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

**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

Patricia Deamond, 121 Jethro St., North East, MD 21901, 410-920-2067

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

**Request for Benefit of the Bessie Marshall Benefit Fund**
**Form A**

**NOTE TO MEMBERS:** This 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_____-_____-_____
**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? (I.e. health insurance, accident, workers compensation)
**YES NO**
If yes please explain: _____
**13**. Explain how you will use these funds to fulfill your needs.

_____
_____
_____
_____
_____

**14.** Under the by-laws of your fire department, are you a member in good standing? **YES NO**
**15.** How long have you been a member of your fire department? _____
**16.** 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_____

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**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.**

_____
**Members Printed Name**

_____
**Notary Seal and Signature** **Members Signature** **Date**

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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**

_____ **President Print**

_____ **Secretary Signature**

_____ **President Signature**

_____ **Secretary Phone Number**

_____ **President Phone Number**

_____ **Chief Print**

_____ **Chief Signature**

_____ **Chief Phone Number**

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**Request for Benefit of the Bessie Marshall Benefit Fund**
**Form C**
**Doctor's Certification**

**DATE: _____**

I hereby certify that _____has been under my medical care

(Name of Patient)

for the following condition_____

since_____

(Please Print)

And may return to work on or about

_____.

(Date or estimated date of return)

The treatment for this patient is medically necessary.

**Date_____ Doctors Signature _____M.D.**

**Printed Name of Doctor_____**

**Address: _____**

**_____**

**Office Phone Number: ( ) _____**

**Medical License Number_____**

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