VOLUNTEER & EXEMPT FIREMEN'S BENEVOLENT ASSOCIATION OF FREEPORT, NEW YORK
416 Atlantic Avenue, Freeport, New York 11520
Application for Assistance-Vision
January 1, 2023 -December 31, 2024

Name:_____ E-mail:_____
Address: _____ Telephone No.:_____
Copy of Prescription Attached: Yes _____No_____
Copy of Paid Bill Attached: Yes _____ No_____
Insurance Covering Eye Care: Yes _____ No_____
If Yes, Company Name: _____
Company Address:_____
Company Tel. No.: _____
Policy No.:_____
Amount of Insurance Payment/Reimbursement:_____ Amount Paid Out of Pocket:_____
Employer (Current or Former)Name: _____
Employer Address: _____
Employer Tel. No. _____
Currently Employed: _____Retired:_____
Benefit from other source, including another Benevolent Association (not this Association): Yes_____No_____
If Yes, Explanation_____

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

_____
Notary Public

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PROVIDER PLEASE COMPLETE ALL INFORMATION

Patient's Name:_____
Address: _____
Prescription for Corrective Lenses Written? Yes_____ No_____.
Diagnosis: _____
Does Uncorrected Vision Constitute: (Please check one for each of (a), (b) and (c)
(a) Impaired Vision* Yes _____No _____
(b) Total Loss of Vision Yes_____No_____
(c) Partial Loss of Vision Yes_____No_____
Ophthalmologist_____ Optician_____Other (specify)_____
License No.: _____State of License:_____
Provider Name: _____ Tel. No.: _____
Address:_____

Date:_____ Signature: _____
Print Name: _____

*impaired, incapacitated, or unable, as a result of illness, disease, disorder, other pathological condition or injury, to discharge any normal physical or mental function, whether permanently or temporarily and whether totally or partially, requiring therapeutic, corrective, rehabilitative or other prescribed treatment or the use of prescribed medication or device or devices.

Return completed/signed Form plus Supporting Documents to the Association at the address listed above.

11/20