



# CONNECTICUT STATE FIREFIGHTERS ASSOCIATION

## TOTAL AND PERMANENT DISABILITY BENEFIT CLAIM FORM (2025 Edition)

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### SECTION 1 – CLAIMANT INFORMATION

**Name of Claimant:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City/Town:** \_\_\_\_\_ **State:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_

**Fire Department / Fire Company:** \_\_\_\_\_

**Employment Status (check one):**

Volunteer Firefighter  
 Career Firefighter

**Employer (if career firefighter):** \_\_\_\_\_

**Member in Good Standing with CSFA:**  Yes  No

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### SECTION 2 – INJURY / OCCUPATIONAL ILLNESS HISTORY

**Original Line-of-Duty Injury or Occupational Illness Date:**

\_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Brief description of original incident or condition. Attach additional files if necessary:**

**Has this condition been previously subject to an Injury/Disability claim?**

Yes  No

If yes, provide approximate date(s): \_\_\_\_\_

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## **SECTION 3 – CLAIM OF TOTAL AND PERMANENT DISABILITY**

The claimant asserts that, as a result of the above-referenced injury or occupational illness:

- They are **totally and permanently disabled**
- They are **no longer capable of performing the essential duties of a firefighter**
- The condition is **permanent, irreversible, and not expected to improve**

**Date claimant ceased all firefighting duties:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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## **SECTION 4 – REQUIRED SUPPORTING DOCUMENTATION**

This application **will not be processed** unless the following documentation is submitted and verified.

### **All Claimants (Required):**

- Physician's certification stating total and permanent disability
- Medical records supporting permanent disability determination
- Completed Physician's Certification (Section 6)

### **Volunteer Firefighters (Required):**

- Letter from Fire Chief certifying permanent inability to serve
- Letter from municipality or governing authority acknowledging permanent removal from service

### **Career Firefighters (Required):**

- Official documentation of **medical retirement, disability retirement, or separation due to medical incapacity**
- Employer or pension authority documentation confirming permanent disability status

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## **SECTION 5 – CERTIFICATION OF FIRE DEPARTMENT**

I hereby certify that \_\_\_\_\_, a member of this department, is no longer capable of performing firefighting duties due to a permanent and disabling condition and has been removed from all firefighting responsibilities.

**Fire Department in Good Standing with CSFA:**  Yes  No

**Member in Good Standing at Time of Disability:**  Yes  No

**Signature of Fire Chief or Authorized Officer:** \_\_\_\_\_  
**Title:** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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## **SECTION 6 – PHYSICIAN’S CERTIFICATION OF TOTAL AND PERMANENT DISABILITY**

I hereby certify that **Mr./Ms.** \_\_\_\_\_, a member of the \_\_\_\_\_ Fire Department, is **totally and permanently disabled** as defined below:

- The condition **prevents** performance of all essential firefighting duties
- The condition is **permanent and irreversible**
- The condition is **directly related to line-of-duty service**

**Primary diagnosis:** \_\_\_\_\_

**Date of determination of permanent disability:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### **Medical Opinion**

Based upon my examination, testing, and medical judgment, the claimant will **never be able to return to firefighting duties in any capacity**.

**Physician Signature:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_

**License Number:** \_\_\_\_\_

**Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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## **SECTION 7 – CLAIMANT ATTESTATION AND LEGAL ACKNOWLEDGMENT**

I hereby affirm under penalty of law that:

- All statements made in this application are true and complete
- I understand that this determination is **final and binding**
- I acknowledge that future employment as a firefighter may invalidate benefits

I further authorize the Connecticut State Firefighters Association to obtain and verify any records necessary to adjudicate this claim.

**Signature of Claimant:** \_\_\_\_\_

**Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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## **SECTION 8 – ASSOCIATION DETERMINATION**

The Connecticut State Firefighters Association hereby determines that the claimant:

Meets the criteria for **Total and Permanent Disability Benefits**  
 Does **not** meet the criteria (see attached findings)

This determination is based upon verified documentation, medical certification, and departmental confirmation.

**Date of Determination:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Secretary Signature:** \_\_\_\_\_

**President Signature:** \_\_\_\_\_

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## **SECTION 9 – FRAUD WARNING**

Any person who knowingly submits false, incomplete, or misleading information in support of this claim may be subject to civil penalties, restitution, and criminal prosecution under Connecticut law.

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## **SECTION 10 – DOCUMENT SUBMISSION**

Submit completed forms and all required documentation to:

**Connecticut State Firefighters Association**

**34 Perimeter Rd.**

**Windsor Locks, CT 06096**

**Email:** [secretary@csfa.org](mailto:secretary@csfa.org)