COLORADO FIREFIGHTER
HEART AND CANCER BENEFITS TRUST

NOTICE OF CLAIM

A claim is being filed for: ☐ Class 1, 2, or 3 Accident Benefits ☐ Class 4 Total and Permanent Disability Benefits

Accident and Disability Benefits: Forward Questions/Claims to: Sedgwick c/o McGriff, PO Box 1539, Portland, OR 97207 Toll-Free: (844) 769-6650 Fax: (503) 943-6622 Email: claims@cfhtrust.com

Section I – Member Information (to be completed by Employer)

Employer Name		Coverage Number (from Memorandum of Coverage)
Employer Address		Manager's Phone Number
Covered Individual Name	Covered Individual Date of Birth	Covered Individual Social Security Number
Covered Individual Address (Street, City, State and ZIP code)		Covered Individual Phone Number and Email
Date of Occurrence	Time of Occurrence	Incident Location
Complete Description of Heart or Circulatory Incident (if more space is required, please attach a report and state "see attachment" in space below)		
Description of the Unusually Stressful and Strenuous Work Activities 48 Hours Immediately Prior to the Incident		

Note: Please also include a copy of the Incident Report (if available).
Employer and Covered Individual must attest that eligibility for benefits under this program has been met by certifying the following is true, false, unknown, or not applicable (NA). The job duties of all sworn fire department staff are included and considered to be directly involved with the provision of fire protection services.

Employer checklist and verification statement:

The above Covered Individual:

Is a full-time, active employee of the employer who regularly works 1,600 hours annually ☐ Yes ☐ No ☐ Unknown ☐ N/A
Is a part-time, active employee of the employer ☐ Yes ☐ No ☐ Unknown ☐ N/A
Is an active volunteer firefighter of the employer ☐ Yes ☐ No ☐ Unknown ☐ N/A
Was listed on the last census filed with the Trust ☐ Yes ☐ No ☐ Unknown
If "no", please explain:
Performs duties that are directly involved with the provision of fire protection services ☐ Yes ☐ No ☐ Unknown
Is a full-time employee or part-time employee who has at least 5 years of continuous employment with any fire protection services employer ☐ Yes ☐ No ☐ Unknown ☐ N/A
Is a volunteer who has at least 5 years of continuous employment with the same employer ☐ Yes ☐ No ☐ Unknown ☐ N/A
To my knowledge has not consumed (e.g., smoked, chewed) tobacco or vaping products in the past 5 years ☐ True ☐ False ☐ Unknown
Immediately after the incident, was hospitalized for ☐ Less than 48 hrs ☐ More than 48 hrs

I hereby certify the Employer is a member of the Trust under the above referenced Coverage Plan and the heart/circulatory malfunction was sustained under adequate supervision while participating in an official Covered Activity.

Title of Manager

Name of Manager (please print)

Signature of Manager

Date Signed

Section II – to be completed by Covered Individual

If filing a claim for Class 1, 2, or 3 Heart and Circulatory Malfunction Benefits, submit the following:

- Hospital Admittance and Discharge
- Physician's Diagnosis
- Last Medical Examination Prior to Incident

Send to: Sedgwick c/o McGriff
PO Box 1539
Portland, OR 97207

After these items have been submitted, sign the Covered Individual Certification statement listed at the end of Section IV.

**Claims for Class 4, Total and Permanent Disability Benefits require an accredited Level II Physician's Disability Determination*

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

I am a full time, active employee of the employer who regularly works 1,600 hours annually ☐Yes ☐No ☐N/A

I am a part time, active employee of the employer ☐Yes ☐No ☐N/A

I am an active volunteer firefighter of the employer ☐Yes ☐No ☐N/A

I perform duties that are directly involved with the provision of fire protection services ☐Yes ☐No ☐N/A

I am a full time or part time employee who has at least 5 years of continuous employment with any fire protection services employer ☐Yes ☐No ☐N/A

I am a volunteer who has at least 5 years of continuous employment with the same employer ☐Yes ☐No ☐N/A

I have not consumed (i.e smoked, chewed) tobacco and vaping products in the past 5 years ☐True ☐False

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
Duties Unable to Perform – Normal Occupation		Contact Name for Normal Occupation Employer	
Date Last Worked - Normal Occupation Employer		Date Returned to Work – Normal Occupation	
Verification of Earnings (Submit Normal Occupation paystubs for the last 3 months).			

All Covered Individuals are required to complete the following section.

Attending ER Physician's Name	ER Physician's Phone Number	ER Physician's Fax Number
ER Physician's Address		
Attending Cardiologist's Name	Cardiologist's Phone Number	Cardiologist's Fax Number
Cardiologist's Address		

Do you have disability (loss of wages) coverage, whether collectible or not, through (check all that apply):

☐Regular Occupation Policy ☐Worker's Comp. ☐Short Term Disability ☐Leave Share ☐Paid Sick Time
☐Other (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 Covered Individual Date Signed

Section III – Fraud Warning Statement – to be signed by Employer and Covered Individual

Any person who knowingly and with intent defrauds 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 Manager	Name of Manager (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 CFHC Trust's Claims Adjusters at Sedgwick Claims Management Service 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, and including information regarding HIV/AIDS, communicable diseases, 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, earnings and personnel records, and client lists; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims; credit information, including credit reports and credit applications; other financial information, including pension benefits, bank records; business transactions billing, invoices, and payment records; academic transcripts; and information concerning Social Security benefits, including, monthly benefit amounts, monthly payment amounts, entitlement dates, and information from my Master Beneficiary Record. The information obtained by use of this Authorization will be used for the purpose of evaluating and administering my claim for benefits under my employer's benefit plan. Such information shall be referred to herein collectively as "My Information." I understand 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 CFHC Trust's Claims Administrators at Sedgwick Claims Management Service.

I ALSO UNDERSTAND that once My Information has been disclosed to the CFHC Trust/Sedgwick Claims Management Service as permitted under this Authorization, it may be re-disclosed by the CFHC Trust/Sedgwick Claims Management Service as permitted by law or my further authorization. I authorize the CFHC Trust/Sedgwick Claims Management Service 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 the CFHC Trust/Sedgwick Claims Management Service may make unless the CFHC Trust/Sedgwick Claims Management Service has taken action in reliance upon this Authorization. I must revoke this Authorization in writing directly to the CFHC Trust/Sedgwick Claims Management Service. I understand that my medical treatment or payment for medical benefits cannot be conditioned on my allowing the CFHC Trust/Sedgwick Claims Management Service 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 CFHC Trust provides claim administration service through Sedgwick Claims Management Service.

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HEART AND CANCER BENEFITS TRUST

NOTICE OF CLAIM

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P.O. Box 1539
Portland, OR 97207

Toll-Free: (844) 769-6650
Fax: (503) 943-6622

Section V – Attending Physician's Statement for Disability Services

To be completed by the Covered Individual

Name of Patient	Social Security Number	Date of Birth
Address of Patient (Street, City, State, and ZIP Code)		
Name of Employer		Coverage Number

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

_____
Name of Patient (please print)

_____ _____
Signature of Patient Date Signed

To be completed by the Attending Physician

Covered Individual Name (please print)	Social Security Number	Date of Birth
Diagnosis and Concurrent Conditions (ICD-9 code)		

Is Treatment due to: ☐ Sickness ☐ Accident ☐ Stressful Activity ☐ Strenuous Activity

When did symptoms first appear, or when did the incident occur? 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 surgical procedure, if any (describe fully), including performed CPT Codes.

Attending Physician's Statement for Disability Services continues on next page

Section V – Attending Physician's Statement for Disability Services (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 to following:

_____ _____

Name of Physician Referred To (please print) Phone Number

_____

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

How long was or will the patient be continuously unable to work at Normal Occupation*? From_____ Through _____

How long was or will the patient be able to 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, City, State & ZIP Code)	

SSN or EIN	Degree	Specialty

_____

Name of Physician (please print)

_____ _____

Signature of Physician Date Signed

Your completed reimbursement form can be sent to the Trust Administrator at:

Colorado Firefighter Heart, Cancer, and Behavioral Health Benefits Trust c/o McGriff Insurance Services LLC
P.O. Box 1539 | Portland, OR 97207
Email: cfhtrust@mcgriff.com
Fax: 503-598-8523