

APPLICATION FOR FIRST RESPONDER PRESUMED COVERAGE FUND

Michigan Department of Licensing and Regulatory Affairs
Workers' Compensation Agency
P.O. Box 30016, Lansing, MI 48909

1. NAME OF EMPLOYEE (Last, First, MI)			2. SOCIAL SECURITY NUMBER		3. DATE OF BIRTH	
4. STREET NUMBER AND NAME			8. TAX FILING STATUS <input type="checkbox"/> A. Single <input type="checkbox"/> B. Single, Head of Household <input type="checkbox"/> C. Married, Filing Joint <input type="checkbox"/> D. Married, Filing Separate			
5. CITY	6. STATE	7. ZIP CODE				
9. SEX <input type="checkbox"/> Male <input type="checkbox"/> Female			10. DATE OF DEATH (If Applicable)			
11. NAME OF DEPENDENTS			12. RELATIONSHIP TO EMPLOYEE		13. BIRTH DATE	
14. NAME OF EMPLOYER			15. DATES OF EMPLOYMENT FROM: _____ TO: _____			
16. FEDERAL I.D. NUMBER (if Known)			17. EARNINGS \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly			
18. STREET ADDRESS			19. CITY		20. STATE	21. ZIP CODE
22. IS THIS EMPLOYER A FULLY PAID FIRE DEPARTMENT OR PUBLIC FIRE AUTHORITY? ARE YOU IN FULL TIME ACTIVE SERVICE OF THIS EMPLOYER?			<input type="checkbox"/> YES		<input type="checkbox"/> NO	
IF NO, PLEASE EXPLAIN: _____			<input type="checkbox"/> YES		<input type="checkbox"/> NO	
BRIEF JOB DESCRIPTION: _____						
NAME OF SUPERVISOR _____ PHONE _____ EMAIL (if known) _____						
23. IN THE COURSE OF YOUR EMPLOYMENT WITH THE FIRE DEPARTMENT/FIRE AUTHORITY WERE YOU EXPOSED TO THE HAZARDS INCIDENTAL TO FIRE SUPPRESSION, RESCUE, OR EMERGENCY MEDICAL SERVICES?			<input type="checkbox"/> YES		<input type="checkbox"/> NO	
24. HAVE YOU FILED A CLAIM AGAINST THE EMPLOYER IN NUMBER 14?			<input type="checkbox"/> YES		<input type="checkbox"/> NO	
25. HAVE YOU FILED AN APPLICATION FOR MEDIATION OR HEARING (WC104A) AGAINST THE EMPLOYER IN NUMBER 14?			<input type="checkbox"/> YES		<input type="checkbox"/> NO	
26. HAVE YOU BEEN DIAGNOSED WITH RESPIRATORY TRACT, BLADDER, SKIN, BRAIN, KIDNEY, BLOOD, THYROID, TESTICULAR, PROSTATE, OR LYMPHATIC CANCER? IF YES, TYPE: _____ DATE OF INITIAL MEDICAL APPOINTMENT RELATED TO DIAGNOSIS: _____ DATE OF DIAGNOSIS: _____			<input type="checkbox"/> YES		<input type="checkbox"/> NO	
27. FATHER <input type="checkbox"/> ALIVE (AGE____) <input type="checkbox"/> DECEASED (AGE____) <input type="checkbox"/> UNKNOWN CAUSE OF DEATH: _____ <input type="checkbox"/> UNKNOWN MOTHER <input type="checkbox"/> ALIVE (AGE____) <input type="checkbox"/> DECEASED (AGE____) <input type="checkbox"/> UNKNOWN CAUSE OF DEATH: _____ <input type="checkbox"/> UNKNOWN						
28. ARE YOU CURRENTLY OR HAVE YOU EVER BEEN A TOBACCO USER? If Yes, proceed to the following: AT WHAT AGE DID YOU FIRST USE TOBACCO? _____ IF YOU HAVE QUIT, PLEASE PROVIDE DATE _____ PLEASE DESCRIBE TOBACCO USE _____			<input type="checkbox"/> YES		NO	
29. ARE YOU RECEIVING A PENSION? IF YES, PLEASE ADVISE THE TYPE OF PENSION: REGULAR OR DISABILITY (circle one) IF NO, HAVE YOU APPLIED FOR A PENSION? HAS YOUR PENSION APPLICATION BEEN DENIED?			<input type="checkbox"/> YES		NO	

30. LIST THE NAMES AND ADDRESSES OF ALL DOCTORS, HOSPITALS AND OTHER HEALTH CARE PROVIDERS. (ATTACH A SEPARATE SHEET IF NECESSARY)				
NAME	ADDRESS (Street Number and Name)	CITY	STATE	ZIP CODE
31. HAVE YOU HAD ANY EMPLOYMENT SINCE THE DATE OF INJURY? IF YES, LIST THE NAME AND ADDRESS OF THE EMPLOYER.		<input type="checkbox"/> YES	<input type="checkbox"/> NO	

THE FILING OF THIS APPLICATION CONSTITUTES A SUSPENSION OF MY CLAIM AGAINST MY EMPLOYER.

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

The submission of this application does not guarantee the right to benefits under the Workers' Disability Compensation Act.

SIGNATURE OF EMPLOYEE	TELEPHONE NUMBER	EMAIL ADDRESS	DATE
ATTORNEY IDENTIFICATION			
NAME OF ATTORNEY	NAME OF LAW FIRM	ATTORNEY ID P.	
ADDRESS (STREET NUMBER AND NAME)	CITY	STATE	ZIP CODE
SIGNATURE OF ATTORNEY	TELEPHONE NUMBER	DATE	
LARA is an equal opportunity employer/program. Auxiliary aids, services and other reasonable accommodations are available upon request to individuals with disabilities.	AUTHORITY: Workers' Disability Compensation Act COMPLETION: Mandatory MCL 418.405 PENALTY: None		

Please make sure you meet all of the following requirements before submitting this application:

- Be a member of a fully paid fire department or public fire authority and be compensated on a full-time basis,
- Be in active service of the department or authority for at least 60 months,
- Be diagnosed with any respiratory tract, bladder, skin, brain, kidney, blood, thyroid, testicular, prostate, or lymphatic cancer,
- Be employed in the active service of the department or authority **at the time** the cancer manifests itself, **and** be exposed to the hazards incidental to fire suppression, rescue, or emergency medical services in the performance of his or her work-related duties,
- First apply for and do all things necessary to qualify for any pension benefits to which you may be entitled. If you have been denied or ineligible please provide documentation.