WORKERS' COMPENSATION BOARD OF NOVA SCOTIA

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Halifax, NS B3J 2Y2
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902-491-8999 local
902-491-8001 fax

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336 King's Road, Suite 117
Medical Arts Building
Sydney, NS B1S 1A9
1-800-880-0003 toll free
902-563-2444 local
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Firefighter Cancer Claim (Surviving Spouse)

FCCS:08/2003

Claim # _____

IMPORTANT MESSAGE:

As the surviving spouse of the deceased firefighter, please provide the following information and complete the attached Firefighter Cancer Claim form. Please contact us if you require assistance.

SURVIVING SPOUSE'S PERSONAL INFORMATION (Please Print)

Last Name: _____ First Name and Initial: _____ Date of Birth: D___ M___ Y_____

Address: _____

SIN: _____ / _____ / _____

Postal Code: _____ Telephone #: _____ Male / Female _____ NS Health Card #: _____

GENERAL INFORMATION

1 The name of the deceased: _____

2 Indicate your relationship with the deceased. Please provide supporting documentation (ie. marriage certificate).

- ☐ Married Date: D___ M___ Y_____
- ☐ Common Law How long: _____
- ☐ Other Details: _____

3 Date of Death: D___ M___ Y_____

4 Was an autopsy performed? ☐ Yes ☐ No

If Yes, where was the autopsy performed: _____

5 Please add any additional comments related to your spouse's cancer:

_____

_____

_____

_____

_____

DECLARATION AND CONSENT

I declare that all the information provided by me is true and correct to the best of my knowledge.

I consent to the WCB obtaining and distributing any information from MSI/Maritime Medical Care Inc., physicians, health-care professionals, governments, and all or any records pertaining to the deceased's current or prior medical history, examinations, treatments and income that the WCB determines is necessary to process this claim.

_____ _____

Spouse's Signature Date (D/M/Y)