

FOR OFFICE USE ONLY

Municipality: _____

Firefighter Last Name: _____

Claimant No.: _____

Date Claim Received: _____

**FFCRF REIMBURSEMENT (A1)**

Rev. 9/12/2024

**CONNECTICUT
OFFICE *of the* TREASURER****CONNECTICUT FIREFIGHTER CANCER RELIEF FUND
*Municipal Reimbursement Request Form (A1)***

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.

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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)

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2. Wage Replacement Benefits (Indemnity)

Please check one:

Wage replacement is for the Firefighter _____ or Spousal/Dependent benefit _____ (skip to section 3 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? _____

3. Payment for Lost Time/Mileage

Firefighter Last Name: _____
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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	Weekly Payment from Municipality in the same amount and same manner as Chapter 568	If applicable, Offset Amount	Type of Offset	Total Claimed:
<i>Itemized by week</i>				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.