



Workers' Compensation Board

VOLUNTEER FIREFIGHTER'S CLAIM FOR BENEFITS

as of 11/2023

Does this claim involve disease or malfunction of the heart or of one or more coronary arteries? (Check one) Yes No

Form with fields: W.C.B. CASE NO. (if known), CARRIER CASE NO. (if known), CARRIER CODE NO., DATE OF INJURY, SOCIAL SECURITY NO., First Name, Middle Initial, Last Name, Address (Give Number and Street, City, State, Zip Code), Apt. No.

INFORMATION, REGULAR WORK section with questions 4-7 regarding marital status, gender, date of birth, duties, work week, and employer's name.

INJURY section with questions 8-9 regarding where and how the injury occurred.

PLACE AND TIME section with questions 9-10 regarding the address and date of the injury.

NATURE AND EXTENT OF INJURY section with questions 11-15 regarding the nature of the injury, amputation, and return to work.

MEDICAL CARE section with questions 16-18 regarding medical care received and hospital treatment.

VOLUNTEER FIREFIGHTERS' BENEFITS section with questions 19-21 regarding benefit payments.

NOTICE section with question 22 regarding notice to the political subdivision.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO FRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO, OR BY AN INSURER, OR SELF INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

I certify that copy of this was filed with Sullivan County Risk Management Office on

Dated Signed by Volunteer Firefighter or

Signed A person on their behalf, or in case of death, by any one or more of their dependents, or person on their behalf. Relationship Telephone No.

VF-3 (6-22)