CITY OF TAMPA

Jane Castor, Mayor

Human Resources & Talent Development

Kelly Austin, Director

Forms Packet

This packet includes forms for current and former City of Tampa Firefighters pursuant to Florida Statute 112.1816 – Firefighter Cancer Diagnosis

Required Forms

- Notice of Initial Diagnosis and Claim of Benefits Affidavit-No Tobacco Product Use in Preceding Five (5) Years
- Affidavit of All Employment in Preceding Five (5) Years from Date of Diagnosis

Other Forms

- Florida Statute 112.1816
- Out of Pocket Reimbursement Request Form For Deductibles, Copayments or Coinsurance (Required only with reimbursement requests)
- Employee Medical Absence Notice

All inquiries should be directed to **City of Tampa Human Resources-Employee Benefits** at benefits@tampagov.net or by calling the Benefits Questions Line at (813) 274-5757

Submit all documentation to:

City of Tampa Human Resources – Employee Benefits
306 E. Jackson St, 5th Floor
Tampa FL 33602
Email: benefits@tampagov.net

CITY OF TAMPA
NOTICE OF INITIAL DIAGNOSIS AND CLAIM OF BENEFITS
Under Statute 112.1816 – Firefighter Cancer Diagnosis

Employee Name: _____ Employee ID: _____

Address: _____ City: _____ State: ___ Zip: _____

email Address: _____ Phone: _____

Physician affirms that claimant has been diagnosed with one of the following types of cancer:

Bladder Cancer	*Kidney Cancer*	*Oral Cavity/Pharynx*
Brain Cancer	*Large Intestinal Cancer*	*Ovarian Cancer*
Breast Cancer	*Lung Cancer*	*Prostate Cancer*
Cervical Cancer	*Malignant Melanoma*	*Rectal Cancer*
Colon Cancer	*Mesothelioma*	*Stomach Cancer*
Esophageal Cancer	*Multiple Myeloma*	*Testicular Cancer*
Invasive Skin Cancer	*Non-Hodgkin's lymphoma*	*Thyroid Cancer*

Date of Diagnosis:_____

Physician Group:_____

Provider Name:_____

Provider Signature:_____

Employee agrees to provide any further documentation that may be required by City's insurance carriers or the City to affirm and process this payment; and that any benefit(s) which may be due under this policy may come either directly from the insurance company, or from the City. Employee is also advised that these benefits may be taxable under the Internal Revenue Code. The payment will be sent to the above address unless otherwise directed in writing on this form.

WAIVER OF OPTION TO PURSUE WORKERS' COMPENSATION BENEFITS UNDER CHAPTER 440

By claiming the one-time cash payout of $25,000 upon the initial diagnosis of cancer, and/or any other reimbursement for eligible out of pocket medical expenditures, I understand that I am waiving my option to pursue workers' compensation benefits under Florida Statutes Chapter 440.

Employee Signature:_____ Date:_____

State of _____ County of _____
On this _____ day of _____ 20____,

_____
personally appeared before me, and proved to me through satisfactory evidence of identification,which were _____, to be the person whose name is signed on the preceding or attached document in my presence.

_____
NOTARY NAME HERE, Notary Public
My Commission Expires _____

CITY OF TAMPA

AFFIDAVIT – NO TOBACCO PRODUCT USE IN PRECEDING FIVE (5) YEARS

Employee Name: _____ Employee ID: _____

Tobacco products may include, and are not limited to, the following:

- Cigarettes
- E-cigarettes
- Vape pens
- Cigars
- Kreteks or Clove Cigarettes
- Chewing tobacco
- Snuff
- Dip
- Snus

I affirm that I have not used tobacco products in the five (5) years preceding my diagnosis of cancer.

Employee Signature:_____ Date:_____

State of _____ County of _____
On this _____ day of _____ 20____,
_____
personally appeared before me, and proved to me through satisfactory evidence of identification,which were _____, to be the person whose name is signed on the preceding or attached document in my presence.

_____
NOTARY NAME HERE, Notary Public
My Commission Expires _____

Submit all documentation to:

City of Tampa Human Resources - Employee Benefits
306 E. Jackson St, 5th Floor
Tampa FL 33602
Email: benefits@tampagov.net

CITY OF TAMPA
AFFIDAVIT OF ALL EMPLOYMENT
IN PRECEDING FIVE (5) YEARS FROM DATE OF DIAGNOSIS

Employee Name: _____ Employee ID: _____

List all previous and current employers other than the City of Tampa in the chart below. If there are no other previous or current employers for whom you have worked during five years prior to your diagnosis of cancer, list NONE.

Date(s) of Service	Employer Name/Address	Summary of Duties

I affirm and confirm that I have not been employed as a firefighter since my employment termination date of_____with the City of Tampa. I further affirm this form includes ALL entities for whom I have worked during the five (5) years prior to my date of diagnosis of cancer other than the City of Tampa.

Employee Signature:_____Date:_____

State of _____ County of _____
On this _____ day of _____ 20____,
_____
personally appeared before me, and proved to me through satisfactory evidence of identification,which were _____, to be the person whose name is signed on the preceding or attached document in my presence.

_____
NOTARY NAME HERE, Notary Public
My Commission Expires_____

To Be Completed by City of Tampa Human Resources

***This is to certify that _____ named above has been continuously employed by the City of Tampa for over five (5) years beginning on _____ and* has been continuously covered under group medical insurance coverage through the City of Tampa or the Health Care Trust.**

City of Tampa Representative Name (print):_____

City of Tampa Representative Signature:_____

EMPLOYEE MEDICAL ABSENCE NOTICE
Pursuant to FL Statute 112.1816

Employee Name: _____ Employee City ID #:_____

(Please legibly print your name)

The area below must be completed by the provider

Date Employee Removed from Normal Job Duties: _____

Date Employee is to be Released to Normal Job Duties: _____

Provider Signature: _____

Provider Name:_____

Practice Name:_____

Provider Address:_____

_____

Provider Telephone Number:_____

Provider Notes:

Complete steps below:

1. Provider completes the Employee Medical Absence Notice for absence from work.
2. Employee to provide completed Employee Medical Absence Notice to your supervisor and then to Human Resources.
3. TFR Personnel Chief/HR to update timekeeping system with the pay code “FD D COP”

I attest the information provided on this form is accurate for my absence from work to receive administrative leave for the dates reflected when I was absent from my normal scheduled work hours. I request use of administrative leave pursuant to FL Statute 112.1816.

Employee Signature:_____ **Date:**_____

PLEASE NOTE: THIS FORM MUST BE PRESENTED AS AN ORIGINAL DOCUMENT

CITY OF TAMPA
OUT OF POCKET REIMBURSEMENT REQUEST FORM FOR DEDUCTIBLES, COPAYMENTS OR COINSURANCE

Under Statute 112.1816 – Firefighter Cancer Diagnosis

Employee Name: _____ Employee ID: _____

Address: _____ City: _____ State: ___ Zip: _____

email Address: _____ Phone: _____

Date of Service	Provider/Facility Name	Service Received	$ Amount

Please submit documentation of your expenses along with this form. Documentation may be an itemized receipt, a detailed bill from your provider and an Explanation of Benefits (EOB) from your insurance company. (Please note that additional information may be requested to process reimbursement payments).

Submit this documentation to:

City of Tampa Employee Benefits
306 E. Jackson St 5th Floor
Tampa FL 33602
Email: benefits@tampagov.net

Employee Signature:_____ Date:_____

112.1816 Firefighters; cancer diagnosis. —

(1) As used in this section, the term:

(a) “Cancer” includes:

1. Bladder cancer.
2. Brain cancer.
3. Breast cancer.
4. Cervical cancer.
5. Colon cancer.
6. Esophageal cancer.
7. Invasive skin cancer.
8. Kidney cancer.
9. Large intestinal cancer.
10. Lung cancer.
11. Malignant melanoma.
12. Mesothelioma.
13. Multiple myeloma.
14. Non-Hodgkin’s lymphoma.
15. Oral cavity and pharynx cancer.
16. Ovarian cancer.
17. Prostate cancer.
18. Rectal cancer.
19. Stomach cancer.
20. Testicular cancer.
21. Thyroid cancer.

(b) “Employer” has the same meaning as in s. 112.191.

(c) “Firefighter” means an individual employed as a full-time firefighter or full-time, Florida-certified fire investigator within the fire department or public safety department of an employer whose primary responsibilities are the prevention and extinguishing of fires; the protection of life and property; and the enforcement of municipal, county, and state fire prevention codes and laws pertaining to the prevention and control of fires; or the investigation of fires and explosives.

(2) Upon a diagnosis of cancer, a firefighter is entitled to the following benefits, as an alternative to pursuing workers’ compensation benefits under chapter 440, if the firefighter has been employed by his or her employer for at least 5 continuous years, has not used tobacco products for at least the preceding 5 years, and has not been employed in any other position in the preceding 5 years which is proven to create a higher risk for any cancer:

(a) Cancer treatment covered within an employer-sponsored health plan or through a group health

insurance trust fund. The employer must timely reimburse the firefighter for any out-of-pocket deductible, copayment, or coinsurance costs incurred due to the treatment of cancer.

(b) A one-time cash payout of $25,000, upon the firefighter's initial diagnosis of cancer.

(c) Leave time and employee retention benefits equivalent to those provided for other injuries or illnesses incurred in the line of duty.

If the firefighter elects to continue coverage in the employer-sponsored health plan or group health insurance trust fund after he or she terminates employment, the benefits specified in paragraphs (a) and (b) must be made available by the former employer of a firefighter for 10 years following the date on which the firefighter terminates employment so long as the firefighter otherwise met the criteria specified in this subsection when he or she terminated employment and was not subsequently employed as a firefighter following that date.

(3)(a) If the firefighter participates in an employer-sponsored retirement plan, the retirement plan must consider the firefighter totally and permanently disabled in the line of duty if he or she meets the retirement plan's definition of totally and permanently disabled due to the diagnosis of cancer or circumstances that arise out of the treatment of cancer.

(b) If the firefighter does not participate in an employer-sponsored retirement plan, the employer must provide a disability retirement plan that provides the firefighter with at least 42 percent of his or her annual salary, at no cost to the firefighter, until the firefighter's death, as coverage for total and permanent disabilities attributable to the diagnosis of cancer which arise out of the treatment of cancer.

(4)(a) If the firefighter participated in an employer-sponsored retirement plan, the retirement plan must consider the firefighter to have died in the line of duty if he or she dies as a result of cancer or circumstances that arise out of the treatment of cancer.

(b) If the firefighter did not participate in an employer-sponsored retirement plan, the employer must provide a death benefit to the firefighter's beneficiary, at no cost to the firefighter or his or her beneficiary, totaling at least 42 percent of the firefighter's most recent annual salary for at least 10 years following the firefighter's death as a result of cancer or circumstances that arise out of the treatment of cancer.

(c) Firefighters who die as a result of cancer or circumstances that arise out of the treatment of cancer are considered to have died in the manner as described in s. 112.191(2)(a), and all of the benefits arising out of such death are available to the deceased firefighter's beneficiary. Such death benefits must be made available by the former employer of the firefighter for 1 year after the date on which the firefighter terminated employment so long as the firefighter otherwise met the criteria specified in this subsection when he or she terminated employment and was not employed as a firefighter after that date.

(5)(a) The costs to provide the reimbursements and lump sum payments under subsection (2) and the

costs to provide disability retirement benefits under paragraph (3)(b) and the line-of-duty death benefits under paragraph (4)(b) must be borne solely by the employer.

(b) The employer or employers participating in a retirement plan or system are solely responsible for the payment of the contributions necessary to fund the increased actuarial costs associated with the implementation of the presumptions under paragraphs (3)(a) and (4)(a), respectively, that cancer has, or the circumstances that arise out of the treatment of cancer have, either rendered the firefighter totally and permanently disabled or resulted in the death of the firefighter in the line of duty.

(c) An employer may not increase employee contributions required to participate in a retirement plan or system to fund the costs associated with enhanced benefits provided in subsections (3) and (4).

(6) The Division of State Fire Marshal within the Department of Financial Services shall adopt rules to establish employer cancer prevention best practices as it relates to personal protective equipment, decontamination, fire suppression apparatus, and fire stations.

History.—s. 1, ch. 2019-21; s. 1, ch. 2022-131; s. 3, ch. 2024-140; s. 1, ch. 2026-99.

CITY OF TAMPA
NOTICE REGARDING FIREFIGHTER CANCER BENEFIT

The Florida Firefighter Cancer Benefit (FFCB) is a voluntary program available to all affected qualifying employees who have been diagnosed with an eligible cancer condition as outlined under Florida SB 426 effective July 1, 2019 (codified at Fla. Stat. §112.1816) and who have elected to forego filing a workers compensation claim under Chapter 440. The program is administered according to federal rules, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the FFCB you will be asked to complete and remit multiple related forms, including but not limited to personal affirmations, and medical and diagnosis materials and receipts received from providers regarding your medical condition, explanation of benefits and other requested materials including deductible and other expenditure information from insurers and TPA's, as it relates to the eligible cancers covered by this bill, or resulting from the treatment thereof.

Qualifying employees who choose to participate in this reimbursement and diagnosis payment program are required to complete the associated relevant forms as a condition to receive the diagnosis payout, and any out-of-pocket reimbursements for treatment of the cancer condition.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personal identifiable health information. Although the FFCB and the City of Tampa may use the information for the purposes of payment and reimbursements it deems due under the program, they will never disclose any of your personal information publicly, except as necessary to respond to a request from you or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the FFCB will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the FFCB, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the FFCB or receive payments under this program. Anyone who receives your information for purposes of providing you with payments or services as part of the FFCB will abide by the same confidentiality requirements.

In addition, all medical information obtained through the FFCB will be maintained separate from your personnel records, and no information you provide as part of the FFCB will be used in making any employment decision.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the FFCB, nor may you be subjected to retaliation if you choose not to participate.
If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Human Resources/Benefits at (813) 274-5757 or email to benefits@tampagov.net.

Leave Time for Absence From Work (Active Employees)

If approved for Firefighter Cancer Benefits, any absence from your scheduled work for treatment of cancer will be coded as FD D COP. This code will not require the employee to use accrued sick leave per FL Statute 112-1816. It is your responsibility to provide the Employee Medical Absence Notice(s) to your supervisor prior to the end of the pay period in order to receive your paid leave. If this cannot be provided timely you may submit the notice(s) after the applicable payroll through your supervisor to Human Resources to have your timecards corrected.