CITY OF WHITE PLAINS
DEPARTMENT OF FINANCE
255 Main Street • White Plains, New York 10601
(914) 422-1248/9 • Fax: (914) 422-1236

THIRD PARTY NOTIFICATION

If you are either 65 years of age or older or disabled and you own and occupy a 1,2, or 3 family residence, you may designate a consenting adult third party to receive duplicate copies of your tax bills and notices of unpaid taxes until further notice.

To designate a consenting adult third party to receive duplicate copies of your tax bills and notices of unpaid taxes, this application must be completed and filed with the Commissioner of Finance at the above address.

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

I request that a duplicate of any tax bill or statement of unpaid taxes with respect to my property as described below be mailed to the person whom I have designated.

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

THIS SECTION TO BE COMPLETED BY PROPERTY OWNER

1. Account Number (section,block,lot) ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

2. Name_____
Last First

3. Property Address_____
Street City State Zip Code

4. Tax Billing Address (if different from above)_____

5. Applicant is (check one): ____ at least 65 years of age ____ disabled*

6. _____
Applicant's Signature Date

THIS SECTION TO BE COMPLETED BY THIRD PARTY

1. Party Name_____
Last First

2. Mailing Address_____
Street City State Zip Code

3. Telephone Number_____

4. _____
Third Party Signature Date

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

PHYSICIANS CERTIFICATION OF PHYSICAL OR MENTAL DISABILITY

1. Physician's Name_____

2. Office Address_____

3. New York State License No._____

4. Patient's Name_____

5. Patient's Address_____

6. Does patient have a physical or mental impairment which substantialy limits one or more major life activities (e.g., walking)? _____ yes _____ No

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

_____
Signature of Physician Date