NEW YORK STATE OF OPPORTUNITY | Division of Veterans' Affairs

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

APPLICATION FOR BLIND ANNUITY

1. APPLICANT'S NAME:			
*(Veteran **OR** Unremarried Surviving Spouse)*	*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:			
(If different from Applicant)	*LAST*	*FIRST*	*MIDDLE*
7. VETERAN'S SOCIAL SECURITY NUMBER:			
8. QUALIFYING DATES OF SERVICE		9. ARE YOU MARRIED? YES ☐ or NO ☐ **If yes, SPOUSE'S NAME**: _____	
FROM	*TO*		

10. ARE YOU PRESENTLY DOMICILED IN NEW YORK STATE?	YES ☐ or NO ☐
11. ARE YOU CURRENTLY A RESIDENT OF NEW YORK STATE?	YES ☐ or NO ☐
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 (Friend or Relative) ***(Not Spouse)*: REQUIRED**	
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**:

Return: Completed Application, Report of Legal Blindness, certificate of Discharge, Proof of Residency & Marriage & Death certificates (if spouse applying) to:	**NYS Division of Veterans' Affairs** **c/o Blind Annuity** **#2 Empire state Plaza, 17th Floor** **Albany, NY 12223**