



CONNECTICUT STATE FIREFIGHTERS ASSOCIATION

INJURY / DISABILITY BENEFIT CLAIM FORM

(Replaces Form 201)

This form is PDF fillable.

IMPORTANT INSTRUCTIONS

This form is used to **submit a claim to the Connecticut State Firefighters Association (CSFA) that a firefighter has sustained a line-of-duty injury or occupational illness and is filing a claim for benefits.**

- This form **must be submitted within sixty (60) days** of the injury or illness.
- Notification submitted after sixty (60) days **requires review and approval by the Executive Board.**
- **All formal claims must be submitted within one (1) year** of the date of injury or illness.
- Failure to submit a claim within one (1) year **may result in disqualification of benefits.**

DO NOT SUBMIT a First Report of Injury/Notice of Claim Form if you are using this form within the first 60 days.

SECTION 1 – CLAIMANT INFORMATION

Name of Claimant: _____ Age: _____

Rank: _____ Assignment: _____

Address: _____

City/Town: _____ State: _____ ZIP: _____

Fire Department / Fire Company: _____

Employer (if career firefighter): _____

Membership Status (check one):

Volunteer (Compensation \$1,000/year or less)

Career (Compensation over \$1,000/year)

Department/Individual Member in Good Standing: Yes No

SECTION 2 – INCIDENT & INJURY INFORMATION

Date of Line-of-Duty Injury or Occupational Illness: ____ / ____ / ____

Time: _____ a.m. / p.m.

Was the claimant disabled as a result of this incident? Yes No

Period unable to perform regular duties:

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

Is this a recurrence of a previous injury or occupational illness?

Yes No

If yes, year of prior occurrence: _____

Describe circumstances and nature of duty that caused recurrence:

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, attached separate from if needed):

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: claims@csfa.org