



# NEW YORK STATE CANCER CLAIM FORM

P.O. Box 5670  
Cortland, NY 13045  
Phone: (800) 822-3747  
Fax: (607) 756-5967  
Loss\_notice@mcneilandcompany.com

## CLAIMANT'S INFORMATION/STATEMENT

Name		Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Today's Date
Address			Home Phone ( )	
City	State, Zip		Cell Phone ( )	
Email Address			Social Security Number	
Name of Emergency Service Organization		Marital Status	Dependent Child(ren) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of Employer at Time of Injury/Illness		Date of Hire	Regular, Full Time Occupation	
Employer's Address			Employer's Phone ( )	
City	State, Zip		Average Monthly Gross Income	
Date of Cancer Diagnosis	Any Time Lost from Full Time Job? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did You File with Workers' Comp? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
Cancer Diagnosis (type)	Are you a volunteer or <u>paid</u> firefighter with another New York Department? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, Department Name: _____ Are you filing benefits with this Department? <input type="checkbox"/> Yes <input type="checkbox"/> No			Service Years: _____
Details Regarding Disability (unable to actively volunteer): Date of First Day Missed: _____ Date Returned for Partial Duty: _____ Date Returned to Full Time Duty: _____				
Attending Physician's Name			Physician's Phone ( )	
Physician's Address		City	State, Zip	

I certify that the above information is true and complete to the best of my knowledge and belief.

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to McNeil & Co., Arch Insurance Company or their representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy identified herein. I authorize the policyholder, employer or benefit plan administrator to provide McNeil & Co., Arch Insurance Company or their representatives with financial and employment-related information.

- I agree that a photographic copy of this Authorization shall be a valid as the original.
- I understand that I or my authorized representative may request a copy of this authorization.
- I understand that I or my authorized representative may revoke this authorization at any time by providing the insurance company with written notification as to my intent to revoke.

Claimant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

OR If the claimant is unable to sign

Authorized Representative's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Claimant: \_\_\_\_\_

## EMERGENCY SERVICE ORGANIZATION CERTIFICATION

To be completed by an official of the Named Insured.

It may not be completed by the claimant or a member of the claimant's immediate family.

Name of Emergency Service Organization	Policy Number
Name of Certifying Official	Title
Email Address	Daytime Phone (     )
Address	
City	State, Zip
Was the Claimant a Member at the Time of Cancer Diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No If NO, when was the claimant last an active member of the organization?	
Does the Claimant have 5 or more years of service as an interior volunteer firefighter for the organization? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Did the Claimant have a physical that failed to detect any evidence of Cancer prior to becoming an Interior Firefighter? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has the Claimant passed 5 annual fit tests? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What is the Claimant's Membership Status? <input type="checkbox"/> Volunteer <input type="checkbox"/> Paid Career <input type="checkbox"/> Auxiliary <input type="checkbox"/> Junior	

I certify that the above information is true and complete to the best of my knowledge and belief.

Official's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### STATE FRAUD STATEMENTS

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**NOTICE: ANY PERSON WHO, KNOWINGLY OR WITH INTENT TO DEFRAUD OR TO FACILITATE A FRAUD AGAINST ANY INSURANCE COMPANY OR OTHER PERSON, SUBMITS AN APPLICATION OR FILES A CLAIM FOR INSURANCE CONTAINING FALSE, DECEPTIVE OR MISLEADING INFORMATION MAY BE GUILTY OF INSURANCE FRAUD.**