



# CONNECTICUT STATE FIREFIGHTERS ASSOCIATION

## INJURY 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.
- Submit a new and updated Injury Claim Form every quarter until the firefighter returns to duty, retires, or files for Total Permanent Disability. Failure to do so will result in lost benefits.

## 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 because of this incident?  Yes  No

Period unable to perform regular duties, off the line, on light duty:

From \_\_\_\_ / \_\_\_\_ / \_\_\_\_ to \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Still out of work:  Yes  No

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 \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Still out of work:  Yes  No

**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](mailto:claims@csfa.org)