



CONNECTICUT STATE FIREFIGHTERS ASSOCIATION

DEATH BENEFIT CLAIM FORM

SECTION 1 – DECEASED MEMBER INFORMATION

Name of Deceased Member: _____

Address: _____

City/Town: _____ State: _____ ZIP: _____

Fire Department / Fire Company: _____

Member in Good Standing: Yes No

Line-of-Duty Incident Date: ____ / ____ / ____

Attach a copy of the official death certificate.

Nature and Circumstances of Injury, Illness, or Line-of-Duty Event

(Provide a full description including how the death was service connected.)

Date of Death: ____ / ____ / ____

SECTION 2 – BENEFICIARY INFORMATION

Primary Beneficiary (Entitled to Benefit) or Guardian for Minor Children

Name: _____

Address: _____

Status of Beneficiary (check all that apply):

- Widow / Widower
- Dependent Parent(s)
- Legally Appointed Guardian
- Executive Committee (no surviving eligible beneficiaries)

SECTION 3 – DEPENDENT CHILDREN (UNDER AGE 18)

(Attach a copy of each child's birth certificate)

Child's Name	Date of Birth	Name of School Attending (if applicable)

If there are **no children under age 18**, list any **surviving children over age 18** here (for record only):

SECTION 4 – CERTIFICATION OF FIRE DEPARTMENT

I hereby certify that the deceased member and this department were in good standing with the Connecticut State Firefighters Association at the time of death, and that the information provided above has been reviewed, verified, and found to be true and correct.

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

SECTION 5 – PHYSICIAN'S CERTIFICATION

I hereby certify that **Mr./Ms.** _____, a member of the _____ Fire Department, contracted an injury or illness during the performance of fire duty on ____ / ____ / _____, which directly resulted in the death that occurred on ____ / ____ / _____.

The following medical conclusions are based upon my examination of the deceased on ___ / ___ / ____, and review of medical records.

Cause of Death / Line-of-Duty Certification

(Describe the medical cause of death and relationship to line-of-duty service.)

Attending Physician Signature: _____

Printed Name: _____ **Date:** ___ / ___ / ____

SECTION 6 – ASSOCIATION CERTIFICATION

It is hereby certified that the deceased member and department were in good standing with the Connecticut State Firefighters Association, and that all dues and assessments were paid as required.

The facts established above constitute due proof of eligibility for benefits.

In accordance with the current CSFA benefit schedule, the State Comptroller is requested to draw an order on the State Treasurer for:

Benefit Amounts

- **Death Benefit:** \$ _____
- **Funeral Expense:** \$ _____
- **Children (under age 18):** \$ _____ each at the rate of \$14.00 per week

Date claim was received by the Secretary: ___ / ___ / ____

Secretary Signature: _____

President Signature: _____

SECTION 7 – EXECUTIVE COMMITTEE APPROVAL (WHEN REQUIRED)

Check applicable reason for Executive Committee approval:

- Special details in the line of duty
- Member's children under 18 attending accredited school (list names and schools)
- No dependent children under 18 – benefits assigned to Executive Committee
- Verification of 30-day claim period due to special circumstances
- Officer signature withheld due to conflict; see attached explanation

State date when action was taken: ____ / ____ / ____

Signature – Secretary, Executive Committee: _____

Date: ____ / ____ / ____

SECTION 8 – FRAUD WARNING

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

SECTION 9 – DOCUMENT SUBMISSION

Submit completed forms and all required documentation to:

Email: claims@csfa.org

OR

**Connecticut State Firefighters Association
34 Perimeter Rd.
Windsor Locks, CT 06096**