

REQUEST FOR MAILING OF DUPLICATE TAX BILLS OR STATEMENTS OF UNPAID TAXES TO A THIRD-PARTY

MAIL TO:
TAX COLLECTING OFFICER

JENNIFER MONTIGLIO, RECEIVER OF TAXES
TOWN OF BABYLON
200 E. SUNRISE HIGHWAY
LINDENHURST, NEW YORK 11757

I request that a duplicate of my tax bill or statement of unpaid taxes with respect to my property as described below be mailed to the person whom I have designated. There is no legal or financial obligation on the part of the third-party.

In making this request, I understand that neither the tax collecting officer nor any local government employee has any liability if for any reason the duplicate is not mailed to or not received by my designee.

1. _____ YOUR NAME (LAST NAME FIRST)				
2. _____ PHYSICAL ADDRESS				
3. _____ CITY	4. _____ STATE	5. _____ ZIP CODE		
DISTRICT [][][][]	SECTION [][][]	BLOCK [][][]	LOT [][][][]	
6. COUNTY TAX MAP NUMBER [][] - [][][][][][][][]		7. ITEM NUMBER [][] - [][][][][][][][]		
8. _____ TAX BILLING ADDRESS (IF DIFFERENT FROM #2 ABOVE)		9. _____ SIGNATURE		_____ DATE
THIS SECTION TO BE COMPLETED BY THIRD PARTY				
1. _____ THIRD-PARTY NAME (LAST NAME FIRST)				
2. _____ MAILING ADDRESS				
3. _____ CITY	4. _____ STATE	5. _____ ZIP CODE		
6. _____ TELEPHONE				
7. _____ THIRD-PARTY SIGNATURE		_____ DATE		

THE APPLICANT IS:

(Check One)

at least 65 years of age

OR

Disabled

If disabled, have physician complete section below, or if applicant is legally blind, you may substitute a certificate from the State Commission for the Blind.

**PHYSICIAN'S CERTIFICATION OF
PHYSICAL OR MENTAL DISABILITY**

Physician's name _____

Office Address _____

New York State License No. _____ Date of Issue _____

Patient's Name _____

Patient's Address _____

a) Does patient have a physical or mental impairment which substantially limits one or more major life activities (e.g. walking) _____ Yes _____ No

b) If yes, note whether physical or mental and give description of patients's disability

I certify that all statements made in this section are true and correct to the best of my knowledge and professional belief.

DATE

SIGNATURE OF PHYSICIAN