CONNECTICUT STATE FIREFIGHTERS ASSOCIATION

TOTAL AND PERMANENT DISABILITY BENEFIT CLAIM FORM (2025 Edition)

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

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): _____

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: ____ / ____ / _____

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:** ____ / ____ / _____

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: ____ / ____ / _____

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: ____ / ____ / _____

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: _____

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.

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