**NYS Division of Veterans' Affairs**
**#5 Empire State Plaza, 28th Floor**
**Albany, New York 12223-1551**
**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 NUMBER, PO BOX* |

| | | | |
|---|---|---|---|
| *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 |
| *FROM* *TO* | SPOUSE'S NAME: |

| **10.** ARE YOU CURRENTLY RECEIVING VA DISABILITY BENEFITS? YES or NO | |
|---|---|
| **11.** IF YES: WHAT IS YOUR VA CLAIM NUMBER? | |
| **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 | |
| **15.** NAME OF APPLICANT'S NEXT OF KIN ***(other than spouse)***: | |
| **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.

**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**
**#5 Empire State Plaza, 28th Floor**
**Albany, NY 12223-1551**

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**Rest Form** **Print Form**