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 member’s 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
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 FIREFMEN’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________________________

******************************************************************************

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

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

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

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