Ladies Auxiliary to the
Maryland State Firemen's Association

Instructions for Bessie Marshall Benefit Fund

Section 1- Any member of a company or department in good standing in the Maryland State Firemen's Association who is sick or injured **(NOT IN THE LINE OF DUTY)** and thereby incapacitated may be entitled to weekly benefits. **MEMBERS MUST BE 18 YEARS OF AGE OR OLDER.** Approval will depend on compliance with the application requirements. Any sick or injured member receiving Social Security Benefits or retirement may be eligible for said benefits. All decisions regarding benefits shall be made by the Bessie Marshall Benefit Committee, whose judgements in all cases shall be final and binding.

Section 2- Should sickness or injury continue for longer than one (1) week for each week after the first week said member may be eligible to receive up to ***ONE HUNDRED SEVENTY DOLLARS ($170.00) per week not to exceed SIX (6) WEEKS OR ONE THOUSAND TWENTY DOLLARS ($1020.00)*** in any calendar year. A member is not eligible for more than two (2) consecutive years. Any additional request for benefits must be based on a new incident, not on an existing one.

Section 3- **IMPORTANT:** No payment will be considered by the Benefit Fund Committee until all three forms (A, B and C) are completely filled out and signed.

_____ Form **A** to be filled out, signed and notarized by member, or family member if member is unable.

_____ Form **B** to be filled out and signed by the **Company Chief, President** and **Secretary** must include the company seal/stamp.

_____ Form **C** to be filled out by members **Doctor**, to include doctors printed name, address, phone number and doctor's medical license number

Please note it could take up to 60 days to receive payment.

Section 4- **BENEFITS WILL NOT BE PAID FOR PREGNANCIES OR ANY ILLNESS RELATED TO PREGNANCY.**

Section 5- **THE INFORMATION ENCLOSED IN THIS APPLICATION WILL NOT IN ANY WAY BE SHARED OR PROMOTED FOR THE PROGRAM. THIS WILL ENSURE THAT ALL LAWS OF HIPPA - HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT, A 1996 FEDERAL LAW WILL BE FOLLOWED.**

Section 6- **ALL APPLICATIONS TO RECEIVE BENEFITS FROM THE BESSIE MARSHALL FUND, MUST BE SUBMITTED WITHIN NINETY (90) DAYS FROM THE RETURN TO WORK DATE LISTED ON THE DOCTORS CERTIFICATION (FORM C). ALL OTHERS WILL BE DENIED.**

Please forward completed forms to:

Bessie Marshall Co-Chair
Teresa Ann Crisman 104 Ivy Lane, Greenbelt, Maryland 20770
EMAIL: tacrisman@hotmail.com Contact Phone: 240-882-6772

Supporting the needs of MSFA members who are ill or injured, not in the line of duty.

Form A

NOTE TO MEMBERS: These forms (A, B, and C) must be filled out completely by the member, signed by said member and notarized. Forms A, B and C should be forwarded to the Chairman of the Bessie Marshall Benefit Fund**. Member must be over the age of 18.** In the event the member is physically unable to execute this form, it may be executed on member's behalf by an immediate family member.

Please be advised it may take 30-60 days to process check.

Disclosure: I agree that by submitting this application my name may be used for promotional or other purposes.

I HERBY REQUEST BENEFITS UNDER THE RULES SET FORTH BY THE BESSIE MARSHALL BENEFIT COMMITTEE-LADIES AUXILIARY OF THE MARYLAND STATE FIREMEN'S ASSOCIATION.

1. Name of Member_____Age_____

2. Address_____Phone ( ) _____

City_____County_____Zip_____State_____

3. Social Security Number---------- _____(Last 4 numbers)

4. Do you have any dependents? **YES/NO** Wife/Husband_____# of Children_____

5. Are you employed? **FULL TIME** **PART TIME** **RETIRED**

6. What is the nature of your illness/injury? _____

7. What is the date of the onset of your illness/injury? _____

8. Was illness or injury received as a result of duties as a fire dept. member? **YES** **NO**

9. Was illness or injury received at work? **YES** **NO**

10. Were you employed at time of illness or injury? **YES** **NO**

11. If employed are you receiving your salary or any other income? **YES** **NO**

12. Are you covered by any type of compensation?

13. (I.e. health insurance, accident, workers compensation) **YES** **NO**

If yes please explain: _____

14. Explain how you will use these funds to fulfill your needs.

_____

_____

_____

_____

_____

_____

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15. Under the by-laws of your fire department, are you a member in good standing? **YES** **NO**

16. How long have you been a member of your fire department? _____

17. Have you applied for benefits from this Fund in the past? **YES** **NO**

If yes please provide the nature of your illness or injury and give the dates_____

****

IMPORTANT: No payment will be considered by the Benefit Fund Committee until all three forms (A, B and C) are completely filled out and signed.

I hereby certify that the information contained herein is true and correct to the best of my knowledge.

_____ _____

Notary Seal and Signature *Members Printed Name*

_____ _____

Date *Members Signature*

_____

Date

Notary Seal

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Request for Benefit of the Bessie Marshall Benefit Fund

Form B Certification for Benefits

TO COMPANY OFFICER: When a member of a company or department in good standing in the Maryland State Firemen's Association is ill or injured **(NOT IN THE LINE OF DUTY),** one copy of this Certificate shall be signed by the President, Chief and Secretary and forwarded to the Chairmen of the Bessie Marshall Committee.

DATE: _____

COMPANY NAME: _____

COMPANY ADDRESS: _____

CITY _____ **ZIP** _____ **COUNTY** _____ **STATE** _____

PHONE NUMBER: ( ) _____

This is to certify that _____ is a
(Name of member)

Fire_____ EMS_____ Administrative____ member of our Department and has been a member in good standing for _____. Their duties are _____.
(Length of service)

By our signatures we certify that the information contained herein is true and correct to the best of our knowledge.

_____
Secretary Print

_____
Secretary Signature

_____
Secretary Phone Number

_____
President Print

_____
President Signature

_____
President Phone Number

Corporation/Department Seal

_____
Chief Print

_____
Chief Signature

_____
Chief Phone Number

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Request for Benefit of the Bessie Marshall

Benefit Fund Form C

DOCTOR'S OR PHYSICIAN ASSISTANT
CERTIFICATION

DATE: _____

I hereby certify that (Patient Name) _____

has been under my medical care for the following condition: ***This information will remain private this allows the committee to ensure that the benefit for the member is awarded properly and meets the conditions of the Bessie Marshal Benefit Fund.***

_____
_____
_____
_____
_____
_____
_____
_____

Since (dates) _____

Return to Work: The patient may return to work on or about: _____
(Date or estimated date of return)

_____**The treatment for this patient is medically necessary.**

Date: _____ **Doctors/PA Signature** _____**M.D. /PA**

Printed Name of Doctor/PA _____

Address: _____

_____

**Office Phone Number: ( ) ** _____

Medical License Number _____

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