VOLUNTEER & EXEMPT FIREMEN'S BENEVOLENT ASSOCIATION OF FREEPORT, NEW YORK
416 Atlantic Avenue, Freeport, New York 11520
Application for Assistance-Vision
January 1, 2019 -December 31, 2020

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:______________
Employer (Current or Former)Name: ______________________________
Employer Address: ______________________________
Employer Tel. No. ______________________________
Currently Employed: ______________ Retired:______________
Benefit from other source, including Benevolent 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

PROVIDER PLEASE COMPLETE ALL INFORMATION

Patient's Name:______________________________
Address: ______________________________
Diagnosis: ______________________________
Prescription for Corrective LensesWritten? Yes______ No______.
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.

10/18