Colorado Firefighter Heart and Cancer Benefits Trust
Cancer Claim Form

A claim is being filed for the covered cancer type below:

☐ **Skin** ☐ **Digestive** ☐ **Genitourinary** ☐ **Brain** ☐ **Hematological**

Description of the severity of the cancer, including the current cancer stage:

Section I – Member Information (to be completed by the Member Supervisor)

Member Name		Coverage Number (from Memorandum of Coverage)
Member Address		Supervisor's Phone Number
Covered Individual Name	Covered Individual Date of Birth	Covered Individual Social Security Number
Covered Individual Address (Street Address, City, State and ZIP Code)		Covered Individual Phone Number
Date of Diagnosis	Member's Workers' Compensation Carrier and Policy Number:	

Note: Please also include a copy of the Diagnosis Report (if available).

Employer and Covered Individual must attest that eligibility for benefits under this program have been met by certifying the following statements.

The above named Covered Individual:

- Is an active full time (FT), part time (PT), or volunteer (Vol.) firefighter of the department ☐ FT ☐ PT ☐ Vol
- Is a full time with 5 years or part time/volunteer who has at least 10 years of active service (36 hours of training each year) with any fire protection services department ☐ Yes ☐ No
- Was listed on the last census filed with the Trust ☐ Yes ☐ No
  If "no", please explain:
- Performs duties that are directly involved with the provision of fire protection services ☐ Yes ☐ No
- Has not filed a claim or is expected to file a claim under any workers' compensation policy ☐ Yes ☐ No ☐ Unknown
- Has had a physical examination that would have reasonably found covered cancer ☐ Yes ☐ No ☐ Unknown
- To my knowledge has not smoked tobacco products in the past 5 years ☐ Yes ☐ No

I hereby certify that the Covered Individual is a member of the Cancer Award Program under the above referenced Coverage Plan.

_____ _____

Title of Supervisor | Name of Supervisor (please print)

_____ _____

Signature of Commanding Officer | Date Signed

Submit Claim Form to TRISTAR c/o McGriff, Seibels & Williams, Inc. PO Box 1539, Portland, OR 97207-1539
Toll Free: 844-769-6650 Fax: 503-943-6622 Email: claims@cfhtrust.com

Section II – to be completed by Covered Individual

The Covered Individual must attest that eligibility for benefits under this program have been met by certifying the following:

- Is an active full time (FT), part time (PT), or volunteer (Vol.) firefighter of the department ☐ FT ☐ PT ☐ Vol
- Is a full time with 5 years or part time/volunteer firefighter who has at least 10 years of active service (36 hours of training each year) with any fire protection services department ☐ Yes ☐ No
- Was listed on the last census filed with the Trust ☐ Yes ☐ No
  If "no", please explain:
- Performs duties that are directly involved with the provision of fire protection services ☐ Yes ☐ No
- Has not filed a claim or is expected to file a claim under any workers' compensation policy ☐ Yes ☐ No ☐ Unknown
- Has had a physical examination that would have reasonably found cancer ☐ Yes ☐ No ☐ Unknown
- I have not smoked any tobacco products in the past 5 years ☐ Yes ☐ No

The following section is for Volunteers only.

Normal Occupation	Normal Occupation Work Hours	Name of Normal Occupation Employer	
Address of Normal Occupation Employer		Contact Phone Number	Contact Fax Number
Contact Name for Normal Occupation Employer		Duties Unable to Perform for Normal Occupation	
Last Year Active as Volunteer (36 hrs of Training)			

All Covered Individuals are required to complete the following section.

Physician's Name	Physician's Phone Number	Physician's Fax Number
Physician's Address (Street Address, City, State and ZIP Code)		
Attending Oncologist's Name	Oncologist's Phone Number	Oncologist's Fax Number
Oncologist's Address		

Other Information (please explain): _____

Covered Individual Signature Required: I hereby certify the above information to be true and accurate to the best of my knowledge.

_____
Name of Covered Individual (please print)

_____ _____
Signature of Participant Date Signed

***Please attach a copy of the physician's diagnosis and the last medical examination record to this claim form.**

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Section III – Fraud Warning Statement (to be signed by Trust Member and Covered Individual)

Any person who knowingly and with intent to defraud any insurance company or other person files an application for Coverage or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I hereby certify the foregoing statements made by me on this form to be true to the best of my knowledge. I am aware that if any of the foregoing statements on this form made by me are willfully false, I may be subject to penalties, which may include criminal prosecution.

Signature of Supervisor	Name of Supervisor (please print)	Date Signed
Signature of Covered Individual	Name of Covered Individual (please print)	Date Signed

Section IV – Authorization to Obtain and Disclose Information

To: Any health care provider, employer, benefit plan, insurer, financial institution, consumer reporting agency, educational institution, or Federal, State, or Local Government Agency, including the Social Security Administration and Veterans Administration. I authorize you to disclose to the Trust's Claims Adjusters at TRISTAR Risk Management a complete copy of any and all of the following personal or privileged information, records, or documents relative to:

Covered Individual's Name (please print)	Date of Birth	Last 4 Digits of SSN

Any and all medical information or records, including x-ray films, medical histories, physical, mental or diagnostic examinations, and treatment notes, alcohol or drug abuse, and mental health, as such information may be related to my claim for benefits; work information and history, including job duties; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims. The information obtained by use of this Authorization will be used for the purpose of evaluating and administering my claim for an Award under my employer's coverage plan. Such information shall be referred to herein collectively as "My Information." I understand that I have the right to revoke this Authorization for future disclosures, except to the extent action has been taken in reliance upon this Authorization. I must revoke this Authorization in writing directly to the Trust's Claims Administrators at TRISTAR Risk Management.

I ALSO UNDERSTAND that once My Information has been disclosed to the Trust/TRISTAR Risk Management as permitted under this Authorization, it may be re-disclosed by the Trust/TRISTAR Risk Management as permitted by law or my further authorization. I authorize the Trust/TRISTAR Risk Management to use or disclose My Information (i) to my employer for: a) functions related to accommodating my disability; b) responding to claims related to accommodation or adverse or discriminatory treatment related to my claim; c) responding to any litigation or agency charge document production request or lawful subpoena; d) federal or state Family & Medical Leave Act administration; e) matters relating to its workers' compensation arrangements; or f) fulfilling fiduciary obligations under my benefit plan; (ii) to the administrator or other service providers of my employer's benefit plan or other benefit plans of my employer for plan-related functions; (iii) to any claim system used for claims processing or insurance broker to carry out functions related to my benefit plan or claim; (iv) to any health care professional who has treated or evaluated me or who may do so; (v) to other persons or entities performing business or legal services related to my claim; vi) to my employer's workers' compensation insurance carrier or administrator; (vii) as may be lawfully required; or (viii) as may be necessary to prevent or detect perpetration of a fraud.

I understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient. I understand that I have the right to revoke this Authorization for future disclosures that the Trust/TRISTAR Risk Management may make unless the Trust/TRISTAR Risk Management has taken action in reliance upon this Authorization. I must revoke this Authorization in writing directly to the Trust/TRISTAR Risk Management. I understand that my medical treatment or payment for medical benefits cannot be conditioned on my allowing the Trust/TRISTAR Risk Management to re-disclose My Information. The authorizations set forth herein expire two years from the date listed below, or upon my revocation, if earlier, but will not exceed the term of my coverage under the policy or benefit plan, except as may be necessary to prevent or detect perpetration of a fraud. I understand that I am entitled to receive a copy of this Authorization upon request. A photocopy or facsimile of this Authorization shall be as valid as the original. If there is a conflict between a prior request for restriction on the disclosure of My Information and this Authorization, this Authorization will control.

Name of Covered Individual (please print)

Signature of Covered Individual	Date Signed

The Trust provides claim administration service through TRISTAR Risk Management Services.

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Section V – Attending Physician's Statement for Cancer Diagnosis Award

To be completed by the Covered Individual

Name of Covered Individual	Social Security Number	Date of Birth

Address of Covered Individual (Street Address, City, State and ZIP Code)

Name of Member	Coverage Number

I hereby authorize release of information on this form by the below named physician for the purpose of claim processing.

_____
Name of Covered Individual (please print)

_____ _____
Signature of Covered Individual Date Signed

To be completed by the Attending Physician

Patient Name (please print)	Social Security Number	Date of Birth

Diagnosis and Concurrent Conditions (ICD-9 code)

When did symptoms first appear? Date _____

When did the patient first consult you for this condition? Date _____

Has patient ever had same or similar condition? ☐ Yes ☐ No If "yes," provide the date and a description below.

Date of Condition: _____

Description of previous similar condition:

Nature of suggested treatment and estimates of reasonable time frame off work:

Attending Physician's Statement for Cancer Diagnosis Award continues on next page

Section V – Attending Physician's Statement for *Cancer Diagnosis Award* (continued)

To be completed by the Attending Physician

Is patient still under your care for this condition? ☐ Yes ☐ No Date _____

Did you refer patient to another physician? ☐ Yes ☐ No If "yes," please provide the following:

_____ _____

Name of Referred Physician (please print) Phone Number

_____

Address of Referred Physician (Street Address, City, State and ZIP Code)

Duration of time that the patient cannot continuously work at Normal Occupation*? From _____ Through _____

Duration of time that the patient can perform some but not all duties of their Normal Occupation*? From _____ Through _____

***LIMITATION** If there is a limitation, please check: ☐ Standing ☐ Climbing ☐ Bending ☐ Use of Hands ☐ Sitting ☐ Walking ☐ Stooping ☐ Lifting ☐ Psychological ☐ Other: _____

Attending Physician's Name (please print)	Phone Number
License Number	Fax Number
Street Address (Street Address, City, State and ZIP Code)	

SSN or EIN	Degree	Specialty

_____

Name of Physician (please print)

_____ _____

Signature of Physician Date Signed

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