

FACTFINDER PROPERTY & CASUALTY / 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 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

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 **Yes** **No**

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

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 reconciled by someone not authorized to deposit or withdraw?

Yes No

Are criminal background checks done on persons who regularly handle money?

Yes No

Are financial records audited by outside parties?

Yes No

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.

<input type="checkbox"/> Commercial Blanket Bond (for use with non-governmental entities)	<input type="checkbox"/> Public Employee Blanket Bond (for use with governmental entities)
Limit: \$ _____	Limit: \$ _____
Faithful performance <input type="checkbox"/> Yes <input type="checkbox"/> No	

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).

Below, please indicate the entity to be covered by the Blanket Bond (CBB or PEBB) and the number of ratable persons for each entity. If more than four entities are to be covered, please include additional information in the "wrap up" section of this Factfinder - page 12.

Covered Entity	<input type="checkbox"/> CBB <input type="checkbox"/> PEBB	Number of ratable persons _____
Covered Entity	<input type="checkbox"/> CBB <input type="checkbox"/> PEBB	Number of ratable persons _____
Covered Entity	<input type="checkbox"/> CBB <input type="checkbox"/> PEBB	Number of ratable persons _____
Covered Entity	<input type="checkbox"/> CBB <input type="checkbox"/> PEBB	Number of ratable persons _____

Rateable persons consist of:

- commissioners, directors or trustees who perform the duties of a volunteer or employee,
- all officers, and
- other volunteers or employees who handle, have custody of or maintain records of money, securities or other property.

Name or Position Schedule Bond

Name or Position	Entity Covered (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

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

- Primary
- Specific excess over the Blanket Bond

Note: Forgery or Alteration coverage is only available if a blanket or schedule bond is 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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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										

- 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

IMPORTANT NOTE: When coverage is bound, a completed and signed Supplement C will be required if coverage is on a claims made basis. Consider getting the appropriate signature now.

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: _____

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

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:** _____

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: _____

Population of area served on a first call basis: _____

Number of locations with emergency operations? _____

Do you operate an ambulance? Yes No

Number of active volunteers: _____

Number of part-time paid employees: _____

A part-time employee is one who works less than 25 hours a week, or has no set number of hours a week, or receives a dollar amount per call.

Number of full-time paid employees: _____

A full-time employee is one who is regularly scheduled to work 25 or more hours a week. These hours may be in a set rotation or in varying shifts from week to week.

IMPORTANT - Number of members age 65 and over responding to emergency calls: _____

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: _____

	<u>AD&D Benefit</u>	<u>Accident Medical Expense</u>	<u>Weekly Accident Indemnity</u>
<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: _____
6. Do you want to cover volunteers only paid employees only both volunteers and paid employees
7. Total number of active volunteers (include volunteers paid per call): _____
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".

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: _____
6. Do you want to cover volunteers only paid employees only both volunteers and paid employees
7. Total number of active volunteers (include volunteers paid per call): _____
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".

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: _____
6. Do you want to cover volunteers only paid employees only both volunteers and paid employees
7. Total number of active volunteers (include volunteers paid per call): _____
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".

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

Submitted by _____ Date _____
 Policy # _____ Location # _____
 Insured _____
 Mailing Address _____
 City _____ State _____ Zip _____

Location Address _____
 City _____ State _____ Zip _____

Current Insured Amount \$ _____
 List the Year(s) when built _____
SEE EXAMPLE ON PAGE 20 FOR THE FOLLOWING ITEMS

Risk Control Use Only
Insured Amount

Indicate the **number** of stories (not including basement)
 1 story 1 ½ stories 2 stories Other _____
 Indicate the **height** of each story (check all that apply) 10' 12' 14' 16' 18'
 Other _____

of Stories

Total Area

Gross Floor Area (include all floors except basement)
 1st fl. _____ sq ft. + 2nd fl _____ sq ft. + 3rd fl _____ sq ft = Total Sq Ft.

Perimeter

Building Perimeter – Indicate approximate perimeter by each floor in feet
 1st fl. _____ feet + 2nd fl _____ feet + 3rd fl _____ feet = Total Perimeter

Design Quality
 Economy 1 _____
 Average 2 _____

Indicate Design Quality
 1. **Economy** – plain bldg. design; interiors plain or unfinished; minimal plumbing & electric
 2. **Average** – most common design for type bldg. – basic design limited trim & ornamentation
 3. **Superior** – complex roof lines; moderate ornamentation; good interior finishes & fixtures
 4. **Premium** – individually designed with high cost materials & workmanship

Superior 3 _____
 Premium 4 _____
 Premium+ 5 _____

Indicate how building occupancy is best described (check all that apply)
 Apparatus room only – small office, storage, restrooms
 Apparatus room – office meeting room, kitchenette
 Apparatus room – office training rooms, kitchen, sleeping quarters
 Social hall; kitchen; restrooms
 Office Building
 Other – Describe: _____

Architectural Fees
 0% 3% 5% 7%

Occupancy/Name Change
 8402 _____ Fire Station
 7110 _____ Social Hall
 6506 _____ Garage
 6505 _____ Storage
 4210 _____ Office
 2100 _____ Amb Bldg.
 Other (occ): _____
 Other (NC): _____

Indicate the ISO Constructions Class by %. Must total 100%

Class 1 Frame	_____ %
Class 2 Masonry (Joisted Masonry)	_____ %
Class 3 Noncombustible (Butler Style)	_____ %
Class 4 Masonry Noncombustible	_____ %
Class 5 Modified Fire Resistive: < 2 hrs fire rating	_____ %
Class 6 Fire Resistive: > 2 hrs fire rating	_____ %

Story Heights _____
Construction Type

1. Frame	_____ %
2. Masonry	_____ %
3. Pre-Engineered	_____ %
4. Steel Frame	_____ %
5. Pro. Steel Frame	_____ %
6. Reinforced Concrete	_____ %

Basement Information

Basement, Unfinished	_____ sq ft	Basement, Partially Finished	_____ sq ft.
Basement, Finished	_____ sq ft		

How is the basement occupied? Storage Office Social Hall Garage
 Other (describe): _____

Basement depth or story height 6' 8' 10' 12' 14' 16' 18'
 Other: _____

Basement Type

(0101)	_____ sq. ft.
(0103)	_____ sq. ft.

Basement Occ. _____
 Depth _____ ft.
 Wall Opening _____ %

Building Exterior					
Wall Type	% of Wall	Risk Control Use Only	Wall Type	% of Wall	Risk Control Use Only
Brick, on studs	%	B ____%	Siding, metal/vinyl, on studs	%	U ____%
Brick, on masonry	%	C ____%	Siding, metal/vinyl, on girts	%	V ____%
Brick, solid (12")	%	D ____%	Siding, metal/vinyl, on masonry	%	W ____%
Brick, solid (24")	%	F ____%	Siding, wood, on studs	%	X ____%
Concrete, block	%	G ____%	Siding, wood, on masonry	%	Y ____%
Concrete, block, Split Face	%	H ____%	Stone, on frame	%	Z ____%
Concrete, poured-in-place	%	I ____%	Stone, on masonry	%	AA ____%
Concrete, pre-cast panels	%	J ____%	Stone, solid (12")	%	BB ____%
EIFS, on studs (Dryvit)	%	N ____%	Stucco, on studs	%	EE ____%
EIFS, on masonry (Dryvit)	%	O ____%	Stucco, on masonry	%	FF ____%
Insulated sandwich panel	%	R ____%	None		

Mechanicals

Heating Systems	% of system	Risk Control Use Only	Heating Systems	% of system	Risk Control Use Only
Boiler & piping only	%	A ____%	Steam or hot water w/radiators	%	G ____%
Electric baseboard or wall unit	%	B ____%	Steam or hot water w/unit heaters	%	H ____%
Forced hot air	%	C ____%	Thru-wall units	%	I ____%
Gas, oil or electric suspended unit heaters	%	D ____%	Ventilation only	%	J ____%
Heat pump	%	E ____%	None	%	K ____%
Rooftop unit	%	F ____%			

Cooling Systems	% of system	Risk Control Use Only	Cooling Systems	% of system	Risk Control Use Only
Chilled H2O w/air handlers	%	A ____%	Rooftop unit	%	F ____%
Chilled H2O w/fan coil units	%	B ____%	Thru wall units	%	G ____%
Evaporative coolers	%	C ____%	Unit AC – air cooled	%	H ____%
Forced cool air	%	D ____%	Unit AC – H2O cooled	%	I ____%
Heat pump	%	E ____%	None	%	J ____%

Fire Protection Systems (Indicate "Y" or Percent of Square Footage Covered)

Sprinkler System – automatic fire sprinkler system (SS) _____ **"Y" or %**

Manual Fire Alarm System – manual fire alarm system includes pull stations with either a horn or bell, or a light. (FAS) _____ **"Y" or %**

Automatic Fire Detection System – automatic fire detection system includes a smoke and/or fire detection system that activates the fire alarm system (AFD) _____ **"Y" or %**

Elevators

Passenger Elevator _____ **# of Elevators**

Freight Elevator _____ **# of Elevators**

Building Condition – (please check box which best describes current condition of building)

Excellent – new; like new; very well maintained; no signs of needed maintenance or repair **(1)**

Good – well maintained; some minor deterioration is visible **(2)**

Average – building shows normal wear and tear **(3)**

Poor – definite deterioration; obvious lack of maintenance and upkeep **(4)**

Very Poor – approaching unsound condition **(5)**

(Risk Control Use Only) Effective Age or Depreciation % _____

Mezzanines – by type and square footage

Finished mezzanine (3075) _____ sq. ft. (3075)

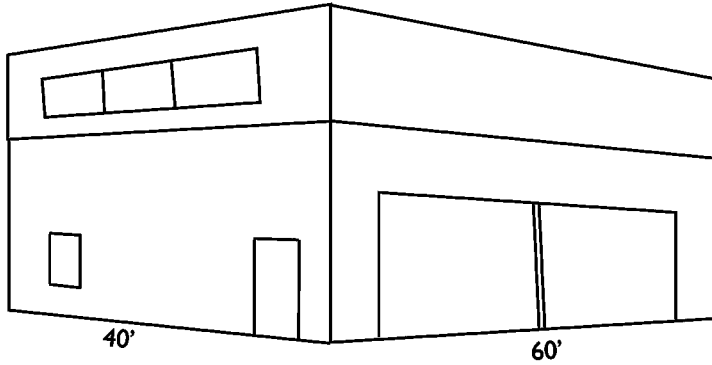
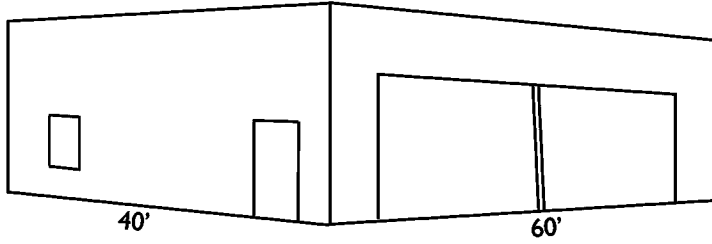
Partially finished mezzanine (3076) _____ sq. ft. (3076)

Unfinished mezzanine (3077) _____ sq. ft. (3077)

ATTACH PHOTOS AND PROVIDE DIAGRAM OF THE BUILDING ON PAGE 21

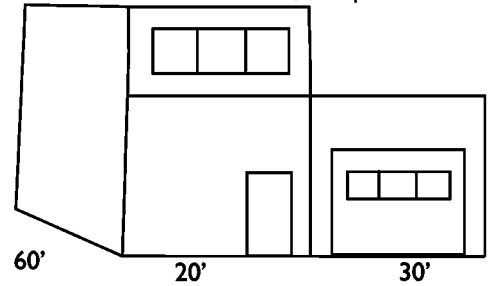
Gross Floor Area - (include all floors except basement)
Examples

1 Story Building
 $40' \times 60' = 2,400 \text{ sq. ft.}$



Partial 2 Story Building

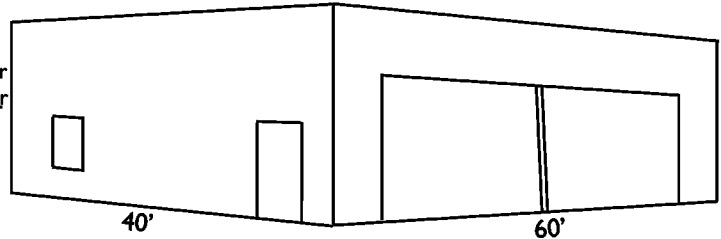
1st $60' \times 20' = 1,200 \text{ sq. ft.}$
 2nd $60' \times 20' = 1,200 \text{ sq. ft.}$
 1st $60' \times 30' = 1,800 \text{ sq. ft.}$
4,200 sq. ft.



2 Story Building
 $40' \times 60' = 2,400 \text{ sq. ft.}$
 $40' \times 60' = 2,400 \text{ sq. ft.}$
4,800 sq. ft.

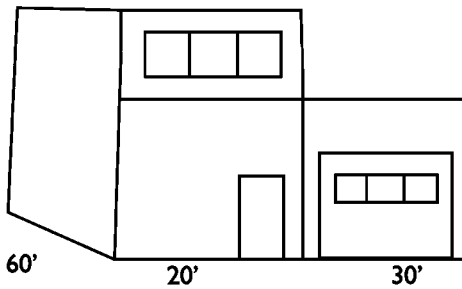
Building Perimeter - Indicate approximate perimeter by each floor in ft.

1 Story Building
 $60' + 40' + 60' + 40' = 200 \text{ ft. perimeter}$



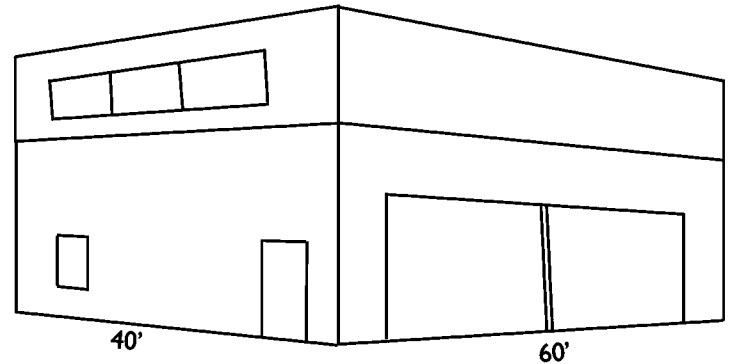
Partial 2 Story Building

1st = $20' + 60' + 20' + 30' + 60' + 30' = 220 \text{ ft. perimeter}$
 2nd = $20' + 60' + 20' + 60' = 160 \text{ ft. perimeter}$
380 ft. total

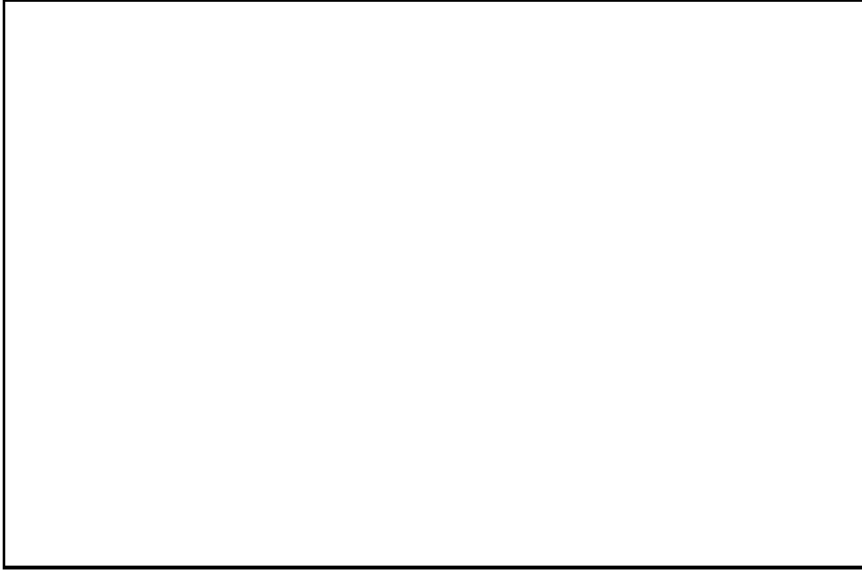


2 Story Building

1st = $60' + 40' + 60' + 40' = 200 \text{ ft. perimeter}$
 2nd = $60' + 40' + 60' + 40' = 200 \text{ ft. perimeter}$
400 ft. total



Diagram



Attach Photos

“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.