

CONNECTICUT FIREFIGHTER CANCER RELIEF FUND

CLAIM APPLICATION



SECTION 1 – CLAIMANT INFORMATION

Name of Claimant: _____

Date of Birth: ____ / ____ / ____

Street Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Status (check one):

Volunteer
Career

Retired
Fire Marshal / Inspector / Investigator

SECTION 2 – FIRE DEPARTMENT / AGENCY INFORMATION

Name of Fire Department / Agency: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

County: _____

Work Phone: _____

Fire Chief / Agency Director: _____

SECTION 3 – CANCER DIAGNOSIS ELIGIBILITY

Cancer diagnosis meets the conditions referenced in **Public Act 16-10, Section 5(b)**, including cancer affecting one or more of the following systems:

Brain	Skin	Skeletal	Digestive	Endocrine
Respiratory	Lymphatic	Reproductive	Urinary	Hematological

Resulting in:

Death	Temporary Total Disability
Permanent Total Disability	Partial Disability

Does the diagnosis meet the statutory conditions above?

Yes No

SECTION 4 – OTHER BENEFITS DISCLOSURE

I am receiving Workers' Compensation for this claim *

I have an employer-sponsored **supplemental insurance policy** and am collecting benefits from this policy *

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Claimant's annual salary at the time of diagnosis: \$ _____

** Additional information may be requested.*

SECTION 5 – CLAIMANT CERTIFICATION

I hereby certify that the above information is true and correct to the best of my knowledge.

Claimant Signature: _____

Date: ____ / ____ / ____

SECTION 6 – CERTIFICATE OF PHYSICIAN

I hereby certify that _____, of _____ (Hospital / Medical Organization), is under my care for _____ cancer and is incapacitated from attending to their regular duties as a firefighter.

Date incapacitation began: ____ / ____ / ____

Medical Certification

The claimant is currently undergoing medical treatment and is experiencing symptoms and/or side effects that impair their ability to perform firefighting duties.

Attending Physician Name (Printed): _____

Physician Signature: _____

Physician ID #: _____

Tax ID #: _____

Date: ____ / ____ / ____

SECTION 7 – CERTIFICATE OF FIRE DEPARTMENT / AGENCY

It is hereby certified that the facts given above by the claimant have been investigated and found to be true and correct, with the following exceptions, if any:

Member Status (check all that apply):

- Member was an Interior Structural Firefighter
- Member is a Fire Marshal / DFM / Fire Investigator / Fire Inspector
- Member was in good standing for at least five (5) years
- If retired, member's last date of active service: ____ / ____ / ____

Date: ____ / ____ / ____

Fire Chief / Agency Director (Printed): _____

Signature: _____

SECTION 8 – SUBMISSION INSTRUCTIONS

One copy of the **Connecticut Firefighter Cancer Relief Fund Claim Application** shall be submitted electronically to FFCancerRelief@ct.gov.

The original shall be submitted to:

Connecticut State Firefighters Association
34 Perimeter Road
Windsor Locks, CT 06096
Attn: Cancer Relief

Upon approval, the original will be submitted by the CSFA Secretary to the Office of the State Comptroller in Hartford. A copy will be retained by the CSFA Secretary.