

APPLICATION FOR CHRISTOPHER R. SLEZAK 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			
5. CITY			6. STATE		7. ZIP CODE	
			<input type="checkbox"/> A. Single		<input type="checkbox"/> C. Married, Filing Joint	
			<input type="checkbox"/> B. Single, Head of Household		<input type="checkbox"/> D. Married, Filing Separate	
			9. DATE OF DEATH (If Applicable)			
10. NAME OF DEPENDENTS			11. RELATIONSHIP TO EMPLOYEE		12. BIRTH DATE	
13. NAME OF EMPLOYER			14. DATES OF EMPLOYMENT			
			FROM:		TO:	
15. FEDERAL I.D. NUMBER (If Known)			16. EARNINGS		<input type="checkbox"/> Hourly	
			\$		<input type="checkbox"/> Weekly	
17. STREET ADDRESS			18. CITY		19. STATE	20. ZIP CODE
21. ARE YOU CURRENTLY OR HAVE YOU EVER BEEN IN FULL-TIME ACTIVE SERVICE OF THIS EMPLOYER?			<input type="checkbox"/> YES	<input type="checkbox"/> NO		
ARE YOU A CURRENT OR FORMER PART-TIME, PAID ON-CALL; VOLUNTEER OF THIS EMPLOYER?			YES	NO		
ARE YOU A FORMER FOREST FIRE OFFICER/CRASH RESCUE OFFICER OF THIS EMPLOYER?			YES	NO		
IF NO, PLEASE EXPLAIN: _____						
BRIEF JOB DESCRIPTION: _____						
NAME OF SUPERVISOR _____ PHONE _____ EMAIL (if known) _____						
22. 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						
23. HAVE YOU FILED A CLAIM AGAINST THE EMPLOYER IN NUMBER 14?						
<input type="checkbox"/> YES <input type="checkbox"/> NO						
24. HAVE YOU FILED AN APPLICATION FOR MEDIATION OR HEARING (WC104A) AGAINST THE EMPLOYER IN NUMBER 14?						
<input type="checkbox"/> YES <input type="checkbox"/> NO						
25. HAVE YOU BEEN DIAGNOSED WITH RESPIRATORY TRACT, BLADDER, SKIN, BRAIN, KIDNEY, BLOOD, THYROID, TESTICULAR, PROSTATE, LYMPHATIC, OVARIAN, BREAST OR NON-HPV CERVICAL CANCER						
IF YES, TYPE: <input type="checkbox"/> YES <input type="checkbox"/> NO						
DATE OF INITIAL MEDICAL APPOINTMENT RELATED TO DIAGNOSIS: _____ DATE OF DIAGNOSIS: _____						
26. 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						
27. ARE YOU CURRENTLY OR HAVE YOU EVER BEEN A TOBACCO USER? If Yes, proceed to the following: <input type="checkbox"/> YES <input type="checkbox"/> NO						
AT WHAT AGE DID YOU FIRST USE TOBACCO? _____						
IF YOU HAVE QUIT, PLEASE PROVIDE DATE _____						
PLEASE DESCRIBE TOBACCO USE _____						

28. ARE YOU RECEIVING A PENSION? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO						

29. 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
30. HAVE YOU HAD ANY EMPLOYMENT SINCE THE DATE OF INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO				
IF YES, LIST THE NAME AND ADDRESS OF THE EMPLOYER.				

I UNDERSTAND MAKING OF THIS CLAIM 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
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		

For additional information regarding the fund, including eligibility requirements, visit the [Workers' Disability Compensation Agency](http://www.michigan.gov/wdca) website at www.michigan.gov/wdca.