



183 Leader Heights Road
 P.O. Box 2726, York, PA 17405
 800.233.1957 | Fax: 717.747.7022
 VFIS.com

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

APPLICATION ACCIDENT & SICKNESS

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
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Organization's website: _____ E-mail address: _____

Contact person's name: _____ Title: _____

Day phone: (____) _____ Cell #: (____) _____

Is your organization: Incorporated? Yes No For-Profit or Not-For-Profit? For-Profit Not-for-Profit

If No, are you an: Unincorporated Association Political Subdivision
 Joint Venture *(attach copy of agreement)* Other (Describe: _____)

If No, are you chartered? Yes No

Population of area served on a first call basis: _____ 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

Estimated number of responses per year:

_____ Fire and other non-medical runs	_____ Non-emergency transports
_____ 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.	

Department Type:

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

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 *(attach loss runs when available)*

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
-

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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 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.

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.

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:** _____