NEW YORK STATE | Homeland Security and Emergency Services | Fire Prevention and Control

EOSB - 210.5 (10/19)

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

Fire District, Department or Company Information

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 *(if different than physical address)*				
City	State	Zip		
Does your fire department have access to internet and computer? ❑ Yes ❑ No	# 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

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:

A

❑ **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.

B

❑ **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 Jurisiction (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.

Attestation

❑ By checking this box, I hearby certify that I, _____, am the Authority Having Jurisiction (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: _____

SUBMIT

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