BENEFITS BY McNeil&Co.

MONTANA BLANKET ACCIDENT INSURANCE APPLICATION
UNDERWRITTEN BY ARCH INSURANCE COMPANY

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GENERAL INFORMATION

Date of survey: _____ Renewal Date: _____ Date proposal needed: _____

Legal Name of Organization: _____
(Include all organizations that are to be included as insureds including Fire Districts, Fire Companies, Rescue Squads and Auxiliaries)

_____ FEIN: _____

Mailing Address: _____

_____ County: _____

Website Address: _____ Phone #: _____

Chief: _____ Phone #: _____ E-Mail: _____

Training Officer: _____ Phone #: _____ E-Mail: _____

Inspection Contact: _____ Phone #: _____ E-Mail: _____

INSURANCE AGENT INFORMATION

Producer: _____ CSR or Other Contact _____

Name of Agency: _____

Address: _____

Telephone: _____ Fax: _____ E-mail address: _____

Do you currently write this account? ☐ Yes ☐ No

If yes, for how long? _____ Carrier Name? _____

Is the account Sub-Brokered? ☐ Yes ☐ No

If yes, please indicate Agency Name and Address: _____

_____

BUSINESS INFORMATION

Which best describes the organization (please check one):

☐ Fire Suppression only (no EMS) ☐ Fire and Rescue/EMS

☐ Rescue/EMS Squad or Ambulance Squad ☐ Other (please describe): _____

The organization is a (please check one):

☐ Tax District ☐ Independent Non-Profit Organization

☐ Municipal, Village or Town Department ☐ Other (please describe): _____

If a municipal, village or town department, is the organization a separate legal entity? ☐ Yes ☐ No

Have you been Cancelled, Non-Renewed or Declined in the past 3 years? ☐ Yes ☐ No

If Yes, Please Explain: _____

_____

OPERATIONS INFORMATION

Total Population Served on a First Call Basis: _____

Total number of emergency responses (excluding Mutual Aid) in the past twelve months (please attach a call-log if available):

Total Fire _____ Total Rescue _____ Total EMS _____

Does the organization service a major highway? ☐ Yes ☐ No

If yes, approximately how many rescue calls can be attributed to this service? _____

Does the organization service a resort area? ☐ Yes ☐ No

If yes, approximately how much does the population increase during peak season? _____

Total number of Volunteers, including Junior Members and Auxiliary Members: _____

Are all Volunteers currently covered by Workers Compensation Insurance? ☐ Yes ☐ No

If Yes, Policy # _____ Effective Dates: _____ Carrier: _____

Total number of Career (Paid) Personnel (works more than 1,300 hours annually): _____

Are all Career (Paid) Personnel currently covered by Workers Compensation Insurance? ☐ Yes ☐ No

If Yes, Policy # _____ Effective Dates: _____ Carrier: _____

Does the organization… (Please check all that apply)

☐ Have a designated safety officer? Name: _____

☐ Have a safety committee?
☐ Require annual physicals for its members?
☐ Have and enforce a seatbelt policy?
☐ Utilize an incident command system on every call?
☐ Have a safe lifting training program?
☐ Have power cots?
☐ Requires all officers be at least NIMS 200 certified?
☐ Require a minimum of 8 hours of safety training annually?
☐ Have organized health and wellness initiatives (i.e. fitness program)?
☐ Have an organized driver training program?
☐ Require annual mask fit tests?
☐ Have annual blood-borne pathogen training requirements?
☐ Have a policy and enforce the use of universal precautions?
☐ Require all firefighters be least firefighter level 1 trained?

☐ Hold any special events? Please describe: _____

ACCIDENT PROGRAM BENEFITS

Core Benefits	Select the Benefit Limits to be Included (choose one in each category). *Please note that limits between those shown below for Plans 1-5 are available, such as $30,000 Indemnity or $150/$300 Weekly Disability. Please write requested limits in Other spaces provided.*					
Indemnity Benefits	☐ **Plan 1**	☐ **Plan 2**	☐ **Plan 3**	☐ **Plan 4**	☐ **Plan 5**	☐ **Other**
Accidental Death & Dismemberment	$10,000	$25,000	$50,000	$100,000	$150,000	$
Illness Loss of Life	$10,000	$25,000	$50,000	$100,000	$150,000	$ same
Permanent Physical Impairment – Injury	$10,000	$25,000	$50,000	$100,000	$150,000	$ same
Permanent Physical Impairment – Illness	$10,000	$25,000	$50,000	$100,000	$150,000	$ same
Permanent Cardiac Impairment	$10,000	$25,000	$50,000	$100,000	$150,000	$ same
Burn Disfigurement	$10,000	$25,000	$50,000	$100,000	$150,000	$ same
HIV (Human Immunodeficiency Virus)	$10,000	$25,000	$50,000	$100,000	$150,000	$ same
Blanket Medical Expense	☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ Other: $					
Weekly Disability Benefit (Week 1- 4 / Week 5+)	☐ $100/$200 ☐ $200/$400 ☐ $300/$600 ☐ $400/$800 ☐ $500/$1,000 ☐ $600/$1,200 ☐ Other: $					
Accidental Death & Dismemberment – Other than Covered Activity	☐ 24-Hour Coverage (includes Line of Duty) ☐ Off Duty Coverage ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ $100,000 ☐ Other: $					
Athletics & Special Events – Injury Only	Medical Expense ☐ $1,000 ☐ $5,000 Total Disability – Per Week ☐ $100 ☐ $200					

ACCIDENT PROGRAM BENEFITS (CONTINUED)

Additional Core Benefits (included with Core benefits selected above – note that if indemnity, medical expense and weekly disability benefits are not all selected, not all of these benefits may apply)

Additional Seatbelt Benefit – Injury Only	25% of Principal Sum
Post-Traumatic Stress Disorder	$20,000
HIV Infection Prevention	$3,500
Family Expense Benefit	$25,000
Family Education Benefit	$5,000
Plastic Surgery	$10,000
Preventive Inoculations	$10,000
Physical Assault Benefit – Injury Only	25% of Principal Sum
Day Care Expense Benefit	up to $30 per day for up to 26 weeks
Permanent Physical Impairment Education	35% of Permanent Physical Impairment Benefit, not to exceed $20,000
Continuation of Coverage – Injury Only	up to $500 per month for 18 months, not to exceed $6,000
Residence and Vehicle Adaptation Expense	$15,000
Burial and Cremation	10% of Principal Sum, not to exceed $5,000
Survivor (Child, Spouse or Domestic Partner, Elder)	10% of Principal Sum, not to exceed $5,000
Critical/Traumatic Incident Stress Management Team	$20,000
Transition Benefit	Weekly Disability Benefit for up to an additional 26 weeks

Optional Benefits (select the optional benefits to be included)

Career Personnel (Career Personnel will receive same benefits selected for Volunteers): ☐ Yes ☐ No

Full Auxiliary* (Auxiliary Members will receive same benefits selected for Volunteers): ☐ Yes ☐ No

Auxiliary Member Benefit*: ☐ Yes ☐ No

- If Yes, how much?

AD&D Benefit	☐ $5,000	☐ $10,000	☐ $25,000			
Medical Expense	☐ $1,000	☐ $5,000	☐ $10,000			
Weekly Disability	☐ $100	☐ $150	☐ $200	☐ $250	☐ $300	

Weekly Hospital Indemnity (per week for up to 104 weeks): ☐ Yes ☐ No

- If Yes, how much per week? ☐ $100 ☐ $200 ☐ $300 ☐ $400 ☐ $500 ☐ $600

Additional Weekly Disability: ☐ Yes ☐ No

- If Yes, how long? ☐ First Week ☐ First 4 Weeks
- If Yes, how much? ☐ $100 ☐ $200 ☐ $300 ☐ $400 ☐ $500 ☐ $600

Organized Team Sports: ☐ Yes ☐ No

- If Yes, provide the following:

Number of Members	Softball/Baseball/Basketball: _____			Bowling/Golf: _____		
AD&D Benefit	☐ $10,000	☐ $25,000	☐ $50,000			
Medical Expense	☐ $1,000	☐ $5,000	☐ $10,000	☐ $25,000		
Medical Expense Deductible	☐ $50	☐ $100				
Weekly Disability	☐ $100	☐ $200	☐ $300	☐ $400	☐ $500	☐ $600
Elimination period	☐ none	☐ 7 days				
Duration of Benefit	☐ 26 weeks	☐ 52 weeks				

* Note: The Auxiliary Member Benefit and the Full Auxiliary Benefit are mutually exclusive. Either one may be included, but not both.

PREMIUM HISTORY

Please indicate the Total Account Premium for the past 3 years.

Carrier(s): _____ $ _____ (current year) (Please provide a copy of dec page from current policy.)

Carrier(s): _____ $ _____ (1st prior year)

Carrier(s): _____ $ _____ (2nd prior year)

APPLICATION SIGNATURES & STATE FRAUD STATEMENTS

NOTICE: ANY PERSON WHO, KNOWINGLY OR WITH INTENT TO DEFRAUD OR TO FACILITATE A FRAUD AGAINST ANY INSURANCE COMPANY OR OTHER PERSON, SUBMITS AN APPLICATION OR FILES A CLAIM FOR INSURANCE CONTAINING FALSE, DECEPTIVE OR MISLEADING INFORMATION MAY BE GUILTY OF INSURANCE FRAUD.

THE UNDERSIGNED REPRESENTS THAT HE/SHE HAS MADE A GOOD FAITH EFFORT TO ASCERTAIN COMPLETE AND ACCURATE ANSWERS TO THE QUESTIONS SET FORTH IN THIS APPLICATION AND THAT THE INFORMATION PROVIDED IN THIS APPLICATION, INCLUDING ANY ATTACHMENTS, IS TRUE, ACCURATE, AND COMPLETE TO THE BEST OF THEIR KNOWLEDGE AND BELIEF.

Applicant's Signature: _____ **Date:** _____

Name and title (please print): _____

Insurance Broker's Signature _____ **Date:** _____

(To be signed by someone who does not have access to funds)