PREVIOUS CALENDAR YEAR INCOME EXEMPTIONS (Use separate sheet for additional dependents)

1. TOTAL ANNUAL GROSS MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE (e.g., payments for doctors, dentists, medications, Medicare, health insurance, hospital and nursing home services) or paid by any other person for you or you and your spouse
2. AMOUNT YOU PAID during CALENDAR YEAR FOR FUNERAL AND BURIAL EXPENSES FOR YOUR DECEASED SPOUSE OR DECEASED CHILD (e.g., veteran or dependent who died)
3. AMOUNT YOU PAID LAST CALENDAR YEAR FOR YOUR EDUCATION (e.g., tuition, books, fees, materials)

SECTION X: PREVIOUS CALENDAR YEAR NET WORTH (Use separate sheet for additional dependents)

1. TOTAL VALUE OF REAL ESTATE
   - FOR VETERAN
   - FOR SPOUSE
   - FOR CHILD 1
2. TOTAL VALUE OF PERSONAL PROPERTY (e.g., automobiles, jewelry, appliances, furniture, etc.)
   - FOR VETERAN
   - FOR SPOUSE
   - FOR CHILD 1
3. TOTAL VALUE OF LIFE INSURANCE POLICIES AND OTHER SOURCES OF INCOME (e.g., stocks, bonds, etc.)
   - FOR VETERAN
   - FOR SPOUSE
   - FOR CHILD 1

SECTION XI: CONSENT TO EQUIPMENT

If you are a 0% rating veteran and do not receive VA monetary benefits or a NCS 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. Each if you agree to pay VA copayments for enrollment. If you exceed the NCS threshold if you are a 0% rating veteran and do not receive VA monetary benefits or a NCS veteran (and you are not a Former POW, Purple Heart Recipient or VA pensioner)

SECTION XII: ASSIGNMENT OF BENEFITS

I understand that pursuant to 38 U.S.C. Section 1779, VA is authorized to recover or collect from my health plan (HP) the reasonable charges of non-service-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.

VA FORM 10-10EZ
Date

1024
**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:**
2. **Other Names Used:**
3. **Gender:**
   - Male
   - Female
4. **Social Security Number:**
5. **Date of Birth:** (mm/dd/yyyy)
6. **Permanent Address:** (Street)
7. **City:**
8. **State:**
9. **ZIP:**
10. **County:**
11. **Home Telephone Number:** (Include area code)
12. **Email Address:**
13. **Cellular Telephone Number:** (Include area code)
14. ** Pager Number:** (Include area code)
15. **Current Marital Status:**
   - Married
   - Never Married
   - Separated
   - Widowed
   - Divorced
   - Unknown
16. **Name of Address and Relationship of Next of Kin:**
17. **Next of Kin’s Home Telephone Number:** (Include area code)
18. **Next of Kin’s Work Telephone Number:** (Include area code)
19. **Next of Kin’s Emergency Contact:**
   - Home Telephone Number:** (Include area code)
   - Work Telephone Number:** (Include area code)

**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. **Name of Policy Holder:**
3. **Group Code:**
4. **Are You Eligible for Medicare?**
   - Yes
   - No
5. **Are you Enrolled in Medicare Hospital Insurance Part A?**
   - Yes
   - No
6. **Effective Date:** (mm/dd/yyyy)
7. **Are you Enrolled in Medicare Hospital Insurance Part B?**
   - Yes
   - No
8. **Effective Date:** (mm/dd/yyyy)

**SECTION III - EMPLOYMENT INFORMATION**

1. **Veteran’s Employment Status:**
   - Full Time
   - Part Time
   - Not Employed
2. **Company Name, Address, and Telephone Number:**
3. **Date of Retirement:** (mm/dd/yyyy)

**SECTION IV - PAPERWORK REDUCTION ACT AND PRIVACY ACT INFORMATION**

This Paperwork Reduction Act of 1995 requires us to certify that the information collected is in accordance with the privacy requirements of Title 5 U.S.C., including Sections 3513, 3514, and 552a. In order for VA to determine your eligibility for continued benefits, information you may be required to verify through a computer matching program. VA may disclose the information you put on this form to organizations under your employer (e.g., a hospital). VA’s Privacy Act of 1974 requires that you be informed that the information you provide may be subject to a penalty for failure to disclose information. You may also view this information at your local veterans benefits office or by calling VA benefits and eligibility, and it be used for other purposes authorized or required by law.
§ 58.12

Department of Veterans Affairs

VETERANS NAME (Last, First, Middle)

SOCIAL SECURITY NUMBER

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) who have been also may answer YES to Section V and complete Sections VI–IX to have their priority for enrollment and financial eligibility for care and medications, long-term care and beneficiary travel for treatment of non-service-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)

3. Spouse’s Social Security Number

4. Child’s Social Security Number

5. Spouse’s date of birth

6. Child’s date of birth

7. Spouse’s address and telephone number

8. Child’s address and telephone number

9. Was child permanently and totally disabled before the age of 18?

10. Did child attend school last calendar year?

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

<table>
<thead>
<tr>
<th></th>
<th>VETERAN</th>
<th>SPOUSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Income</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

SECTION VIII. PREVIOUS CALENDAR YEAR DEEDITABLE EXPENSES

1. Total non-reimbursable medical expenses paid by you or your spouse, last calendar year (e.g., payments for dentists, medicines, medical supplies, health expenses, hospices and nursing homes). VA will calculate a benefit and the non-medical expenses you and your spouse have paid.

2. Amount you and your spouse have paid for funeral and burial expenses for your deceased spouse or dependent child (if deceased) last calendar year.

3. Amount you and your spouse have paid for funeral and burial expenses for your deceased spouse or dependent child (if deceased) last calendar year.

SECTION IX. PREVIOUS CALENDAR YEAR NET WORTH (Use a separate sheet for additional dependents)

<table>
<thead>
<tr>
<th></th>
<th>VETERAN</th>
<th>SPOUSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value of home, land, and improvements</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

SECTION X. CONSENT TO COPAYMENTS

If you are a VA spouse, dependent child, or non-service-connected VA beneficiary (a person who is not a veteran - please see note on VA spousal VA service-connected (a person who is not a veteran - please see note on VA spousal VA service-connected VA beneficiaries, their household income (as determined by the Social Security Administration) is $1000, then this application will be considered for enrollment. You may only choose to pay the copayments for treatment of your WSC conditions. If you are such a veteran by signing this application, you are agreeing to pay the applicable VA copayments as required by law.

INSTRUCTIONS: Applicants must sign and date this form. Refer to instructions on who can sign on behalf of the veteran.

Date: July 2009

10-0EZ

(65 FR 981, Jan. 6, 2000, as amended at 74 FR 19439, Apr. 29, 2009)