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REQUEST FOR BENEFIT CLAIM PAPERS
CONNECTICUT STATE FIREFIGHTERS ASSOCIATION, INC.
P.O. BOX 9
MANSFIELD CENTER. CT. 06250
TEL (860) 423-5799

Please print all information

FIRE DEPT. INFORMATION

Fire Department_____

Address_____ FAX_____ Phone_____

City _____ Zip_____ County_____

Chief _____ Date _____

INSURED FIREFIGHTERS INFORMATION

I hereby make application for benefit claim papers of the Connecticut State Firefighters Association in the name of:

Name: _____ Age:_____

Address:_____ D.O.B._____

City: _____ State_____ Zip_____

Phone: Work _____ Home _____

Company assignment _____ Bureau/Division assignment_____

Please Check Career (☐) Volunteer (☐)

Sick (☐) Hurt (☐) Killed (☐)

INFORMATION ABOUT INJURY

Nature of injury: (State what claimant was doing at the time of injury and what type of bodily injury occurred. Use back of form if necessary.)

_____

_____

_____

Time of incident_____ Date of injury_____

Date put off duty_____ N.F.I.R.S. #_____

TYPE OF CLAIM

Death Claim_____ New claim_____ Continuing Claim_____

FOR OFFICE USE ONLY: Date Received _____

Disposition 1: ( ) Disposition 2: ( ) Disposition 3: ( )