

DEAR VETERAN:

Would you please provide us with the following information on your health insurance coverage, including Medicare supplemental coverage so that we may complete your application for medical benefits. If you are a first time enrollee with the VA, then send this form back with your 10-10EZ application package. If this is for updated information only, please mail the form to:

Department of Veterans Affairs Outpatient Clinic
Attn: Enrollment Center
2900 Veterans Way
Viera, FL 32940

VETERAN'S NAME: _____

VETERAN'S SOCIAL SECURITY NUMBER: _____

Policy Holder's Name: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Telephone #: _____

Insurance Policy Number: _____

Group Name/Number (if any): _____

EFFECTIVE DATE OF POLICY: _____

Second Insurance Policy (if applicable):

Policy Holder's Name: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Telephone #: _____

Insurance Policy Number: _____

Group Name/Number (if any): _____

EFFECTIVE DATE OF POLICY: _____

SIGNATURE OF VETERAN: _____

DATE SIGNED: _____