NEW YORK STATE | Military and Naval Affairs

Application for World Trade Center Accidental Disability Presumption

DMNA 911-B

New York Division of Military and Naval Affairs
330 Old Niskayuna Road
Latham New York 12110-3514

Received Date
DMNA Use Only

Military ID Number (if available)

☐☐☐☐☐☐☐☐☐☐

Social Security Number [last 4 digits]

XXX-XX- ☐☐☐☐

Please return this application to DMNA in an envelope marked "Personal and Confidential 9/11 Claim"

INSTRUCTIONS: Please type or print clearly in blue or black ink. The application must be signed on the reverse side.

INFORMATION ABOUT YOU (The Service Member)	
1. Name: (First, Middle Initial, Last)	2. Date of Birth:
3. Address: (Including Street, House or Apt #, City, State and Zip Code)	4. Telephone Numbers: HOME( ) WORK ( ) CELL ( )
5. Current Employer: (If retired, last employer)	6.Military Retirement Date:
7. I am permanently disabled because of the following condition or impairment of health: (Use additional sheets if required)	
8. Have you filed an Application for World Trade Center Notice? (Form DMNA 911-A or DMNA 911-A2) Yes ☐ No ☐	

YOU MUST HAVE FILED A WORLD TRADE CENTER NOTICE BY SEPTEMBER 11, 2026:

Medical Record Information prior to September 11, 2001

9. I HAVE BEEN TREATED BY THE FOLLOWING DOCTORS: (Use DMNA Form 9/11-H if additional sheets are required)		
Primary Care Physician:	Doctor:	Doctor:
Internal Med/Family Practitioner:	Medical Specialty:	Medical Specialty:
Address:	Address:	Address:

10. LIST HOSPITILIZATIONS, IF ANY: (Use DMNA Form 9/11-H if additional sheets are required)			
Hospital:	Dates of Admission:	Hospital:	Dates of Admission:
Street:		Street:	
City, State and Zip Code:		City, State and Zip Code:	

IMPORTANT – You must complete other side

Medical Record Information after September 11, 2001

11. I HAVE BEEN TREATED BY THE FOLLOWING DOCTORS: (Use DMNA Form 9/11-H if additional sheets are required)		
Primary Care Physician:	Doctor:	Doctor:
Internal Med/Family Practitioner:	Medical Specialty:	Medical Specialty:
Street:	Street:	Street:
City, State and Zip Code:	City, State and Zip Code:	City, State and Zip Code:
Doctor:	Doctor:	Doctor:
Medical Specialty:	Medical Specialty:	Medical Specialty:
Street:	Street:	Street:
City, State and Zip Code:	City, State and Zip Code:	City, State and Zip Code:

12. LIST HOSPITILIZATIONS, IF ANY: (Use DMNA Form 9/11-H if additional sheets are required)			
Hospital:	Dates of Admission:	Hospital:	Dates of Admission:
Street:		Street:	
City, State and Zip Code:		City, State and Zip Code:	

13. INFORMATION ABOUT YOUR INTENDED BENEFICIARY:	
Beneficiary:	Relationship to you (if any)
Street:	Date of Birth:
City, State, and Zip Code:	

I certify that the information on my application is true and complete to the best of my knowledge. I further certify that I am aware that any false statement I knowingly make or permit to be made on this or any record of the Division of Military and Naval Affairs constitutes a crime punishable by potential incarceration and other sanctions.

_____ _____

Applicant Name/Title (Please Print) Applicant Signature (Sign Name in Full/Date)

RELATIONSHIP TO MEMBER: ☐ Self ☐ Personal Representative ☐ Other _____

(If applicant is not the service member, you must submit original documentation that authorizes you to file.)

***Social Security Disclosure Requirement**
In accordance with the Federal Privacy Act of 1974, you are hereby advised that disclosure of your Social Security account number is voluntary. Disclosure will be used in the processing and verification of the data supplied to determine eligibility for benefits. However, failure to submit requested data may delay or prevent further processing of this application.

Personal Privacy Protection Law
The Division of Military and Naval Affairs is required by law to maintain records to determine eligibility for benefits. Failure to provide information may interfere with the timely payment of benefits. The Division may be required to provide certain information to participating employers.