



VOLUNTEER FIREFIGHTER ENHANCED CANCER DISABILITY BENEFITS PROGRAM ATTESTATION / PROOF OF BENEFITS

(Authority: NYS General Municipal Law Section 205-cc and 9 New York Codes, Rules, and Regulations Part 210)

NOTE: THIS FORM MUST BE COMPLETED AND RECEIVED BY THE OFFICE OF FIRE PREVENTION AND CONTROL BY JANUARY 1ST OF EACH YEAR.

MAIL TO: New York State Division of Homeland Security and Emergency Services • Office of Fire Prevention and Control Volunteer Firefighter Cancer Benefits • Attn: Standards Unit • 1220 Washington Avenue • Building 7A, Floor 2 • Albany, NY 12226-9801

Questions, email vfecdb@dhses.ny.gov or phone 518-474-6746

Fire District, Department or Company Information

Year of Submission 2 0 2 4

Form with fields for: The full legal name of the fire district, department or company; FD Identification #; FD Phone; FD Fax; FD Physical Address; City; State; Zip; FD Mailing Address; City; State; Zip; Does your fire department have access to internet and computer?; # of active volunteers; # of eligible volunteers\*

\*Eligibility Requirements:

- 1. the volunteer firefighter is an active volunteer firefighter as of January 1, 2019; and
2. the volunteer firefighter has 5 or more years of service as interior firefighter; and
3. the volunteer firefighter has successfully completed a physical examination, prior to the commencement of duties as an interior firefighter, which failed to reveal any evidence of cancer; and
4. the volunteer firefighter has passed 5 yearly fit tests.

Authorized Representative Information

Form with fields for: Name of the representative of the fire district, department or company authorized to sign the attestation on page 2; Representative Title; Phone; Cell Phone; Email Address

**Select either option A or B below:**

**Check this box if the fire district, department or company has chosen to insure with an insurance company**

The following information must be provided:

Insurance Company Name: \_\_\_\_\_

Name of Insured Fire District, Department or Company: \_\_\_\_\_

Insured Fire District, Department or Company FDID Number: \_\_\_\_\_

Insurance Policy Number: \_\_\_\_\_

Insurance Company's Address: \_\_\_\_\_

Insurance Company's phone number: \_\_\_\_\_

Number of firefighters covered by the policy: \_\_\_\_\_

Attached proof from the insurance company that all benefit claims of eligible volunteer firefighters and/or their beneficiaries are covered.

**A**

**Check this box if the fire district, department or company has chosen to self-fund through its Authority Having Jurisdiction**

Name of the Authority Having Jurisdiction (AHJ): \_\_\_\_\_

Attached written proof from the AHJ that establishes: (1) the AHJ possesses taxing authority; and (2) the AHJ has agreed to fund all benefit claims of eligible volunteer firefighters and/or their beneficiaries through current and future revenues.

**B**

**Attestation**

By checking this box, I hereby certify that I, \_\_\_\_\_, am the Authority Having Jurisdiction (AHJ) for completing this Volunteer Firefighter Enhanced Cancer Disability Benefits Program Attestation / Proof of Benefits form on behalf of the above named agency. I understand the information in this document will be presented to the Division of Homeland Security and Emergency Services for filing, and I certify that it is true to the best of my knowledge and belief. I understand the aboved named agency is responsible for providing this information pursuant to NYS General Municipal Law Section 205-cc and 9 New York Codes, Rules, and Regulations Part 210. Date: \_\_\_\_\_

**Note: This form must be received by the Office of Fire Prevention and Control by January 1<sup>st</sup> of each year.**