



# 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:

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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)