Fax or mail the completed application to:
The Hartford
P.O. Box 14869
Lexington, KY 40512-4869
Fax Number: (833) 357-5153
Phone: (866) 783-6566

Clear Form

HARTFORD LIFE INSURANCE COMPANY
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
POLICYHOLDER SECTION FOR NY VOL FF CANCER PROGRAM
APPLICATION FOR DISABILITY CANCER BENEFITS (DCB)

THE HARTFORD

Policyholder's Section - To be Completed by the Policyholder

This claim is for (Firefighter's Name):	Social Security Number:	Date of Birth:
Firefighter's Address: (Street, City, State, Zip)		Telephone Number: ( )

A. Information About the Policyholder

Policyholder's Name:		Group Policy Number:
New York State Volunteer Firefighter Cancer Benefit Association		681360
Address: (Street, City, State, Zip)	Telephone Number: ( )	Fax Number: ( )
107 Washington Ave, Suite 2 Albany , NY 12210-2200		
Name and address of division where Firefighter works: (if different from above)	Class:	Location:

B. Information About the Firefighter

Date Firefighter was hired:	Date Firefighter became insured under this plan:	What was the Firefighter's regularly scheduled work week? _____ hours per week.

Was the Firefighter's DCB insurance issued on the basis of a Personal Health Statement ? ☐ Yes ☑ No If "Yes," attach copy.

Was the Firefighter insured under your prior DCB policy? ☐ Yes ☐ No If "Yes," please provide the inclusive date of coverage.
From _____ Through _____ Has the Firefighter been terminated? ☐ Yes ☐ No If "Yes," date. _____
Reason:

Was the Firefighter on Qualified Family Leave when disability began? ☐ Yes ☐ No Did DCB insurance continue while on Family Leave? ☐ Yes ☐ No Date Leave of Absence started under Family Leave Act: _____	Is the Firefight a union member? ☐ Yes ☑ No If Yes, name of union and local number.

C. Information Needed for Withholding and Reporting Taxes

What percent of this Firefighter's DCB benefits is taxable? 100 %.
What percentage, if any, do you contribute towards the cost of the DCB premium? 0 %
Does the Firefighter contribute towards the cost of the DCB premium? ☐ Yes ☑ No
If "Yes," is it on a ☐ Pre or ☐ Post Tax basis?

D. Information About the Claim

Were there any changes to the Firefighter's job responsibilities due to the disabling condition before the Firefighter became totally disabled? ☐ Yes ☐ No If "Yes," what were the changes, and when were they made?

What was the Firefighter's permanent job on his or her last day at work?	How long has the Firefighter been in this job ?
Why did Firefighter stop working?	Is the Firefighter's condition work related? ☐ Yes ☐ No
Last day Firefighter actually worked:	On that day, did the Firefighter work a full day ☐ Yes ☐ No If "No," how many hours were worked? _____
Has a claim been filed with Workers' Compensation? ☐ Yes ☐ No If "Yes," send initial report of illness or injury and award notice.	Date Firefighter is expected/did return to work: _____ Full time? ☐ Yes ☐ No
Name and address of your compensation carrier	

E. Information About Your Pension Plan (Do not complete for maternity claim.)

Do you have a pension plan? ☐ Yes ☑ No If "Yes," what type? (Check as many as applicable)
☐ Defined contribution ☐ Profit Sharing ☐ Defined benefit ☐ 401 K ☐ Other (specify) _____

Is the Firefighter eligible for your pension plan? ☐ Yes ☑ No If "No," why?	If eligible, does the Firefighter participate? ☐ Yes ☐ No If "No," why?

If the Firefighter is participating, when is he or she eligible for benefits under the plan? _____

At what point does the Firefighter qualify for a full pension? _____

Is there a Disability Retirement Option available to this Firefighter? ☐ Yes ☑ No

F. Information About Your Rehire or Return-to-Work Policies

Does your company have a rehire or return-to-work policy for disabled Firefighters? ☐ Yes ☐ No
What is the name and title of the manager we should contact if we identify a rehabilitation or return-to-work option?

G. Information About the Firefighter's Salary

Basic Salary or wage immediately prior to cessation of work because of disability: (exclude bonuses, overtime, pay, etc.)
$ N/A (Flat Amount) ☐ Annually ☐ Monthly ☐ Bi-Weekly ☐ Weekly ☐ Hourly Number of Hours/Week: _____

Is this Firefighter eligible for salary continuation? ☐ Yes ☑ No or Sick Pay? ☐ Yes ☑ No
If "Yes," what is the bi-weekly amount? $_____ When do benefits begin? _____ End? _____

Will the Firefighter file for Short Term Disability? ☐ Yes ☑ No or State Disability benefits? ☐ Yes ☑ No
If "Yes," what is the weekly amount? $_____ When do benefits begin? _____ End? _____

List any other sources of income to which the Firefighter is entitled as a result of this disability:

H. Information About the Physical Aspects of the Firefighter's Job

Check the items below that relate to the Firefighter's job and complete the information requested.
Select either majority of workday or sporadically.

Activity	Majority of workday (with standard breaks)		Sporadically throughout day	If sporadically circle time for each section below: Hours at one time	Total hours/8 hour
Sit	☐	or	☒	☒ 2 3 4 5 6 7 8	1 ☒ 3 4 5 6 7 8
Stand	☒	or	☐	1 2 3 4 5 6 7 8	1 2 3 4 5 6 7 8
Walk	☒	or	☐	1 2 3 4 5 6 7 8	1 2 3 4 5 6 7 8

Can the job be performed alternating sitting and standing? ☐ Yes ☑ No

Activity	Never	Occasionally (1-33%)	Frequently (34-67%)	Constantly (68-100%)
Driving	☐	☒	☐	☐
Balancing	☐	☐	☐	☒
Bending at Waist	☐	☐	☐	☒
Kneeling/Crouching	☐	☐	☐	☒
Crawling	☐	☐	☐	☒
Climbing	☐	☐	☐	☒

Lift/Carry/Push/Pull: Task Description (Describe object moved and any mechanical assistance in the last column)				
Lifting		lbs.	lbs. 50+ lbs.	Firefighter equipment
Carrying		lbs.	lbs. 50+ lbs.	Firefighter equipment
Pushing/Pulling		lbs.	lbs. 50+ lbs.	Firefighter equipment

Upper Extremity Activity (not load bearing) Specify right (R) or left (L) if not bilateral)					**Describe task performed**
Fine manipulation (fingering, keyboard)	☒	☐	☐	☐	Firefighter equipment
Gross manipulation (grip/grasp, handle)	☐	☐	☐	☒	Firefighter equipment
Reach (extend arms) above shoulder	☐	☐	☐	☒	Firefighter equipment
Reach (extend arms) below shoulder at desk or workbench level	☐	☐	☐	☒	Firefighter equipment

I. Information About the Job as it Relates to the Disability

Can the job be modified to accommodate the disability either temporarily or permanently? ☐ Yes ☑ No If "Yes," explain:

Is it possible to offer the Firefighter assistance in doing the job? (e.g., through the use of technology or personal assistance)
☐ Yes ☑ No If "Yes," explain:

J. Required Attachments and Signature

- If salary is based on a W-2, K-1, 1099, or a similar document, attach a copy of the document.
- If you have medical information from the Firefighter's file relating to this disability, please attach copies.
- If a Workers' Compensation claim is filed, send initial report of injury or illness and award notice.

Name of person completing this form (if this claim is approved for disability cancer benefits, the benefit check will be sent to the Firefighter with a copy to you). Please attach a copy of the Firefighter's job description.

Name (Please print or type) _____ Title _____

Signature _____ Date _____