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WORKERS' COMPENSATION BOARD OF NOVA SCOTIA

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# Firefighter Cancer Claim (Surviving Spouse)

FCCS: 09/2017

_____ 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)