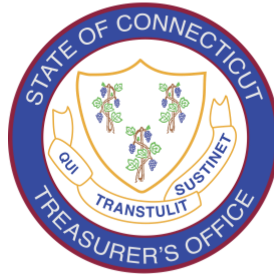
FOR OFFICE USE ONLY
Municipality: ___________________
Firefighter Last Name: ___________
Claimant No.: __________________
Date Claim Received: ____________



FFCRF REIMBURSEMENT (A1)
Rev. 9/16/2024

CONNECTICUT
OFFICE *of the* TREASURER

CONNECTICUT FIREFIGHTER CANCER RELIEF FUND

Municipal Reimbursement Request Form (A1)

This form must be submitted by the municipality. Forms must be submitted to ott.firefighterfund@ct.gov.

Form A1 may be submitted by the municipality multiple times over duration of a claim, but must be associated with completed Eligibility Form A for each firefighter.

Date Reimbursement Form Submitted: ___ / _____ /______

Municipality: ________________________________

State Claimant Number: ________________________________

Name of Firefighter: ____________________________________

Personal or Group Health Insurance Provider: __________________________________ (N/A if none)

Name of Dependent or Spouse, if Applicable: ___________________________________

The Municipal Official submitting this reimbursement request certifies that:

1. _____ Any benefits provided under Public Act 23-204, Section 159 (C.G.S. section 7-313p) and for which reimbursement is requested below were offset by any other benefits a firefighter or such firefighter's dependents may be entitled to receive under state workers' compensation laws or the municipal or state retirement system under which they are covered as a result of any condition or impairment of health caused by occupational cancer resulting in such firefighter's death or permanent total or partial disability.

2. _____ The reimbursements requested below are to cover compensation or benefits pursuant to Public Act 23-204, Section 159 (C.G.S. section 7-313p) not covered by health insurance, specifically costs associated with a firefighter's treatment of cancer that are reasonable or necessary and not covered by such firefighter's personal or group health insurance or State workers' compensation.

3. _____ The compensation and benefits being sought for reimbursement below have been determined and documented to be allowable under the relevant statutes and already have been paid out by the municipality seeking this reimbursement.[5]

4. ______ If the claimed reimbursement relates to a spouse or dependent(s), proper documentation of the relationship and entitlement to a dependent(s) benefit has been secured by the municipality.

I hereby certify that the above information is true and correct to the best of my knowledge and that the municipality has secured supporting documentation to verify each of these requirements.

Municipal Official Print Name: ____

Municipal Official Signature: ______________________________________ Date: _____/______/_____

Title: ____

1. **Out-of-Pocket Costs for Reasonable or Necessary Medical Treatment**

Date of Service	Type of Reasonable or Necessary Treatment/Description of Treatment	Name of Medical Professional/Facility	TOTAL Cost of Treatment on Service Date	Portion of Cost of Treatment Paid by Group Health Insurance	**Total Claimed:** **Out-of-Pocket Treatment Costs Not Covered by Personal or Group Health Insurance (Co-pays and Deductibles)**

2. **Wage Replacement Benefits (Indemnity)**

Please check one:

Wage replacement is for the Firefighter ____ or Spousal/Dependent benefit_____ (skip to section 4 below)

Is this payment expected to be reoccurring? Yes _____ No _______

Has the Firefighter Reached Maximum Medical Improvement? Yes _____ No _______

What is the MMI date and PPD rating/number of weeks? ____

Dates Covered *Itemized by week*	Amount of Weekly Wage Replacement Payment from Municipality in	If applicable, Retirement Offset Amount	Type of Offset *Workers' compensation payment, municipal pension/retirement, state pension/retirement*	**Type of Benefit** **(TP, TT, PPD)**	**Total Claimed:** **Total Wage Replacement Reimbursement Cost Claimed After Offset**

3. **Payment for Lost Time/Mileage**

Date	Description of Payment type (Lost time/Mileage)	Hours Covered and Lost Time *If applicable*	Mileage To/From *Location and purpose*	**Total Claimed**

4. Dependent Benefits

Date of Death: ______/_______/______

Name of Spouse/Dependent: ____

Type of Benefit: ____ [spouse/dependent]

Funeral/Burial Expenses Under C.G.S. Section 31-306 (maximum per statute): ____________________

Dates Covered *Itemized by week*	Weekly Payment from Municipality in the same amount and same manner as Chapter 568 *Attach voluntary agreement, if available*	If applicable, Offset Amount *For entitlements under Chapter 568 or the municipal or state retirement systems*	Type of Offset *Workers' compensation payment, municipal pension/retirement, state pension/retirement*	**Total Claimed:** **Total Spouse/Dependent Replacement Reimbursement Cost Claimed After Offset**

THE MUNICIPALITY IS NOT REQUIRED TO SUBMIT SUPPORTING DOCUMENTATION WITH THIS FORM, BUT SHOULD RETAIN ALL PROPER DOCUMENTATION IN ITS FILE FOR THE DURATION OF THE CLAIM OR OTHERWISE AS REQUIRED BY LAW.