



NYS Division of Veterans' Affairs  
 2 Empire State Plaza, 17<sup>th</sup> Floor  
 Albany, New York 12223  
 518-486-3602

**APPLICATION FOR BLIND ANNUITY**

1. APPLICANT'S NAME:			
<i>(Veteran OR Unremarried Surviving Spouse)</i>	LAST	FIRST	MIDDLE
2. APPLICANT'S ADDRESS:			
	NUMBER, STREET		APARTMENT, PO BOX
		NY	
CITY/TOWN	COUNTY	STATE	ZIP CODE
3. TELEPHONE:		4. DATE OF BIRTH:	
5. APPLICANT'S SOCIAL SECURITY NUMBER:			
6. VETERAN'S NAME:			
<i>(If different from Applicant)</i>	LAST	FIRST	MIDDLE
7. VETERAN'S SOCIAL SECURITY NUMBER:			
8. QUALIFYING DATES OF SERVICE		9. ARE YOU MARRIED? YES <input type="checkbox"/> or NO <input type="checkbox"/>	
		If yes, SPOUSE'S NAME: _____	
FROM	TO		
10. ARE YOU PRESENTLY DOMICILED IN NEW YORK STATE?		YES <input type="checkbox"/> or NO <input type="checkbox"/>	
11. ARE YOU CURRENTLY A RESIDENT OF NEW YORK STATE?		YES <input type="checkbox"/> or NO <input type="checkbox"/>	
12. NAME OF PHYSICIAN PROVIDING EVIDENCE OF VETERANS LOSS OF SIGHT:			
13. ADDRESS OF PHYSICIAN:			
14. CERTIFICATION BY THE COMMISSION FOR THE BLIND & VISUALLY HANDICAPPED NUMBER:			
15. NAME OF APPLICANT'S NEXT OF KIN <small>(Friend or Relative)</small> <b>(Not Spouse): REQUIRED</b>			
16. NEXT OF KIN TELEPHONE NUMBER:			
I certify that the above statements are true and complete; and I make these statements with the knowledge that willfully issuing a false or fraudulent statement is a misdemeanor pursuant to New York State Law.			
APPLICANTS SIGNATURE:		DATE:	
PREPARER'S NAME		PHONE NUMBER:	
<b>Return: Completed Application, Report of Legal Blindness, certificate of Discharge, Proof of Residency &amp; Marriage &amp; Death certificates (if spouse applying) to:</b>		NYS Division of Veterans' Affairs c/o Blind Annuity #2 Empire state Plaza, 17 <sup>th</sup> Floor Albany, NY 12223	