



**NYCPD Veterans Foundation**  
**P.O. Box 1013**  
**Lecanto, FL 34460**

# Surviving Spouse Benefit Application

## Personal Information (Surviving Spouse)

First Name	M.I.	Last Name	Social Security Number	Phone Number
Street Address		City	State	Zip Code
Do you have minor children under 18: _____		If Yes, how many: _____	Have you remarried: _____	Your Date of Birth: ____/____/____

## Deceased Spouse Information

First Name	M.I.	Last Name	Social Security Number	Date of Death
Date Retired from NYPD: ____/____/____		Tax Registry Number: _____	Last Command: _____	

## Health Care Information

Provider: _____	Providers Phone: _____	Contact Name: _____	Next Payment Due Date: ____/____/____
ID#: _____	Network: _____	Category: _____	Other #'s (Describe): _____

## Financial Inquiry Section

## Reference Section

<p>If approved, how much are you applying for to meet your health care needs? \$ _____</p> <p>Can you comfortably pay any portion of your health care coverage? \$ _____</p> <hr/> <p style="text-align: center;"><b>Annual Income</b></p> <p>Social Security (Without Medicare Premiums) and/or Railroad Retirement \$ _____</p> <p>Pensions and Annuities \$ _____</p> <p>Other Income (Rental, IRA, Wages, Capital Gains, Business etc.) \$ _____</p> <p>Interest and Dividends \$ _____</p> <p>Total Income \$ _____</p>	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%;">Name</td> <td style="width:20%;">Phone</td> <td style="width:30%;">Relationship</td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> <tr> <td>Name</td> <td>Phone</td> <td>Relationship</td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> <tr> <td>Name</td> <td>Phone</td> <td>Relationship</td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </table> <div style="background-color: #e0e0e0; padding: 5px;"> <p><b>For Official Use Only</b> Case Number: <input style="width: 100px;" type="text"/></p> <p><input type="checkbox"/> Approved Date: ____/____/____</p> <p><input type="checkbox"/> Disapproved Date: ____/____/____</p> <p>Reason for Disapproval: _____</p> <p>Investigator: _____</p> <p style="text-align: center;">Use additional paper if necessary to Complete investigation</p> </div>	Name	Phone	Relationship				Name	Phone	Relationship				Name	Phone	Relationship			
Name	Phone	Relationship																	
Name	Phone	Relationship																	
Name	Phone	Relationship																	

## Certification

I certify that to the best of my knowledge, the information provided in this application is the most current and correct. I have completed this application with the understanding that this application and the information provided by me is now the property of the foundation. I further understand that if my financial status should change during the processing of this application, I am duty bound to notify the Foundation at the earliest convenience.

Applicants Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

<div style="border: 2px solid black; border-radius: 50%; width: 150px; height: 100px; margin: auto; display: flex; align-items: center; justify-content: center;"> <p style="text-align: center;">Application Must be Notarized</p> </div>	<p>Subscribed and sworn to before me this _____ day of _____, 20____</p> <p>_____ (Seal)</p> <p>My Commission Expires _____</p>
--	---

How did you hear about the NYCPD Veterans Foundation: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

This application shall have a life term of one year. If applicant continues to be in need of further financial assistance for health care, than applicant must resubmit an updated application for each subsequent year thereafter.

The Foundation would appreciate a good faith testimonial letter from all who receive awards, although there is no obligation nor will your decision be part of the scoring.

If you agree to submitting a letter please check this box if not leave it blank.