Municipality_____

Firefighter Last Name_____
Claimant No. _____
For Office Use Only
Date Claim Received __/___/__

REIMBURSEMENT RQT (A1)

Rev. 12/1/2025

OFFICE OF THE STATE TREASURER
STATE OF CONNECTICUT

CONNECTICUT FIREFIGHTER CANCER RELIEF FUND
PUBLIC ACT 23-204, Section 159

Municipal or State Employer Reimbursement Request Form (A1)

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

Date Reimbursement Form Submitted ___ / _____ /_____

TOTAL CLAIMED REIMBURSEMENT: _____

This total should be the sum of the totals related to this specific reimbursement request as totaled from all of the tabs of the attached excel sheets, reflected on the first tab

Name of Municipal or State Employer _____

Assigned Office of the Treasurer Claimant Number: _____

Name of Firefighter: _____

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

If applicable:

Name of Dependent or Spouse_____

Date of Claimant's Death: _____

Type of Benefit: _____ [spouse/dependent]

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

Firefighter Last Name _____
Claimant No. _____

The Municipal or State 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 municipal or state employer 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 municipal or state employer.

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

Municipal or State Official Print Name: _____

Municipal or State Official Signature: _____ Date: _____/_____/_____

Title: _____

ATTACHMENT – EXCEL SPREADSHEET WITH CLAIMED REIMBURSEMENTS

THE MUNICIPAL OR STATE EMPLOYER IS NOT REQUIRED TO SUBMIT SUPPORTING DOCUMENTATION WITH THIS FORM ASIDE FROM THE EXCEL SPREADSHEET ITEMIZING THE REIMBURSEMENT, BUT SHOULD RETAIN ALL PROPER DOCUMENTATION IN ITS FILE FOR THE DURATION OF THE CLAIM OR OTHERWISE AS REQUIRED BY LAW.