



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

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:

Fire Department / District	Search & Rescue Team
Fire Department / District with Ambulance	County / State Association (Please complete the attached County Rated A&S Supplement)
Ambulance Corps (pre-survey may be required)	911 Emergency Dispatch (pre-survey required; call VFIS for assistance before proceeding)
Rescue Squad	Training School (call VFIS for assistance before proceeding)
First Responder	Haz Mat Team (call VFIS for assistance before proceeding)
Relief Association	Hospital EMS (pre-survey required; call VFIS for assistance before proceeding)
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 Include unpaid members, paid per call and part-time members averaging less than 30 hours per week.	Career Members Members who average 30 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 30 hours or more a week (hourly or salary).
Part-Time Paid Employees One who averages less than 30 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 (first dollar)		
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		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>
Option #1	\$5,000	\$5,000	\$100
Option #2	\$10,000	\$10,000	\$200

24-Hour Accident Benefit – Injury Only**	OR	Off-Duty Accident Benefit – Injury Only**
AD&D for Covered Activities AND Off-Duty Activities		AD&D for Off-Duty Activities Only
\$ (\$10,000 - \$50,000)		\$ (\$10,000 - \$50,000)
(This limit cannot exceed the primary AD&D limit.)		(This limit cannot exceed the primary AD&D limit.)

Specify class and number of persons on roster for 24-Hour or Off-Duty benefits.

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

FRAUD WARNING NOTICE – PLEASE READ CAREFULLY

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 act, which is a crime, and may subject such person to criminal and civil penalties.

Alabama	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	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.
California	For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
Colorado	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.
District Of Columbia	WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
Florida	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	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, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance that such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.
Kentucky	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	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	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	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.
Minnesota	A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
New Jersey	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	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	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.
Ohio	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	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	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, may be guilty of a fraudulent act, which may be a crime, and may subject such person to criminal and civil penalties.
Pennsylvania	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.
Rhode Island	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	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	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	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	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	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: