Department of Veterans Affairs

INSTRUCTIONS FOR COMPLETING HEALTH BENEFITS UPDATE FORM

Please Read Before You Start . . . What is VA Form 10-10EZR used for?

VA Form 10-10EZR is used by VA to update your personal, insurance, or financial information after you are enrolled.

Where can I get help filling out the form and if I have questions? This update form is available for completion online at www.va.gov/health-care.

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).
- 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.
SPOUSE: If you are certifying that a person is your spouse for the purpose of VA benefits, your marriage must be recognized by the place where you and/or your spouse resided at the time of marriage, or where you and/or your spouse reside when you file your claim (or at a later date when you become eligible for benefits) (38 U.S.C. 103(c)). Additional guidance on when VA recognizes marriages is available at http://www.va.gov/opa/marriage/.

ALL VETERANS MUST COMPLETE SECTIONS I, II, VI, and VII

Directions for Sections I - II:

Section I - General Information: Answer all questions.
Section II - Insurance Information: Include information for all health insurance companies that cover you, this includes coverage provided through a spouse or significant other. If you have more than one health insurer, provide this information on a separate sheet of paper and attach to the application. If you have access to a copier, attach a copy of your insurance cards, Medicare card and/or Medicaid card (Medicaid is a federal/state health insurance program for certain low-income people). Bring these cards with you to each health care appointment.

COMPLETE SECTION III only if you complete Sections IV:

Section III - Dependent Information: Your spouse and dependent social security numbers(s) are required so we can verify their financial information through a computer-matching program. You may count your spouse as your dependent even if you did not live together, as long as you contributed support last calendar year. You may count your biological children, adopted children, and stepchildren as dependents. These children must be unmarried and under the age of 18, or be at least 18 but under 23 and attending high school, college or vocational school on a full or part-time basis, or have become permanently unable to support themselves before reaching the age of 18.

Directions for Sections IV - V:

Veterans **may** provide a financial assessment to update their eligibility for cost-free care or services, beneficiary travel eligibility, and/or waiver of the beneficiary travel deductible requirement.

Veterans rated 50-100% disabled due to SC conditions and Veterans receiving VA pension are **not required** to provide a financial assessment.

Complete only the sections that apply to you; ***sign and date the form****.*

Continued ...

Section IV - 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 Compensation 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 V - Previous Calendar Year Deductible Expenses.

Report non-reimbursed medical expenses paid by you or your spouse. Include expenses for medical and dental care, medications, 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 VI - 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.

Section VII - Submitting Your Update.

1. Read Paperwork Reduction and Privacy Act Information, Section VI Consent to Copays and Assignment of Benefits.
2. Sign and Date the form. 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.
3. Attach any continuation sheets, a copy of supporting materials or your Power of Attorney documents to your application.

Where do I mail my update?

Mail the completed VA Form 10-10EZR and any 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 15 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 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 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.

OMB Approved No. 2900-0091
Estimated Burden Avg. 24 min
Expiration Date: 06/30/2024

Department of Veterans Affairs

HEALTH BENEFITS UPDATE FORM

VA DATE STAMP
(For VHA Use Only)

SECTION I - GENERAL INFORMATION

Federal law provides criminal penalties, including a fine and/or imprisonment, for any materially false, fictitious, or fraudulent statement or representation. (See 18 U.S.C. 287 and 1001).

1A. VETERAN'S NAME *(Last, First, Middle Name)*

2. SOCIAL SECURITY NUMBER

1B. VETERAN'S PREFERRED NAME *(Last, First, Middle Name)*

3A. BIRTH SEX
☐ MALE
☐ FEMALE

3B. SELF-IDENTIFIED GENDER IDENTITY
☐ MALE ☐ FEMALE
☐ TRANSMALE/TRANSMAN/FEMALE-TO-MALE
☐ TRANSFEMALE/TRANSWOMAN/MALE-TO-FEMALE
☐ CHOOSE NOT TO ANSWER

4. DATE OF BIRTH *(mm/dd/yyyy)*

5. HOME TELEPHONE NUMBER *(optional)* *(Include area code)*

6. MOBILE TELEPHONE NUMBER *(optional)* *(Include area code)*

7A. MAILING ADDRESS *(Street)*

7B. CITY

7C. STATE

7D. ZIP CODE

7E. COUNTY

8A. HOME ADDRESS *(Street)*

8B. CITY

8C. STATE

8D. ZIP CODE

8E. COUNTY

9. E-MAIL ADDRESS *(optional)*

10. CURRENT MARITAL STATUS
☐ MARRIED ☐ NEVER MARRIED ☐ SEPARATED
☐ WIDOWED ☐ DIVORCED

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

1. ENTER YOUR HEALTH INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER *(include coverage through spouse or other person)*

2. NAME OF POLICY HOLDER

3. POLICY NUMBER

4. GROUP CODE

5. ARE YOU ELIGIBLE FOR MEDICAID? *(Federal Health Insurance for low income adults)*
☐ YES ☐ NO

6. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A? ☐ YES ☐ NO

7. EFFECTIVE DATE *(mm/dd/yyyy)*

SECTION III - DEPENDENT INFORMATION *(Use a separate sheet for additional dependents)*

1. SPOUSE'S NAME *(Last, First, Middle Name)*

2. SPOUSE'S SOCIAL SECURITY NUMBER

3. SPOUSE'S DATE OF BIRTH *(mm/dd/yyyy)*

4. SPOUSE'S SELF-IDENTIFIED GENDER IDENTITY
☐ MALE ☐ FEMALE ☐ TRANSMALE/TRANSMAN/FEMALE-TO-MALE
☐ TRANSFEMALE/TRANSWOMAN/MALE-TO-FEMALE
☐ CHOOSE NOT TO ANSWER

5. DATE OF MARRIAGE *(mm/dd/yyyy)*

6. SPOUSE'S ADDRESS AND TELEPHONE NUMBER *(Street, City, State, ZIP - if different from Veteran's)*

7. CHILD'S NAME *(Last, First, Middle Name)*

8. CHILD'S DATE OF BIRTH *(mm/dd/yyyy)*

9. CHILD'S SOCIAL SECURITY NUMBER

10. DATE CHILD BECAME YOUR DEPENDENT *(mm/dd/yyyy)*

11. CHILD'S RELATIONSHIP TO YOU *(Check one)*
☐ SON ☐ DAUGHTER ☐ STEPSON ☐ STEPDAUGHTER

12. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18?
☐ YES ☐ NO

13. IF CHILD IS BETWEEN 18 AND 23 YEARS OF AGE, DID CHILD ATTEND SCHOOL LAST CALENDAR YEAR?
☐ YES ☐ NO

14. EXPENSES PAID BY YOU FOR YOUR DEPENDENT CHILD FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING *(e.g., tuition, books, materials)*

15. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR, DID YOU PROVIDE SUPPORT? ☐ YES ☐ NO

REMEMBER TO SIGN AND DATE THE FORM ON THE REVERSE PAGE
PREVIOUS EDITIONS OF THIS FORM ARE NOT TO BE USED

HEALTH BENEFITS UPDATE FORM	VETERAN'S NAME *(Last, First, Middle)*	SOCIAL SECURITY NUMBER

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

	VETERAN	SPOUSE	CHILD 1
1. GROSS ANNUAL INCOME FROM EMPLOYMENT *(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 V - PREVIOUS CALENDAR YEAR DEDUCTIBLE EXPENSES

1. TOTAL NON-REIMBURSED MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE *(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 (INCLUDING PREPAID BURIAL EXPENSES) FOR YOUR DECEASED SPOUSE OR DEPENDENT CHILD *(Also enter spouse or child's information in Section III.)*	$
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 VI - 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.

SECTION VII - SUBMITTING YOUR UPDATE

ALL APPLICANTS MUST SIGN AND DATE THIS FORM. REFER TO INSTRUCTIONS WHICH DEFINE WHO CAN SIGN ON BEHALF OF THE VETERAN.

Federal law provides criminal penalties, including a fine and/or imprisonment, for any materially false, fictitious, or fraudulent statement or representation. (See 18 U.S.C. 287 and 1001).

I declare under penalty of perjury that the foregoing is true and accurate to the best of my knowledge. I understand that any materially false, fictitious, or fraudulent statement or representation, made knowingly, is punishable by a fine and/or imprisonment pursuant to title 18, United States Code, Sections 287 and 1001.

SIGNATURE OF APPLICANT:
(Sign in ink) _____ **DATE** *(mm/dd/yyyy)*: _____