

Total Days of Disability

Total Days of Disability: _____

(Sundays omitted for volunteer firefighters)

(Saturdays and Sundays omitted for career firefighters)

Circumstances and nature of line-of-duty activity which caused the disability:

(Describe fully)

Claimant Attestation

I certify that the above statements are true and correct to the best of my knowledge.

Signature of Claimant: _____ **Date:** ____ / ____ / ____

SECTION 3 – INFORMATION RELEASE AUTHORIZATION

If you **do not** want this claim information released to any entity upon request, check below:

☐ **Do NOT release claim information**

Otherwise, I authorize any physician, hospital, employer, insurance company, municipality, or agency to release any information necessary for processing this claim. A photocopy of this authorization is as valid as the original.

Claimant Signature: _____ **Date:** ____ / ____ / ____

SECTION 4 – CERTIFICATION OF FIRE DEPARTMENT

It is hereby certified that the facts stated above by the claimant have been investigated and found true and correct.

Department in Good Standing: ☐ Yes ☐ No

Claimant in Good Standing: ☐ Yes ☐ No

Signature of Chief or Authorized Officer: _____
Title: _____ Date: ____ / ____ / ____

SECTION 5 – PHYSICIAN’S CERTIFICATION

I certify that Mr./Ms. _____, a member of the
_____ Fire Department, has been under my care for:

☐ Injury ☐ Occupational Illness

Injury/Illness Date: ____ / ____ / ____

Period unable to perform regular duties:

From ____ / ____ / ____ to ____ / ____ / ____

Nature and extent of disability (clinical findings):

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Signature of Physician: _____

Physician’s Name (Printed): _____

Date: ____ / ____ / ____

SECTION 6 – ASSOCIATION CERTIFICATION

It is hereby certified that the claimant and department are recognized members of the
Connecticut State Firefighters Association in good standing and that all dues and assessments
have been paid. The facts presented constitute due proof of eligibility for benefits.

Benefit Calculation (Updated 2025 Rates)

- **Career Firefighters:** \$27.00 per eligible day
- **Volunteer Firefighters:** \$33.00 per eligible day

The State Comptroller is requested to draw an order on the State Treasurer for:

\$ _____ based upon disability of _____ days at the applicable daily
rate.

Date Application Approved: ____ / ____ / ____

Secretary Signature: _____

President Signature: _____

SECTION 7 – MANDATORY FRAUD WARNING

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

SECTION 8 – HIPAA-COMPLIANT MEDICAL INFORMATION RELEASE

I authorize release of all medical records relating to this injury or illness, including diagnosis, treatment notes, and disability status, to the Connecticut State Firefighters Association solely for purposes of evaluating this claim. This authorization expires one year from the date below unless revoked in writing.

Signature of Claimant: _____

Date: ____ / ____ / ____

SECTION 9 – DOCUMENT SUBMISSION

Submit completed forms to:
Connecticut State Firefighters Association
34 Perimeter Rd.
Windsor Locks, CT 06096

Email: secretary@csfa.org