Form 201C
10/18/2022 Rev.

Claim #_____
For Office Use Only

CONNECTICUT FIREFIGHTER CANCER RELIEF FUND
CLAIM APPLICATION

Name of Claimant _____ DOB _____/_____/_____

Street Address _____ City _____ZIP _____

Home Phone _____ Cell Phone _____

Email Address _____

☐ Volunteer ☐ Career ☐ Retired ☐ Fire Marshal/Inspector/Investigator

Name of Fire Department/Agency_____

Street Address _____ City _____ZIP _____

County _____ Email Address _____

Work Phone _____ Fire Chief/Agency Director_____

Cancer diagnosis meets conditions referenced in PA 16-10 Sec. 5(b): Cancer affecting the brain, skin, skeletal system, digestive system, endocrine system, respiratory system, lymphatic system, reproductive system, urinary system or hematological system that results in death, or temporary or permanent total or partial disability.

☐ YES ☐ NO

☐ I am receiving Workers' Compensation for this claim *

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

☐ I have an employee sponsored supplemental insurance policy and I am collecting benefits from this policy*

Claimant's annual salary at time of diagnosis was $ _____.

* Additional information may be requested.

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

➢ Claimant to Sign Here: _____ Date:____/_____/_____

CERTIFICATE OF PHYSICIAN

I hereby certify that _____ of the _____ Organization is under my care for _____ cancer and is incapacitated from attending to their regular duties since ____/_____/____.

_____

_____

_____

Date: ___/___/___ Attending Physician: _____ID # _____

Physician Signature: _____

CERTIFICATE OF 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 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: _____Signature: _____

Note: One copy of the Connecticut Firefighter Cancer Relief Fund (CT FFCRF) Claim Application shall be submitted electronically to FFCancerRelief@ct.gov. The original must be submitted by U.S. Mail to: CSFA Secretary, P.O. Box 9 Mansfield Center, CT 06250. Upon approval, the original will be sent by the CSFA Secretary to the Office of State Comptroller in Hartford. A copy will be made and retained by the CSFA Secretary.

Connecticut FireFighter Cancer Relief Fund
Affidavit

I _____ (Claimant), member of _____ (Department/Agency/Municipality), makes application to the CT Firefighter Cancer Relief Fund per CGS §§ 7-313g -313k and do solemnly affirm the following statements to be true:

1. Claimant passed a physical examination upon entry into service, or subsequent to entry, that failed to reveal any evidence of such disease, and passed annual physicals that failed to reveal any evidence of cancer or propensity for cancer.

2. Claimant worked or volunteered at a Fire Department/Agency/Municipality for at least five years since February 1, 2017.

3. Claimant has not used any cigarettes or any other tobacco products within 15 years of applying for benefits.

4. Claimant has a disease that is identified in PA 16-10, § 5, §§ b, cancer affecting the brain, skin, skeletal system, digestive system, endocrine system, respiratory system, lymphatic system, reproductive system, urinary system or hematological system.

5. Claimant met the definition of firefighter and is either a fire marshal, investigator, or inspector or an interior structural firefighter, which is an individual who performs fire suppression, rescue, or both, inside of buildings or enclosed structures that are involved in a fire situation beyond the incipient stage as defined in federal regulations.

6. Claimant complied with Federal Occupational Safety and Health Act (OSHA) standards 1910.134 and 1910.156 for at least five consecutive years.

I solemnly state that the contents of this affidavit are true to the best of my knowledge and belief and that it conceals nothing and that no part of it is false under penalty of perjury.

Claimant _____ _____ _____

Signature Print Date