



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

Mail to:

(Tax Collecting Officer's Name and Address)

TOWN OF BEDFORD TAX RECEIVER  
321 BEDFORD RD.  
BEDFORD HILLS, NY 10507

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.

- I am:  At least 65 years of age  
or  
 Disabled

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

1. \_\_\_\_\_  
Your name (last name first)

2. \_\_\_\_\_  
Mailing address

\_\_\_\_\_ Zip code

3. \_\_\_\_\_  
Property Identification no. (see tax bill or assessment roll)

4. \_\_\_\_\_  
Tax billing address (if different from #2, above)

\_\_\_\_\_

5. \_\_\_\_\_ Signature \_\_\_\_\_ Date

**THIS SECTION TO BE COMPLETED BY THIRD PARTY**

1. \_\_\_\_\_  
Third party name (last name first)

2. \_\_\_\_\_  
Mailing address

\_\_\_\_\_ Zip code

3. \_\_\_\_\_ Day telephone no. \_\_\_\_\_ Evening telephone no.

4. \_\_\_\_\_ Third party signature \_\_\_\_\_ Date

**PHYSICIANS' CERTIFICATION FOR APPLICATIONS MADE ON BEHALF OF  
AGED OR DISABLED PERSONS**

\_\_\_\_\_  
Physician's name                      New York State license no.                      Date of issue

\_\_\_\_\_  
Physician's office address  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Patient's name  
\_\_\_\_\_  
Patient's address  
\_\_\_\_\_

Does patient have a physical or mental impairment which substantially limits on or more major life activities (e.g., walking)?  
\_\_\_\_\_ Yes                      \_\_\_\_\_ No

Describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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