

FACTFINDER ACCIDENT & SICKNESS

GENERAL INFORMATION

Date of Application: _____

Date Proposal Needed By: _____ Current Carrier: _____

Expiration Date: _____ (Attach a copy of the declarations page if available)

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

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

Organization's Mailing Address: _____
Street or PO Box

City County State Zip Code

Contact person's name: _____ Title: _____

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

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 County / State Association (Please complete the attached County Rated A&S Supplement)
 Fire Department with Ambulance Search & Rescue Team
 Ambulance Corps 911 Emergency Dispatch
 Rescue Squad Training School
 First Responder Haz Mat Team
 Hospital EMS Other (Describe:) _____
 Relief Association

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: _____

A volunteer performs services without expectation of any compensation.

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 CFR29 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

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

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

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

Do you want Medical Expense Benefits for Volunteers to be:

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

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

- Excess of Workers' Compensation
- Excess of Group Insurance
- Primary (first dollar)
- 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			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"/> \$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 _____

Career Members _____

Auxiliary Members _____

Junior Members _____

Trustees, Commissioners or Director: _____

**** Coverage cannot be bound without a copy of the insured's roster indicating the members covered for this benefit.**

Name of Producing Agency: _____

Producer Address: _____

Producer Telephone: (_____) _____ Producer Fax:(_____) _____

Producer Signature: _____

County Rated Accident And Sickness
(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".

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4. Does this entity operate an ambulance? Yes No
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3. Population on a First Call Basis: _____
4. Does this entity operate an ambulance? Yes No
5. Number of calls on an annual basis: _____
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7. Total number of active volunteers (include volunteers paid per call): _____
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 Excess of Group Insurance N/A
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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 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.

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: _____