NEW YORK STATE | Military and Naval Affairs

Application for World Trade Center Notice DMNA 911-I

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 review the following statements and initial where indicated. This form must be notarized.

☐ Initials

I Understand the submission of this claim authorizes the Division of Military and Naval Affairs (DMNA) to collect this information in accordance with New York State Law and HIPAA. Consistent with that understanding, **I Consent** to the disclosure of any records or information relating to my claim, and **I Further Authorize** such disclosure for purposes of determining qualification and/or compensation of my claim to: agency contractors assisting in the administration of DMNA's claims review processes; other state, federal, or local agencies; and other individuals or entities having information related to the claim, such as physicians, medical service providers, insurers, and employers.

☐ Initials

I Certify that the information provided in this application and any documents provided in support of this claim are true and accurate to the best of my knowledge, and I declare under penalty of perjury that the foregoing is true and correct. **I Understand** that false statements or claims made in connection with the application may result in fines, imprisonment and/or any other remedy available by law, and that claims that appear to be potentially fraudulent or to contain false information will be forwarded to federal, state, and local law enforcement authorities for possible investigation and prosecution.

☐ Initials

I Authorize DMNA to obtain any information relating to my claim for benefits under New York State Military Law Section 217 for the purpose of evaluating my claim for compensation from: individuals; employers; hospitals; medical service providers; other state, federal, or local agencies; or other sources having information relating to my claim. This information may include, but is not limited to, medical, government, and financial information (including pension records, pension files, or pension information) about me or the individual whom I represent.

☐ Initials

I Further Authorize individuals, entities, and federal, state and local agencies having information pertinent to my claim, to release such information to DMNA, regardless of any previous agreement to the contrary. Copies of this authorization that show my signature are as valid as the original release signed by me. I acknowledge that I have the right to revoke this Authorization at any time, except to the extent that DMNA and the entities listed above have already acted based on this Authorization. I understand that the knowing and willful request for, or acquisition of, a record pertaining to an individual under false pretenses is a criminal offense subject to a $5,000 fine.

IMPORTANT – You must complete other side

For claimants with an attorney or other authorized representative or alternative contact, please initial in acknowledgment of the following:

Initials

I Authorize the Division of Military and Naval Affairs to contact my attorney or other persons authorized to act on my behalf.

For claimants filing on behalf of an individual, please initial in acknowledgment of the following:

Initials

I Certify that I have provided the required Notice of Filing of Claim to all of the decedent's living relatives and potentially interested parties by either personal delivery or certified mail, return receipt requested, and that I am not aware of anyone else to whom such notice should be provided.

Signature of Claimant or Authorized Representative

Date (mm/dd/year)

Print Name

ACKNOWLEDGEMENT TO BE COMPLETED BY A NOTARY PUBLIC

State of _____
County of _____
On the _____ day of _____ in the year _____ before me, the undersigned, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

_____
NOTARY PUBLIC (Please sign and affix stamp)