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VFIS.com

Return completed application to your
Regional Director or submissions@vfis.com

APPLICATION

PROPERTY & CASUALTY / ACCIDENT & SICKNESS / BENEFITS

GENERAL INFORMATION

Date of Application: _____ Date Proposal Needed By: _____

Current Carrier and Agency: _____ Expiration Date: _____

Type of Organization: Independent Department Municipally Owned Tax District
 Other (Describe: _____)

Full Legal Name: _____
(List all legal entities such as Fire Districts, Fire Companies, Rescue Squads, Auxiliaries and other organizations that are to be Named Insureds.)

Federal Employer Identification Number (FEIN): _____

Organization's Mailing Address: _____
Street or PO Box

City County State Zip Code

Organization's fax number: (____) _____ Organization's website: _____

Inspection and Insurance Contact Name: _____

Phone: (____) _____ E-mail: _____

Is your organization incorporated? Yes No
If No, are you an: Unincorporated Association
 Political Subdivision
 Joint Venture (attach copy of agreement)
 Other (Describe: _____)

If No, are you chartered? Yes No

Is the applicant a for-profit or not-for-profit organization? For-Profit Not-for-Profit

- Type of Department: Fire Department / District
 Fire Department / District with Ambulance
 Ambulance Corps (pre-survey may be required)
 Rescue Squad
 First Responder
 Hospital EMS (pre-survey required; call VFIS for assistance before proceeding)
 Relief Association
 County / State Association (Please complete the attached County Rated A&S Supplement)
 Search & Rescue Team
 911 Emergency Dispatch (pre-survey required; call VFIS for assistance before proceeding)
 Training School (call VFIS for assistance before proceeding)
 Haz Mat Team (call VFIS for assistance before proceeding)
 Other (Describe: _____)

Population of area served on a first call basis: _____

Number of full-time paid employees: _____

A full-time employee is one who is regularly scheduled to work 35 or more hours a week. These hours may be in a set rotation or in varying shifts from week to week.

Number of part-time paid employees: _____

A part-time employee is one who works less than 35 hours a week, or has no set number of hours a week, or receives an hourly rate per call.

Number of active volunteers: _____

A volunteer performs services without expectation of any compensation.

Number of publicly elected trustees, commissioners or directors: _____

Estimated number of responses per year:

Fire and other non-medical runs. _____

Emergency medical or first responder medical runs. Include number of runs involving medical treatment either at the scene of an emergency or while in transport (or both). _____

Non-emergency transports. _____

Are all volunteers covered by Workers' Compensation? Yes No N/A

Are all paid employees covered by Workers' Compensation? Yes No N/A

If No to either of the above, is there an Accident & Sickness policy in force with primary medical benefits of at least \$10,000? Yes No

REAL & PERSONAL PROPERTY Yes No

(Multiple Property Addendum available on website if there are more than 4 locations.)

Coverage type desired: Scheduled Building Scheduled Contents Blanket Contents

Deductible desired: \$500 (Standard) \$1,000 \$2,500 \$5,000

Premises #	Item #	Building Occupied As:	Owner or Tenant?	Total Area of Building (including all floors)	Street Address City, State County, Zip Code

Premises #	Item #	Amount of Insurance (Show 100% replacement cost values. In the building amount, include the values of towers, sirens, antennas, etc. wherever located)		Protection Class	Construction Code * Y / N	Sprinkler System Y / N	Mortgagee Name and Address
		Building	Contents (\$5,000 minimum)				

* Construction codes: 1 – frame 4 – masonry noncombustible 7 – heavy timber joisted masonry
 2 – joisted masonry 5 – modified fire resistive 8 – superior noncombustible
 3 – noncombustible 6 – fire resistive 9 – superior masonry noncombustible

Premises #	Item #	Year Built	Age of electrical system if more than 35 years old	If more than one entity is insured, to which one is this property assigned?	Occupied 24 hours per day?	Are there any structures at this premises that you <u>don't</u> want to insure? If so, describe them below and make sure their values are not included in the "amount of insurance" requested on the previous page.

Do you want VFIS to estimate the building value for you? Yes No (If Yes, complete Supplement B for each building.)

GENERAL LIABILITY <input type="checkbox"/> Yes <input type="checkbox"/> No

- Limits desired:
- | | |
|---|---|
| <input type="checkbox"/> \$300,000 occ. / \$1,000,000 agg. | <input type="checkbox"/> \$5,000 Medical Expense (standard) |
| <input type="checkbox"/> \$500,000 occ. / \$1,000,000 agg. | <input type="checkbox"/> \$10,000 Medical Expense |
| <input type="checkbox"/> \$1,000,000 occ. / \$2,000,000 agg. | |
| <input type="checkbox"/> \$1,000,000 occ. / \$3,000,000 agg. | |
| <input type="checkbox"/> \$1,000,000 occ. / \$10,000,000 agg. (aggregate limit does not apply to each named insured with this option) | |

Do you desire a \$10,000 Line of Duty Accidental Death Benefit? Yes No
(not available in CA, NH, NY, OH, TX and VA)

If the Workers' Compensation coverage does not provide Employer's Liability, does the applicant want Employer's Liability coverage as part of the General Liability? Yes No

If yes, show the total annual payroll: \$ _____

If yes, choose limits:

	Bodily injury by accident – each accident	Bodily injury by disease – policy limit	Bodily injury by disease – each volunteer or employee
<input type="checkbox"/>	\$100,000	\$500,000	\$100,000
<input type="checkbox"/>	\$500,000	\$500,000	\$500,000
<input type="checkbox"/>	\$500,000	\$1,000,000	\$500,000
<input type="checkbox"/>	\$1,000,000	\$1,000,000	\$1,000,000
<input type="checkbox"/>	\$1,000,000	\$2,500,000	\$1,000,000

Check all applicable fundraising or social activities that apply and provide the information requested for each:

<input type="checkbox"/>	Carnivals or field days with mechanical amusement rides	Number of days held annually: ____	Are rides operated by an amusement ride contractor? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, does the contractor carry at minimum \$1 million in liability limits? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, does the contractor name this applicant as an Additional Insured and provide them with a COI? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Conventions sponsored	Number of days held annually: ____	
<input type="checkbox"/>	Fireworks sponsored	Number of days held annually: ____	Fireworks are detonated by: <input type="checkbox"/> Qualified outside contractor <input type="checkbox"/> Applicant If detonated by outside contractor, does the contractor carry at minimum \$1 million in liability limits? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, does the contractor name this applicant as an Additional Insured and provide them with a COI? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Bingo	Number of days held annually: ____	
<input type="checkbox"/>	Motorized events <ul style="list-style-type: none"> • tractor pulls • mud bogs • etc. 	Type of event: _____ Number of days held annually: ____	
<input type="checkbox"/>	Hall rentals	Number of days rented annually: ____	Written agreement signed by renter? <input type="checkbox"/> Yes (attach specimen copy) <input type="checkbox"/> No COI obtained if renter is other than an individual? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Social Club	Square footage of club: _____	
<input type="checkbox"/>	Boats greater than 100hp (do not include jet skis or wave runners)	Number: _____	If physical damage is desired please be sure to schedule coverage under portable equipment
<input type="checkbox"/>	Grandstand or bleachers	Number: _____	
<input type="checkbox"/>	Vacant Land	Number of acres: _____	
<input type="checkbox"/>	Other (describe):		

Do all areas of public assembly have emergency lighting? Yes No N/A

Do you participate in any sports activities on a league basis? Yes No

If Yes, do you have an Accident & Sickness policy with a league sports rider (or similar first-party medical coverage for sports activities)? Yes No

Which of the following best describes the organization's use of alcoholic beverages?

The organization sells alcohol year-round (bar or club)

Show annual gross receipts: \$ _____
License or permit required by the state? Yes No
License or permit obtained? Yes No

The organization sells alcohol at special events.

Describe event(s): _____
Show annual gross receipts: \$ _____
License or permit required by the state? Yes No
License or permit obtained? Yes No

The organization permits alcohol on the premises or at sponsored functions, but does not sell it.

The organization provides bartenders to serve alcohol supplied by others at functions such as the rental of the social hall.

The organization prohibits alcohol on the premises and at sponsored functions.

Have you entered into any written agreements to have another entity perform fire / EMS / rescue or dispatching services for you?

Yes No If Yes, please forward a copy of all such contracts.

Do you use paramedics or firefighters that are contracted out to you by a labor leasing firm?

Yes No If Yes, please forward a copy of all such contracts and answer the following:

Number of employees leased on a full-time basis: _____

Number of employees leased on a part-time basis: _____

Do you have a specially organized hazardous materials response team as part of your organization? Yes No

Do you own or are you responsible for any above ground storage tanks? Yes No

(If yes, and you'd like pollution liability coverage, please complete Supplement D. Note that VFIS does not offer pollution liability coverage for underground storage tanks.)

What is the organization's level of state certification or licensing?

- Not state certified or licensed
- First Responder
- Basic Life Support
- Advanced Life Support

If "not state certified or licensed" or "first responder" was checked above, describe the highest level of service provided:

- Non-medical only
- Basic Life Support
- Advanced Life Support

Do you sponsor a Junior Firefighter program (or explorer post)? Yes No

If yes, are criminal background checks done on leaders? Yes No

If yes, do you have written rules stating that one leader should never be alone with a junior member? Yes No

CRIME **Yes** **No**

Do checks require at least two signatures?

Yes, in excess of \$ _____ No

Do purchases require the signed approval of two or more people?

Yes, in excess of \$ _____ No

Are bank accounts, credit card statements and vendor payments reconciled at least monthly? Yes No

Are bank accounts and credit card statements reconciled by someone not authorized to deposit, withdraw or use the card? Yes No

Are criminal background checks done on persons who regularly handle money? Yes No

Are you aware of, or do you have knowledge of, any dishonest or criminal act committed by any of your members prior to the date of this questionnaire, whether committed during the course of their membership with you or otherwise? Yes No

If yes, explain:

Are financial records audited by outside parties?

If yes, how often? _____

Does your organization run bingo nights or other games of chance? Yes No

If yes, how often? Annually Monthly Weekly or more often

If yes, approximate annual revenues raised by such gaming? \$ _____

Note: If you are requesting a bond that exceeds \$4,000,000 in limits, please provide us with your most current financial statement.

Below, please indicate the entity to be covered by the bond. If more than eight entities are to be covered, please include additional information in the "Wrap-Up" section of this application - page 13.

<input type="checkbox"/> Employee Dishonesty – Blanket (for use with non-governmental entities) Limit: \$ _____	Covered Entities: _____ _____ _____ _____ _____ _____ _____
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<input type="checkbox"/> Public Employee Dishonesty – Blanket (for use with governmental entities) Limit: \$ _____ Faithful Performance: <input type="checkbox"/> Yes <input type="checkbox"/> No	Covered Entities: _____ _____ _____ _____ _____ _____ _____
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Faithful performance is not available for non-governmental entities unless it's specifically required in the organization's by-laws, constitution, or resolution (please provide a copy).

<input type="checkbox"/> Employee Dishonesty - Name or Position Schedule Bond			
Name or Position	Covered Entity (if more than one)	Limit	Faithful Performance (governmental entities only)
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

Answer only if you've requested both a Blanket Employee Dishonesty bond and a Name or Position Schedule bond. Is the Name or Position Schedule bond intended to be:

- Primary
- Specific excess over the Blanket Employee Dishonesty bond

Note: Forgery or Alteration, Computer Fraud and Identity Fraud Expense are coverage extensions that are only available if Employee Dishonesty coverage was requested.

<input type="checkbox"/> Forgery or Alteration Limit: <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$250,000 <input type="checkbox"/> \$500,000 <input type="checkbox"/> \$1,000,000 Other: \$ _____	Covered Entities: _____ _____ _____ _____ _____ _____
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<input type="checkbox"/> Computer Fraud Limit: <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$100,000 * \$10,000 limit is included automatically for any insured that purchases blanket employee dishonesty or blanket public employee dishonesty coverage of \$10,000 or more.	Covered Entities: _____ _____ _____ _____ _____ _____
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<input type="checkbox"/> Identity Fraud Expense Limit: <input type="checkbox"/> \$25,000 * \$10,000 limit is included automatically for any insured that purchases blanket employee dishonesty or blanket public employee dishonesty coverage of \$10,000 or more.	Covered Entities: _____ _____ _____ _____ _____ _____
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VEH #	YEAR	MAKE	DESCRIPTION (MODEL / TYPE)	VEHICLE CLASS (below)	SERIAL NUMBER (VIN)	GVW*	AGREED VALUE	OPTIONAL AGREED VALUE	Garaged at Premises #	TERR.
EX.	2004	Freightliner	1000 GPM Pumper	PR	1HTLFTVL6KH666870	40,000	\$250,000	\$350,000	3	045
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

(Supplemental Vehicle Schedule available on website if additional space is required for more than 10 vehicles.)

- If you have unique names or numbers to identify your vehicles (for example, Truck 55), we can include them on the policy for your convenience. Just provide them in the DESCRIPTION column above the model/type.
- If there is more than one Named Insured, please tell us which one is responsible for each vehicle. Just write in an abbreviation or other appropriate identifier in the GARAGED AT column above the premises number.

***If trailer, please provide load capacity in lieu of GVW.**

VEHICLE CLASSES

PR	Pumper (regular)	BV	Brush Vehicle	RTH	Heavy Rescue Truck	ANTQ	Antique	CF	Chemical and Foam Unit
PLDH	Pumper with large diameter hose	AD	Aerial Device	ALS	Advanced Life Support Ambulance	SNOW	Snowmobile	AC	Air Cascade Unit
T	Tanker	QR	Quint (regular)	BLS	Basic Life Support Ambulance	TRL	Trailer	S	Salvage Truck
PT	Pumper/Tanker	QLDH	Quint with large diameter hose	FR	First Responder Vehicle	SERV	Non-emergency vehicle (give "original cost new" in the "agreed value" column)	PPT	Chief's Car
MP	Mini-Pumper	RTL	Light Rescue Truck	HM	Hazardous Materials Vehicle	TOUR	Tournament Vehicle	BUS	Bus

PORTABLE EQUIPMENT **Yes** **No**

Indicate the type of coverage needed: Blanket Scheduled Blanket and Scheduled

Choose a deductible: \$250 \$500 \$1,000 \$2,500 \$5,000

For blanket coverage, you must complete the "Vehicle Class" column on the vehicle schedule. Account for all vehicles owned by the organization or furnished to the organization for regular use. Use the codes defined on page 10.

For scheduled coverage, please provide the following for each item insured. Attach a separate sheet if necessary.

Item #	Description	Serial Number	Unit Value	Quantity

(Portable Equipment Addendum available on website if additional space is required.)

Unmanned Aircraft Systems (Drones)

Does your organization own or operate drones? Yes No

Model	Serial Number	Weight (lbs./oz.)	Value of Drone	Value of Attached Equipment

Are all operations being conducted in accordance with FAA rules? Yes No

How many personnel are authorized to operate the drones? _____

How many hours of training are required prior to personnel being authorized to operate the drones? _____

Does your organization loan, rent or lease the drones to others? Yes No

If "Yes,"

a. Describe whom: _____

b. Will you loan, rent or lease: with your authorized operator without your operator

For scheduled search and rescue dogs, please provide the following for each animal. Attach a separate sheet if necessary.

Breed	Sex	Year of Birth	Name	Agreed Value

- Yes No Do you have current firewall management software installed on your computer network?
- Yes No Do you have current antivirus management software installed on your computer network?
- Yes No Do you have a written security and privacy policy?

Cyber Liability and Privacy Crisis Management Expense Comments: _____

EXCESS LIABILITY **Yes** **No**

Indicate limits: \$ _____ occurrence / \$ _____ aggregate

Note: Underlying limits of \$1,000,000 are required.

Coverage desired over: General Liability Management Liability Automobile Liability
 (Check all that apply)

WRAP-UP INFORMATION

Any special information the underwriter should know? If available, include the current premiums and attach loss runs for the past four years.

Answer in all states except Missouri: Has the applicant's insurance program been cancelled or non-renewed by another carrier? Yes No If Yes, please provide details:

Name of Producing Agency: _____

Agency's Address: _____

Agency's Phone: (____) _____ Agency's Fax: (____) _____

Agency's E-mail Address: _____

Agent's Signature: _____

Applicant's Signature: _____

If you are not licensed as a broker, are you a property / casualty agent? Yes No

Name and email address of producer or CSR (for contact purposes): _____

If you have never placed business with us before, please provide the person responsible for agency/brokerage licensing and contracting:

- Contact's Name: _____
- Contact's Email: _____
- Contact's Direct Phone: _____

PLEASE READ CAREFULLY --- GENERAL FRAUD WARNING NOTICE

Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act, which is a crime and may subject the person to criminal and civil penalties.

STATE-SPECIFIC FRAUD WARNING NOTICES

Alabama Fraud Warning

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arkansas Fraud Warning

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado Fraud Warning

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware Fraud Warning

Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act, which is a crime and may subject the person to criminal and civil penalties.

Florida Fraud Warning

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kansas Fraud Warning

Any person who commits a fraudulent insurance act is guilty of a crime and may be subject to restitution, fines and confinement in prison. A fraudulent insurance act means an act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer or insurance agent or broker, any written statement as part of, or in support of, an application for insurance, or the rating of an insurance policy, or a claim for payment or other benefit under an insurance policy, which such person knows to contain materially false information concerning any material fact thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

Kentucky Fraud Warning

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana Fraud Warning

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maine Fraud Warning

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland Fraud Warning

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Hampshire Statement of Residency

To procure automobile insurance, I hereby attest that I am, and each named insured is, a resident of the State of New Hampshire. I understand that if I falsely claim for myself or any named insured to be a resident of the State of New Hampshire, I am subject to prosecution, imprisonment of up to one year, a fine of \$2,000 and the denial of coverage for any loss, not occurring in New Hampshire, under the automobile insurance policy for which I am applying. I also understand that this statement will be relied upon in connection with future renewals of the automobile insurance policy for which I am applying, and that it is my responsibility to inform my insurance company before my next renewal after I or any named insured ceases to be a New Hampshire resident and that I will be subject to the penalties listed above if I fail to do so.

New Jersey Fraud Warning

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New Mexico Fraud Warning

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

New York Fraud Warning

Commercial Insurance: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Automobile Insurance: Any person who knowingly and with intent to defraud any insurance company or other person files an application for commercial insurance or a statement of claim for any commercial or personal insurance benefits containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who, in connection with such application or claim, knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the value of the subject motor vehicle or stated claim for each violation.

Ohio Fraud Warning

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma Fraud Warning

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon Fraud Warning

Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

Pennsylvania Fraud Warning

All Types of Insurance: Any person who knowingly and with intent to defraud any insurance company or other person files an application or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Motor Vehicle Insurance: Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and payment of a fine of up to \$15,000.

Rhode Island Warning

All Types of Insurance: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Tennessee Fraud Warning

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Vermont Fraud Warning

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Virginia Fraud Warning

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Washington Fraud Warning

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

West Virginia Fraud Warning

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Your signature below acknowledges that you have read the General Fraud Warning Notice and the State Specific Fraud Warning Notice that applies to your state of domicile.

The undersigned is an authorized representative of the applicant and certifies the information provided to obtain this coverage is accurate to the best of their knowledge; this includes any applications, locations schedules, valuation statements, loss history information and engineering reports.

Applicant's signature: _____ **Title:** _____ **Date:** _____

Agent's signature: _____ **Date:** _____

ACCIDENT & SICKNESS

(Supplement A)

Important Note: If quoting A&S only, pages 1 and 2 of this application must be completed

Current Carrier: _____ Date Proposal Needed By: _____

Number of locations with emergency operations? _____

Do you operate an ambulance? Yes No

Does your organization perform medical evaluations meeting the requirements of NFPA 1582 or OSHA CFR 29 910.134 Respiratory Protection Standard? Yes No

Does your organization have a Safety Officer meeting the requirements of NFPA 1500 and/or NFPA 1521? Yes No

Do you want to cover: Volunteers only Paid Personnel only Both Volunteers and Paid Personnel

Indicate number of Members based on the following classifications:

Volunteer Members	Career Members
Include unpaid members, paid per call and part-time members averaging less than 25 hours per week.	Members who average 25 hours or more employment per week (hourly or salary).
_____ Active Volunteers One who receives no compensation or is paid per call.	_____ Full-Time Paid Employees One who averages 25 hours or more a week (hourly or salary).
_____ Part-Time Paid Employees One who averages less than 25 hours a week, has no set number of hours a week, or receives an hourly rate per call.	_____ Administrative Personnel Paid Employee whose job description does not include emergency response or training.
_____ Auxiliary Members _____ Junior Members _____ Trustees, Commissioners, Directors	Illinois and Ohio Please complete Supplement for Membership Classification. Contact the VFIS Regional Director for additional information.

Who is covered by Workers' Compensation? Volunteers Paid Personnel

Volunteers are covered for: Disability? Medical? Both?

Specify Carrier: _____

Provide Medical Expense Benefits: *(Check appropriate box.)*

	Volunteers	Paid Personnel
Excess of Workers' Compensation		
Primary <i>(first dollar)</i>		
Not Applicable		

THREE YEAR LOSS HISTORY <i>(attach loss runs when available)</i>				
Date	Type	Paid	Reserved	Total Incurred

Benefit Limits:

AD&D / Loss of Life (\$20,000 - \$500,000)

Weekly Indemnity (\$100 - \$1,000)

Medical Expense (\$2,500 - \$100,000)

First 28 _____
 After 28 _____

Weekly Hospital Benefit Yes No
 First Week Total Disability Benefit Yes No
 Coordinated 28 Day Total Disability Benefit* \$ _____ Volunteer \$ _____ Career
 Transition Benefit Yes No – Volunteer Yes No – Career
 Extended Total Disability Benefit Yes No – Volunteer Yes No – Career
 Long-Term Total Disability Benefit* Yes No – Volunteer Yes No – Career
 Weekly Injury Perm. Impairment Benefit COLA Yes No – Volunteer Yes No – Career
 Long-Term Total Disability Benefit COLA* Yes No – Volunteer Yes No – Career
 Extra Expense Benefit Yes No – Volunteer Yes No – Career
 Special Events Rider Yes No – **Contact your Underwriter for quote information.**

***Not available in all states.**

Billing Schedule: Annual Semi-Annual Installments (\$1,500 minimum premium; Not available in MA, RI or WA.)

Florida Only: Yes No – Florida Statutory Death Benefits per Title X, Chapter 112.191(a), (b) and (c).

League Sports Rider		<input type="checkbox"/> Yes <input type="checkbox"/> No
Type of Sport: _____	Number of participants: _____	
Start date: _____	Length of season: _____	
	<u>AD&D Benefit</u>	<u>Accident Medical Expense</u>
<input type="checkbox"/> Option #1	\$5,000	\$5,000
<input type="checkbox"/> Option #2	\$10,000	\$10,000
		<u>Weekly Accident Indemnity</u>
		\$100
		\$200

24-Hour Accident Benefit – Injury Only**	OR	Off-Duty Accident Benefit – Injury Only**
<i>AD&D for Covered Activities AND Off-Duty Activities</i>		<i>AD&D for Off-Duty Activities Only</i>
\$ _____ (\$10,000 - \$50,000)		\$ _____ (\$10,000 - \$50,000)
<i>(This limit cannot exceed the primary AD&D limit.)</i>		<i>(This limit cannot exceed the primary AD&D limit.)</i>
<u>Specify class and number of persons on roster for 24-Hour or Off-Duty benefits.</u>		
Active Volunteers _____		Trustees, Commissioners or Directors _____
Part-Time Paid Employees _____		Administrative Personnel _____
Auxiliary Members _____		Full-Time Paid Employees _____
Junior Members _____		
** Coverage cannot be bound without a copy of the insured's roster indicating the members covered for this benefit.		

Name of Producing Agency: _____

Agency's Address: _____

Agency's Phone: (____) _____ Agency's Fax: (____) _____

Agent's E-mail Address: _____

Producer Signature: _____

County Rated Accident and Sickness Supplement
(Photocopy this page if more than three departments)

For each department that is to be covered, complete the following questions:

1. Department Name: _____
 2. Number of Locations: _____ First Call Population: _____
 3. Does this entity operate an ambulance? Yes No
 4. Number of calls annually: Fire _____ EMS: _____
 5. Do you want to cover volunteers only paid employees only both volunteers and paid employees
 6. Total number of: Volunteers _____ Auxiliary Members _____ Administrative Personnel _____
Trustees _____ Jr. Members _____ Part-time paid employees _____ Full-time paid employees _____
 7. Are all volunteers covered by Workers' Compensation? Yes No N/A
 8. Are paid employees covered by Workers' Compensation? Yes No N/A
 9. Provide Medical Expense for volunteers: Excess of Workers' Comp Primary (First Dollar) N/A
 10. Provide Medical Expense for paid employees: Excess of Workers' Comp Primary (First Dollar) N/A
-

For each department that is to be covered, complete the following questions:

1. Department Name: _____
 2. Number of Locations: _____ First Call Population: _____
 3. Does this entity operate an ambulance? Yes No
 4. Number of calls annually: Fire _____ EMS: _____
 5. Do you want to cover volunteers only paid employees only both volunteers and paid employees
 6. Total number of: Volunteers _____ Auxiliary Members _____ Administrative Personnel _____
Trustees _____ Jr. Members _____ Part-time paid employees _____ Full-time paid employees _____
 7. Are all volunteers covered by Workers' Compensation? Yes No N/A
 8. Are paid employees covered by Workers' Compensation? Yes No N/A
 9. Provide Medical Expense for volunteers: Excess of Workers' Comp Primary (First Dollar) N/A
 10. Provide Medical Expense for paid employees: Excess of Workers' Comp Primary (First Dollar) N/A
-

For each department that is to be covered, complete the following questions:

1. Department Name: _____
2. Number of Locations: _____ First Call Population: _____
3. Does this entity operate an ambulance? Yes No
4. Number of calls annually: Fire _____ EMS: _____
5. Do you want to cover volunteers only paid employees only both volunteers and paid employees
6. Total number of: Volunteers _____ Auxiliary Members _____ Administrative Personnel _____
Trustees _____ Jr. Members _____ Part-time paid employees _____ Full-time paid employees _____
7. Are all volunteers covered by Workers' Compensation? Yes No N/A
8. Are paid employees covered by Workers' Compensation? Yes No N/A
9. Provide Medical Expense for volunteers: Excess of Workers' Comp Primary (First Dollar) N/A
10. Provide Medical Expense for paid employees: Excess of Workers' Comp Primary (First Dollar) N/A

VFIS BUILDING VALUATION FORM
Photos of Building Must Accompany Completed Form
(Supplement B)

Submitted by: _____ Date: _____

General Information

<u>Client Information</u>	<u>Policy Information</u>
Name: _____	Coverage Amount: _____
Location Address: _____ _____	Policy Number: _____
City: _____	Location Number: _____
State/Zip Code: _____	

Structure Information

(Answer only the applicable information for each structure. Some fields on the worksheet do not apply for every structure.)

<u>Structure Type:</u>	
<input type="checkbox"/> Fire Station, Paid: _____%	Year Built: _____
<input type="checkbox"/> Fire Station, Volunteer: _____%	Total Square Footage: _____
<input type="checkbox"/> Social Club: _____%	Ground Floor Area: _____
<input type="checkbox"/> Govt. Buildings: _____%	Number of Floors: _____
<input type="checkbox"/> Office: _____%	Perimeter: _____
<input type="checkbox"/> Other: _____%	Basement Square Footage: _____
	Type: <input type="checkbox"/> Finished <input type="checkbox"/> Unfinished
	Other Area Type (<i>mezzanine, balcony, etc.</i>) and Square Footage Amount: _____
<i>(Check all that apply)</i>	

<u>Building Code Class</u>	<u>Construction Type</u>
<input type="checkbox"/> 1 – Frame Combustible: _____%	<input type="checkbox"/> Framing, Wood: _____%
<input type="checkbox"/> 2 – Joisted Masonry: _____%	<input type="checkbox"/> Metal Frame: _____%
<input type="checkbox"/> 3 – Noncombustible: _____%	<input type="checkbox"/> Masonry, Block: _____%
<input type="checkbox"/> 4 – Noncombustible (Masonry): _____%	<input type="checkbox"/> Masonry, Brick: _____%
<input type="checkbox"/> 5 – Modified Fire Resistive: _____%	<input type="checkbox"/> Other: _____%
<input type="checkbox"/> 6 – Fire Resistive: _____%	
<i>(Check all that apply)</i>	<i>(Check all that apply)</i>

<u>Construction Quality</u>
<input type="checkbox"/> Basic – Plain, square/rectangular, no trim or decoration
<input type="checkbox"/> Average – Typical building style for occupancy, limited trim or decoration
<input type="checkbox"/> Above Average – More complex in shape or building style with more features, trim, decoration
<input type="checkbox"/> Expensive – Complex shape/roofline, specialized/costly materials or features
<input type="checkbox"/> Very Expensive – Involves well known architect/developer, expensive or vintage features
<input type="checkbox"/> Exceptional – Unique/vintage building, extensive use of artisans, finest materials/quality

Building Exterior

<input type="checkbox"/> Brick veneer, standard _____% <input type="checkbox"/> Brick wall, reinforced w/ rebar _____% <input type="checkbox"/> Concrete block _____% <input type="checkbox"/> Concrete block, split face _____% <input type="checkbox"/> Metal siding, corrugated aluminum _____% <input type="checkbox"/> Siding, hardboard (wood) _____% <input type="checkbox"/> Panels, cement fiber siding _____%	<input type="checkbox"/> Siding, vinyl _____% <input type="checkbox"/> Stone veneer, frame _____% <input type="checkbox"/> Stone veneer, masonry _____% <input type="checkbox"/> Stucco _____% <input type="checkbox"/> Tilt up, concrete wall _____% <input type="checkbox"/> Other _____% <i>(Check all that apply)</i>
---	---

Foundation Type

<input type="checkbox"/> Concrete block <input type="checkbox"/> Concrete slab <input type="checkbox"/> Partial concrete slab	<input type="checkbox"/> Poured concrete walls <input type="checkbox"/> Pier and beam <input type="checkbox"/> Other _____
Slope of Site <input type="checkbox"/> Flat <input type="checkbox"/> Slight <input type="checkbox"/> Moderate <input type="checkbox"/> Steep <input type="checkbox"/> Very steep	

Roof Covering

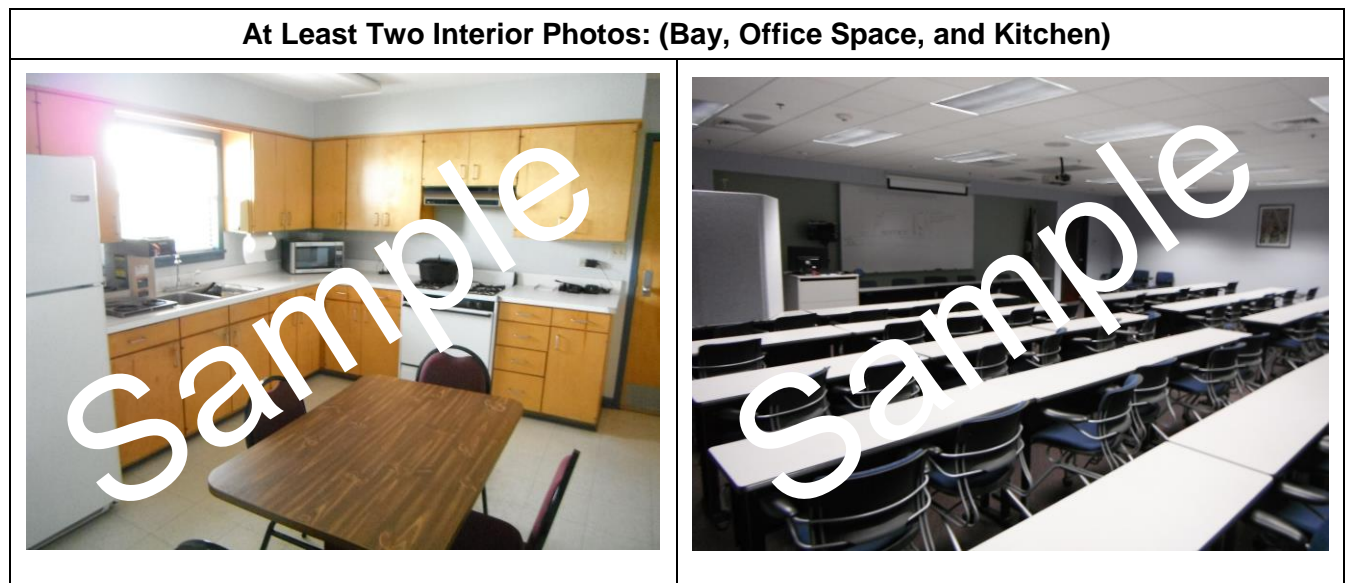
<input type="checkbox"/> Corrugated Aluminum _____% <input type="checkbox"/> Metal, other than standing seam _____% <input type="checkbox"/> Metal, standing seam _____% <input type="checkbox"/> Rubber/Membrane _____% <input type="checkbox"/> Built Up Tar & Gravel _____%	<input type="checkbox"/> Shingles, architectural (30-40 year) _____% <input type="checkbox"/> Shingles, asphalt (Composition Shingle) _____% <input type="checkbox"/> Tiles, Slate _____% <input type="checkbox"/> Other _____% <i>(Check all that apply)</i>
Roof Pitch <input type="checkbox"/> Flat <input type="checkbox"/> Slight <input type="checkbox"/> Moderate <input type="checkbox"/> Steep	

HVAC

<input type="checkbox"/> Complete HVAC _____% <input type="checkbox"/> Electric (Metal baseboards) _____% <input type="checkbox"/> Electric, wall _____% <input type="checkbox"/> Evaporative cooling _____% <input type="checkbox"/> Floor Furnace _____% <input type="checkbox"/> Forced air unit _____% <input type="checkbox"/> Heat pump _____% <input type="checkbox"/> Hot water _____%	<input type="checkbox"/> Hot water, radiant (Floor, walls, etc.) _____% <input type="checkbox"/> Space heater (Overhead Heat Unit) _____% <input type="checkbox"/> Steam _____% <input type="checkbox"/> Steam boiler _____% <input type="checkbox"/> Ventilation _____% <input type="checkbox"/> Warmed and chilled air (Chiller) _____% <input type="checkbox"/> Warmed and cooled air (Condenser) _____% <input type="checkbox"/> None _____% <i>(Check all that apply)</i>
---	--

Equipment/Contents/Other Cost Items: (if any) i.e.: Generators, Radio Towers, Etc.	
Item:	
Item:	
Item:	
Risk Control Use Only: Equipment/Contents Percentage of Structure Value _____%	

Note: Attach Photos and Provide Diagram of Building



Photos of Building Must Accompany Completed Form

“CLAIMS-MADE” MANAGEMENT LIABILITY APPLICATION
(Supplement C)

1. Legal name of applicant: _____
2. Address: _____
3. Desired effective date of coverage: _____
4. Limits of liability requested (cannot be greater than the General Liability limit):
 - \$300,000 each offense or wrongful act / \$1,000,000 aggregate
 - \$500,000 / \$1,000,000
 - \$1,000,000 / \$2,000,000
 - \$1,000,000 / \$3,000,000
 - \$1,000,000 / \$10,000,000 (aggregate limit does not apply to each named insured with this option)
5. Does the applicant have knowledge of any incidents which would cause a reasonable person to believe that a claim or suit might result? Yes No
If Yes, please give complete details, including date: _____

6. Name of person designated to receive any and all notices from the company or agent concerning this insurance:

COVERAGE CANNOT BECOME EFFECTIVE PRIOR TO THE DATE THIS SIGNED APPLICATION IS APPROVED BY THE COMPANY.

THE APPLICANT ACCEPTS NOTICE THAT ANY POLICY WHICH MAY BE ISSUED AND ANY RENEWALS THEREOF WILL APPLY ON A “CLAIMS MADE” BASIS.

The applicant agrees that in the event they become aware of any fact which would serve to alter any answer previously given to one or more of the foregoing questions, they will so advise the agent. The applicant further agrees that based on such revised information, the agent may revise or withdraw any quotation previously given.

The undersigned, being authorized by and acting on behalf of the applicant, declares that to the best of his / her knowledge and after having made proper inquiry, the responses to the foregoing are true and that no facts have been suppressed or any material facts misstated. The applicant further agrees that this application shall be the basis of any policy issued. The application is valid for 90 days from the date it is signed.

Agent's Signature: _____ Applicant's Signature: _____

Address: _____ Title: _____

City / State / Zip: _____ Date: _____

APPLICABLE TO NEW YORK ONLY:

The **CLAIMS MADE** policy covers only claims:

- (1) actually made against the insured while the policy remains in effect, or
- (2) arising from incidents reported to the insurer while the policy remains in effect.

All coverage provided by the policy ceases upon the termination of the policy, except for the automatic (basic) extended reporting period coverage, unless the insured purchases additional (supplemental) extended reporting period coverage.

The automatic (basic) extended reporting period is 90 days. The additional (supplemental) extended reporting period is unlimited, with any period of time less than that being at the insured's option.

The applicant should be aware that there are potential coverage gaps that may arise upon expiration of the applicable (either basic or supplemental) extended reporting period. For example, there is no coverage for a claim made after the applicable extended reporting period terminates unless the incident giving rise to such claim was reported to the insurance company prior to the termination of the applicable extended reporting period.

There is no separate premium charge for the basic extended reporting period. The premium for the supplemental extended reporting period is 50% of the annual premium for the last policy.

If the applicant is changing from an occurrence policy to a claims made policy, the receipt of information from the insurer describing the limited scope of coverage and potential coverage gaps inherent in claims made forms is acknowledged.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Agent's Signature: _____

Applicant's Signature: _____

Address: _____

Title: _____

City / State / Zip: _____

Date: _____

POLLUTION LIABILITY – ABOVE GROUND STORAGE TANKS (Supplement D)

Legal Name: _____

Mailing Address: _____

1. Address / location of tank? _____

2. What was the date of installation? _____
Was the tank new at installation? Yes No
If no, what is the age of the tank? _____

3. What is being stored in the tank? _____

4. What is the maximum tank capacity in gallons? _____

5. What is the distance in feet to nearest adjoining property? _____

6. What is the distance in feet to surface water (lakes, rivers, streams, etc.) or wells? _____
What is the surface water? _____

7. What material is the tank constructed of? _____

8. Does the AST have any secondary containment safeguards? Yes No
If yes, please explain: _____

9. Does the insured routinely monitor the tank to insure they are not leaking? Yes No
If yes, how frequently? _____

10. Do employees, volunteers know and follow release reporting, investigation and confirmation procedures?
 Yes No

11. Physical protection - Is there a vehicle barrier in place to prevent collision? Yes No
Is the tank properly grounded with lightning protection? Yes No

12. Security protection from vandalism – fencing, lighting etc.? Yes No
If yes, please explain: _____

13. Is there any mechanical or electrical equipment attached to the AST such as an electric generator?
 Yes No
If yes, call your VFIS Underwriter for assistance.

Tank # _____ of _____

A photo(s) of the tank as it appears on the premises is required as part of this submission.

SPECIALTY BENEFITS
(Supplement E)

GROUP TERM LIFE **Yes** **No**

Data Required: Census data including member's name, and date of birth.

Proposed Effective Date for the Plan: _____

Basic Face Amount including Basic AD&D: \$ _____

Covered Activity AD&D (from 100% – 200%): _____ %

Reduction Schedule: Standard Reduction (50% at age 70)
(Please check one) None
 Other (explain) _____

Type of Organization: Volunteer Career Combination (Volunteer/Career)

GROUP LONG TERM DISABILITY - CAREER **Yes** **No**

Data Required: Census data including member's name, date of birth, and annual salary.

Proposed Effective Date for the Plan: _____

CRITICAL ILLNESS **Yes** **No**

Proposed Benefits:	Critical Illness <small>(Covered Illness – Cancer Heart Attack and Stroke)</small>	AD&D	Aggregate Limit <small>(per covered accident)</small>
<input type="checkbox"/> Option 1	\$10,000	\$10,000	\$500,000
<input type="checkbox"/> Option 2	\$20,000	\$10,000	\$500,000
<input type="checkbox"/> Option 3	\$30,000	\$10,000	\$500,000

Number of Eligible Persons: _____

Agent's Signature: _____

Applicant's Signature: _____