



FACTFINDER ACCIDENT & SICKNESS

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: _____

Contact person's name: _____ Title: _____

Day phone: (____) _____ Evening phone: (____) _____ E-mail address: _____

Is this individual (check all that apply): the contact for inspection purposes?
 the contact for education and training purposes?
 the head of the organization?

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 looks to the insured for their primary source of income and averages 25 hours or more employment per week, whether hourly or salaried. 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 averages less than 25 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

ACCIDENT & SICKNESS (Supplement A)

Number of locations with emergency operations? _____

Do you operate an ambulance? Yes No

Illinois only:

Part-time personnel (include members paid per call if more than 25 hours per week): _____

Full-time / collective bargaining members: _____

Does your organization perform medical evaluations meeting the requirements of NFPA 1582 or OSHA CFR 29 1910.134 Respiratory Protection Standard? Yes No

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

Does your organization provide EMS Service beyond First Aid? Yes No

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

If Yes, are they covered for: Disability? Medical? Both?

If Yes, please specify carrier: _____

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

Do you want Medical Expense Benefits for volunteers to be:

- Excess of Workers' Compensation Primary (first dollar)
 Excess of Group Insurance Not applicable

Paid career (or full-time / collective bargaining) to be:

- Excess of Workers' Compensation Primary (first dollar)
 Excess of Group Insurance Not applicable

NOTE: If your volunteers or paid employees are covered by Workers' Compensation, the Medical Expense option is limited to "Excess of Workers' Compensation."

Do you want to cover: volunteers only paid employees only both volunteers and paid employees

THREE YEAR LOSS HISTORY (attach loss run if available)

Date	Type	Paid	Reserved	Total Incurred

Do you want a: 1 year policy? 3 year pre-paid policy? 3 year annual installment policy?

Indicate limits desired:

AD&D / Loss of Life (\$20,000 - \$500,000)	Weekly Indemnity (\$100 - \$1,000)		Medical Expense (\$2,500 - \$100,000)
	First 28	After 28	
<input type="checkbox"/> _____	_____	_____	_____
<input type="checkbox"/> _____	_____	_____	_____
<input type="checkbox"/> _____	_____	_____	_____
<input type="checkbox"/> \$150,000	\$290	\$290	\$75,000 (Indiana Year 2009 Statutory)

Is coverage desired for these options?

- Extended Total Disability Benefit * Yes No – Volunteer Coverage Only
- Weekly Injury Perm. Impairment Benefit COLA Yes No – Volunteer Coverage Only
- Additional First Week Indemnity Yes No
- Special Events Rider * Yes No – **Call your Underwriter for quote information**
- Weekly Hospital Indemnity Yes No

League Sports Rider Yes No

Type of Sport: _____ Number of participants: _____

Start date: _____ Length of season: _____

	AD&D Benefit	Accident Medical Expense	Weekly Accident Indemnity
<input type="checkbox"/> Option #1	\$5,000	\$5,000	\$100
<input type="checkbox"/> Option #2	\$10,000	\$10,000	\$200

FL Statutory Benefit Rider Yes No – Florida Only (Illegal Loss of Life - \$150,000 additional)

* Not available in all states

24-Hour Benefit (AD&D for covered & non-covered activities) **
 Yes No \$ _____ (\$10,000-\$50,000) Not exceeding AD&D amount selected

Non-Covered/Off-Duty Activity (AD&D only for non-covered activities) **
 Yes No \$ _____ (\$10,000-\$50,000) Not exceeding AD&D amount selected

Do you want to cover: Specify number on roster

Active Volunteers	<input type="checkbox"/>	_____
Career Members	<input type="checkbox"/>	_____
Auxiliary Members	<input type="checkbox"/>	_____
Junior Members	<input type="checkbox"/>	_____
Trustees, Commissioners or Director:	<input type="checkbox"/>	_____

**** 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: (____) _____

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: _____
3. Population on a First Call Basis: _____
4. Does this entity operate an ambulance? Yes No
5. Number of calls on an annual basis: Fire _____ EMS: _____
6. Do you want to cover volunteers only paid employees only both volunteers and paid employees
7. Total number of: Volunteers _____ Part-time paid employees _____ Full-time paid employees _____
8. Are all volunteers covered by Workers' Compensation? Yes No N/A
9. Do you want Medical Expense Benefits for volunteers to be Excess of Workers' Compensation Primary (First Dollar)
 Excess of Group Insurance N/A
10. Total number of paid employees: _____
11. Are paid employees covered by Workers' Compensation? Yes No N/A
12. Do you want medical Expense Benefits for paid employees Excess of Workers' Compensation Primary (First Dollar)
 Excess of Group Insurance N/A

NOTE: If your volunteers or paid employees are covered by Workers' Compensation, the Medical Expense option is limited to "Excess of Workers' Compensation".

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2. Number of Locations: _____
3. Population on a First Call Basis: _____
4. Does this entity operate an ambulance? Yes No
5. Number of calls on an annual basis: Fire _____ EMS: _____
6. Do you want to cover volunteers only paid employees only both volunteers and paid employees
7. Total number of: Volunteers _____ Part-time paid employees _____ Full-time paid employees _____
8. Are all volunteers covered by Workers' Compensation? Yes No N/A
9. Do you want Medical Expense Benefits for volunteers to be Excess of Workers' Compensation Primary (First Dollar)
 Excess of Group Insurance N/A
10. Total number of paid employees: _____
11. Are paid employees covered by Workers' Compensation? Yes No N/A
12. Do you want medical Expense Benefits for paid employees Excess of Workers' Compensation Primary (First Dollar)
 Excess of Group Insurance N/A

NOTE: If your volunteers or paid employees are covered by Workers' Compensation, the Medical Expense option is limited to "Excess of Workers' Compensation".

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1. Department Name: _____
2. Number of Locations: _____
3. Population on a First Call Basis: _____
4. Does this entity operate an ambulance? Yes No
5. Number of calls on an annual basis: Fire _____ EMS: _____
6. Do you want to cover volunteers only paid employees only both volunteers and paid employees
7. Total number of: Volunteers _____ Part-time paid employees _____ Full-time paid employees _____
8. Are all volunteers covered by Workers' Compensation? Yes No N/A
9. Do you want Medical Expense Benefits for volunteers to be Excess of Workers' Compensation Primary (First Dollar)
 Excess of Group Insurance N/A
10. Total number of paid employees: _____
11. Are paid employees covered by Workers' Compensation? Yes No N/A
12. Do you want medical Expense Benefits for paid employees Excess of Workers' Compensation Primary (First Dollar)
 Excess of Group Insurance N/A

NOTE: If your volunteers or paid employees are covered by Workers' Compensation, the Medical Expense option is limited to "Excess of Workers' Compensation".

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

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.

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.

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 and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and 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

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 \$5,000 and the value of the subject motor vehicle or stated claim for each violation.

Other Types of 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 \$5,000 and the stated value of the claim for each such 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 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 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.

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.

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.

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:** _____

Producer's signature: _____ **Date:** _____