



VOLUNTEER FIREFIGHTER ENHANCED CANCER INSURANCE APPLICATION UNDERWRITTEN BY ARCH INSURANCE COMPANY

P.O. Box 5670 Cortland, NY 13045 Phone: (800) 822-3747 Fax: (607) 756-5051 Email: applications@mcneilandcompany.com

This form is for changes to your current policy. Any new policies need to be entered through our Enhanced Cancer Insurance Application Website. For more information about the Enhanced Cancer Insurance Program, please visit our website.

GENERAL INFORMATION

Date of survey: Effective Date: Date proposal needed: Legal Name of Organization: (Include all organizations that are to be included as insureds including Fire Districts and Fire Companies) 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: Phone # Fax: E-mail: Do you currently write this account? If yes, for how long? Carrier Name? Is the account Sub-Brokered? If yes, please indicate Agency Name and Address:

BUSINESS INFORMATION

The Volunteer Fire 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? Population served on a first-call basis: Years in operation: Have you been Cancelled, Non-Renewed, Declined, or Cancelled in the past 3 years? If Yes, Please Explain:

OPERATIONS INFORMATION

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

Total number of Volunteers that have 5 or more years of faithful and actual service: _____

Total number of Volunteers that have 5 or more years of faithful and actual service as an interior firefighter: _____

Do you want to cover all Volunteers that have 5 or more years of faithful and actual service Yes No

Does the organization... (Please check all that apply)

Have a designated safety officer? Name: _____

Have a safety committee?

Require annual physicals for its members?

Require annual mask fit tests?

Please attach a census for all named Legal Organizations covered by this policy that includes but not limited to Volunteer names, dates of birth, date volunteer service began/ended (if applicable), Volunteer service status, years of interior firefighter service, years of passed Fit Tests and verification of completion of the required Physical Examination.

ENHANCED CANCER BENEFIT PLAN

Required Plan

Initial Diagnosis Benefits – included

Monthly Disability Benefit – included

Death Benefit – included

Upgrade Plan

Upgrade Cancer Definition – included

Initial Diagnosis Benefits – included

Monthly Disability Benefit – included

Death Benefit – included

Skin Cancer Benefit - included

PREMIUM HISTORY

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

Carrier(s): _____ \$ _____
(current year)

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

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

APPLICATION SIGNATURES & STATE FRAUD STATEMENTS

NOTICE TO NEW YORK APPLICANTS: 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.

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: _____

APPLICABLE IN NEW YORK - NEW YORK CLAIMS-MADE INSURANCE NOTICE

IF ANY LIABILITY COVERAGE IN YOUR POLICY IS PROVIDED ON A CLAIMS-MADE BASIS THEN COVERAGE IS LIMITED TO LIABILITY FOR ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST AN INSURED AND REPORTED IN WRITING WHILE THE POLICY IS IN FORCE, DURING A RENEWAL OF THE POLICY, OR DURING ANY EXTENDED REPORTING PERIOD. VARIOUS PROVISIONS IN THE POLICY MAY RESTRICT COVERAGE. PLEASE READ THE ENTIRE POLICY CAREFULLY TO DETERMINE RIGHTS, DUTIES, AND WHAT IS AND IS NOT COVERED.

Applicant's Signature: _____ Date: _____

Name and title (please print): _____