APPLICATION FOR ASSISTANCE (Disabled Status)
(All Questions Must Be Answered)

1. Name _____ Date of Birth _____
   First MI Last Mo Day Year

2. Address _____
   No. Street City State Zip Code

3. Former Address (if less than 2 years)

   _____
   No. Street City State Zip Code

4. Marital Status: Unmarried _____
   Married _____ Date _____
   Separated _____ Date _____
   Divorced _____ Date _____
   Widowed _____ Date _____

5. Number of Dependents _____ Names Relationship
   _____ _____
   _____ _____
   _____ _____

6. Social Security Number _____

7. Home Telephone Number _____

8. Employer: _____ _____
   Name Address

   _____
   Telephone No.

9. Business Telephone No. _____

10. Date of Original Membership in Association _____

11. Are you a member of a Benevolent Association other than Freeport? Yes _____ No _____
    If yes, Name _____ Address _____
    Telephone No. _____

12. Are you a member of a Fire Department other than Freeport? Yes _____ No _____
    If yes, Name _____ Address _____
    Telephone No. _____

FOR ASSOCIATION USE ONLY:

Approved _____ Rejected _____ Date _____

By (& Title) _____

Amount _____

Conditions _____

_____

_____

4/18

APPLICANT'S STATEMENT

Please print or type

1. My disability is (if injury, also state how, when, and where it occurred)

_____

_____

_____

2. Date Disability commenced _____
   Mo Day Year

3. Have you recovered from this disability? Yes _____ No _____
   If yes, date of recovery _____
   Mo Day Year

4. Are you covered by any medical, surgical, dental, optical or other health insurance or indemnity insurance? Yes _____ No _____
   If yes, name, address and telephone number of each insurance company and type of coverage and policy number (including group number if applicable)

   _____

   _____

   _____

   _____

5. Are you covered by any disability insurance? Yes _____ No _____
   If yes, name, address and telephone number of each insurance company and policy number (including group number, if applicable)

   _____

   _____

6. Amount requested: $_____

7. Purpose of Assistance (attach health care provider bills/invoices or other bills, invoices or other bills, invoices or information, if any)

   _____

   _____

   _____

8. a) Are you a member of a Benevolent Association other than Freeport? Yes _____ No _____
   If yes, Name_____Address_____
   Telephone No._____

   b) Have you applied for or received assistance from any other Benevolent Association other than Freeport in relation to matters contained in this application? Yes _____ No _____
   If yes, Name_____Address_____
   Telephone No._____
   Explanation_____

   _____

   _____

   c) Are you a member of a fire department other than Freeport? Yes _____ No _____
   If yes, Name_____Address_____
   Telephone No. _____

d) Do you own real estate? Yes_____ No _____
If yes, is the property mortgaged or subject to a lien? Yes _____ No _____

e) If yes, principal balance unpaid (mortgage) or amount of lien $_____
Maturity date of Mortgage _____

f) Are there any outstanding judgments against you? Yes _____ No _____
If yes, amount (s) $_____ Date of Judgment _____
Judgment Creditor _____

g) Have you had property foreclosed upon or given title or deed in lieu thereof?
Yes _____ No _____ If yes, Date_____
Explanation _____

h) Have you ever filed for voluntary bankruptcy or been placed into involuntary bankruptcy or made an assignment for the benefit of creditors? Yes ___ No___ If yes, Date_____

i) Are you a co-maker or endorser on a note? Yes _____ No _____
If yes, amount(s) $_____ Comments_____

j) Are you a party to a law suit? Yes _____ No _____ If yes, Plaintiff _____
Defendant_____ Comments _____
_____

REPRESENTATION AND AUTHORIZATION: The undersigned applies for the assistance in this application; and further represents that all statements and information made or contained in this application and any accompanying statements or information are true, accurate and complete and are made for the purpose of obtaining the assistance. All information requested has been disclosed herein. Verification may be obtained from any source named in this application.

The undersigned hereby authorizes any bank, insurance company, pension plan, former employer, current employer, physician, surgeon, hospital, or other health care provider, or any other person, firm or corporation, whether named herein or otherwise, having any personal information regarding my finances, former employment, current employment, health, medical, dental or optical treatment, insurance or pension entitlements, death benefits, or other personal information, to disclose the same and provide copies thereof to any agent or representative of The Volunteer and Exempt Firemen's Benevolent Association of Freeport, New York, and I release and discharge any such person, firm or corporation from any liability whatsoever in doing so.

The applicant expressly agrees that any money received by the applicant from a provider or otherwise due to insurance coverage or otherwise in connection with the subject matter of this application up to the amount provided on behalf of the applicant by the Volunteer and Exempt Firemen's Benevolent Association of Freeport, N.Y. shall be paid to said Association upon receipt.

The original or a copy of this application and any verifications or copies of same shall be retained by the Association, even if the assistance requested is not approved.

Date_____ Applicant_____

Sworn to before me, under penalty of perjury,
this day of , 20

_____
Notary Public
4/18

DOCTOR'S CERTIFICATION

The Doctor's Statement must be filled in completely:

1. Applicant's Name_____
   First Middle Last

2. Age _____

3. Male _____ Female _____

4. Diagnosis/Analysis:_____
   a) Applicant's symptions_____
   _____
   b) Objective findings_____
   _____

5. Enter dates for the following:

   a) In your opinion, did the applicant/patient present with a disability as defined below?
   Yes _____ No _____

   b) If yes, date disability commenced _____
   date disability ended or expected to end _____

   c) Is disability: total _____partial _____ permanent _____ temporary _____

   d) Date of your first treatment for this disability _____
   Month Day Year

   e) Date of your most recent treatment for this disability _____
   Month Day Year

NOTE: Definitions Of disabled –

impaired, incapacity, or unable, as a result of illness, disease, disorder, other pathological condition or injury, to discharge any normal physical or mental function, and which significantly or substantially limits one or more major life activities, whether permanently or temporarily and whether totally or partially, and requiring therapeutic, corrective, rehabilitative or other prescribed treatment or the use pf prescribed medication or device or devices.

A physical or physiological impairment includes, but is not limited to cosmetic disfigurement or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genito-urinary, immune, circulatory, hemic, lymphatic, skin or endocrine.

A mental impairment includes, but is not limited to mental or psychological disorder such as mental retardation, organic brain syndrome, emotional or mental illness or learning disability.

Major life activities include, but are not limited to caring for oneself, performing manual tasks, seeing, hearing, eating sleeping, walking standing, sitting, reaching, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, interacting with others and working.

6. Applicant Hospitalized? Yes ____ No_____ From _____To _____

   Name and address of Hospital _____
   _____

7. Operation indicated? Yes _____ No _____

a) type _____

b) date _____

8. Remarks (attach additional sheet if necessary)_____

_____

_____

9. I affirm that I am a _____
Physician, Podiatrist, Chiropractor, Dentist

licensed in the state of _____ License No. _____

Doctor's Signature_____

Doctor's Name (Please print)

Office address _____
No. Street Town State Zip

Telephone No. _____

Date_____