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APPLICATION FOR FIRST RESPONDER PRESUMED COVERAGE FUND

Michigan Department of Labor and Economic Opportunity
Workers' Disability 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 ☐ A. Single ☐ C. Married, Filing Joint ☐ B. Single, Head of Household ☐ D. Married, Filing Separate	
5. CITY	6. STATE	7. ZIP CODE		
9. SEX ☐ Male ☐ 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 $ ☐ Hourly ☐ Weekly	
18. STREET ADDRESS			19. CITY	20. STATE / 21. ZIP CODE

22. IS THIS EMPLOYER A FULLY PAID FIRE DEPARTMENT OR PUBLIC FIRE AUTHORITY? ☐ YES ☐ NO

ARE YOU IN FULL TIME ACTIVE SERVICE OF THIS EMPLOYER? ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN:_____

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? ☐ YES ☐ NO

24. HAVE YOU FILED A CLAIM AGAINST THE EMPLOYER IN NUMBER 14? ☐ YES ☐ NO

25. HAVE YOU FILED AN APPLICATION FOR MEDIATION OR HEARING (WC104A) AGAINST THE EMPLOYER IN NUMBER 14? ☐ YES ☐ NO

26. HAVE YOU BEEN DIAGNOSED WITH RESPIRATORY TRACT, BLADDER, SKIN, BRAIN, KIDNEY, BLOOD, THYROID, TESTICULAR, PROSTATE, OR LYMPHATIC CANCER? ☐ YES ☐ NO
IF YES, TYPE:_____

DATE OF INITIAL MEDICAL APPOINTMENT RELATED TO DIAGNOSIS:_____ DATE OF DIAGNOSIS:_____

27. FATHER ☐ ALIVE (AGE____) ☐ DECEASED (AGE_____) ☐ UNKNOWN CAUSE OF DEATH:_____ ☐ UNKNOWN

MOTHER ☐ ALIVE (AGE____) ☐ DECEASED (AGE_____) ☐ UNKNOWN CAUSE OF DEATH:_____ ☐ UNKNOWN

28. ARE YOU CURRENTLY OR HAVE YOU EVER BEEN A TOBACCO USER? If Yes, proceed to the following: ☐ YES ☐ NO

AT WHAT AGE DID YOU FIRST USE TOBACCO?_____

IF YOU HAVE QUIT, PLEASE PROVIDE DATE_____

PLEASE DESCRIBE TOBACCO USE_____

_____

29. ARE YOU RECEIVING A PENSION? ☐ YES ☐ NO

IF YES, PLEASE ADVISE THE TYPE OF PENSION: REGULAR OR DISABILITY (circle one)

IF NO, HAVE YOU APPLIED FOR A PENSION? ☐ YES ☐ NO

HAS YOUR PENSION APPLICATION BEEN DENIED? ☐ 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? ☐ YES ☐ NO
IF YES, LIST THE NAME AND ADDRESS OF THE EMPLOYER.

☐ 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	

LEO 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 <u>before</u> 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.