



PROPERTY/CASUALTY INSURANCE APPLICATION  
MONTANA

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

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: \_\_\_\_\_

Location 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       Professional/Trade Association
- Rescue/EMS Squad or Ambulance Squad       Relief Association       Training Center

The organization is a (please check one):

- Tax District       Independent Non-Profit Organization       County Department/Organization
- Municipal, Village or Town Department       For Profit Organization

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

If a county department or organization:

Does the county utilize a risk manager who oversees each department/emergency service organization and designs/implements loss control procedures?  Yes  No

Is each department/emergency service organization assessed and responsible for their share of premiums?  Yes  No

Population served on a first-call basis: \_\_\_\_\_ Year established: \_\_\_\_\_

**BUSINESS INFORMATION (CONTINUED)**

Have you been Cancelled, Non-Renewed or Declined in the past 3 years?

Yes  No

If Yes, Please Explain: \_\_\_\_\_

**REAL AND PERSONAL PROPERTY**

Please complete the schedule below. If the coverage is blanket, be sure to show a breakout of the building and contents values at each location.

Loc . No.:		Address:			
Building Limit: \$		Personal Prop. Limit: \$		Occupancy Type:	
Construction Type: <input type="checkbox"/> Type 1-Frame <input type="checkbox"/> Type 2-Joisted Masonry <input type="checkbox"/> Type 3-Non-combustible <input type="checkbox"/> Type 4-Masonry non-combustible <input type="checkbox"/> Type 5-Modified fire resistive <input type="checkbox"/> Type 6-Fire resistive		Building Protection: (Check all that apply) <input type="checkbox"/> Local Alarm <input type="checkbox"/> Heat Detection <input type="checkbox"/> Other: _____ <input type="checkbox"/> Central Station Alarm <input type="checkbox"/> Smoke Detection <input type="checkbox"/> Burglar Alarm <input type="checkbox"/> Motion Detection <input type="checkbox"/> Fire Extinguishers <input type="checkbox"/> Security Guard/Service <input type="checkbox"/> Sprinklers (____%) <input type="checkbox"/> Cameras <input type="checkbox"/> Full Intrusion Perimeter Alarm			
Own/Lease:	Building Info:	Year:	Updated/Inspected	Additional Occupancies	
<input type="checkbox"/> Own	Number of Stories: _____	Roof: _____	/	_____	
<input type="checkbox"/> Lease	Building Sq. Ft.: _____	Plumbing: _____	/	_____	
	Sq. Ft. You Occupy: _____	Wiring: _____	/	_____	
	Year Built: _____	HVAC: _____	/	_____	
Loc . No.:		Address:			
Building Limit: \$		Personal Prop. Limit: \$		Occupancy Type:	
Construction Type: <input type="checkbox"/> Type 1-Frame <input type="checkbox"/> Type 2-Joisted Masonry <input type="checkbox"/> Type 3-Non-combustible <input type="checkbox"/> Type 4-Masonry non-combustible <input type="checkbox"/> Type 5-Modified fire resistive <input type="checkbox"/> Type 6-Fire resistive		Building Protection: (Check all that apply) <input type="checkbox"/> Local Alarm <input type="checkbox"/> Heat Detection <input type="checkbox"/> Other: _____ <input type="checkbox"/> Central Station Alarm <input type="checkbox"/> Smoke Detection <input type="checkbox"/> Burglar Alarm <input type="checkbox"/> Motion Detection <input type="checkbox"/> Fire Extinguishers <input type="checkbox"/> Security Guard/Service <input type="checkbox"/> Sprinklers (____%) <input type="checkbox"/> Cameras <input type="checkbox"/> Full Intrusion Perimeter Alarm			
Own/Lease:	Building Info:	Year:	Updated/Inspected	Additional Occupancies	
<input type="checkbox"/> Own	Number of Stories: _____	Roof: _____	/	_____	
<input type="checkbox"/> Lease	Building Sq. Ft.: _____	Plumbing: _____	/	_____	
	Sq. Ft. You Occupy: _____	Wiring: _____	/	_____	
	Year Built: _____	HVAC: _____	/	_____	
Loc . No.:		Address:			
Building Limit: \$		Personal Prop. Limit: \$		Occupancy Type:	
Construction Type: <input type="checkbox"/> Type 1-Frame <input type="checkbox"/> Type 2-Joisted Masonry <input type="checkbox"/> Type 3-Non-combustible <input type="checkbox"/> Type 4-Masonry non-combustible <input type="checkbox"/> Type 5-Modified fire resistive <input type="checkbox"/> Type 6-Fire resistive		Building Protection: (Check all that apply) <input type="checkbox"/> Local Alarm <input type="checkbox"/> Heat Detection <input type="checkbox"/> Other: _____ <input type="checkbox"/> Central Station Alarm <input type="checkbox"/> Smoke Detection <input type="checkbox"/> Burglar Alarm <input type="checkbox"/> Motion Detection <input type="checkbox"/> Fire Extinguishers <input type="checkbox"/> Security Guard/Service <input type="checkbox"/> Sprinklers (____%) <input type="checkbox"/> Cameras <input type="checkbox"/> Full Intrusion Perimeter Alarm			
Own/Lease:	Building Info:	Year:	Updated/Inspected	Additional Occupancies	
<input type="checkbox"/> Own	Number of Stories: _____	Roof: _____	/	_____	
<input type="checkbox"/> Lease	Building Sq. Ft.: _____	Plumbing: _____	/	_____	
	Sq. Ft. You Occupy: _____	Wiring: _____	/	_____	
	Year Built: _____	HVAC: _____	/	_____	

\*Stock Autos includes autos (including customer's autos) held in storage, for servicing, for demonstration or for sale, raw materials and in-process or finished goods



**GENERAL LIABILITY (CONTINUED)**

Please indicate the area (square footage) and usage (occupancy) for each location.

	Location No.				
	1	2	3	4	5
Fire Department (including garage areas)					
Ambulance/Rescue Squad (including garage areas)					
Social Hall					
Other (please describe)					
•					
•					
<b>TOTAL</b>					

For additional locations please complete and attach a separate Property Supplement.

**FELLOW MEMBER COVERAGE**

Are all paid staff covered by Workers Compensation?  Yes  No  N/A

Are all volunteer staff covered by Workers Compensation?  Yes  No  N/A

If no, please explain: \_\_\_\_\_

**OPERATIONS**

Employees/Volunteers:

Total number of career personnel:

Full Time: \_\_\_\_\_ Part Time: \_\_\_\_\_

Total number of emergency service volunteers: \_\_\_\_\_

Turn-over rate for career personnel: \_\_\_\_\_

Does the organization utilize a licensed physician as its Medical/EMS Director?  Yes  No

Do you contract out any of your personnel?  Yes  No

If yes, please provide a copy of the contract.

Emergency Operations:  N/A

Annual Fire/Rescue Calls \_\_\_\_\_

Emergency Ambulance Calls \_\_\_\_\_ Emergency – The assignment was dispatched as a true emergency

Non-Emergency Ambulance Calls \_\_\_\_\_ Non-Emergency – The Assignment was not dispatched as a true emergency

Non-Emergency Operations:  N/A

Are you involved in:

Community Paramedicine Annual Visits: \_\_\_\_\_ Annual Revenue: \_\_\_\_\_

Community Health Check-ups Annual Visits: \_\_\_\_\_ Annual Revenue: \_\_\_\_\_

Wheelchair Transport Annual Calls: \_\_\_\_\_ Annual Revenue: \_\_\_\_\_

Do you dispatch for other entities?  Yes  No

If yes, please complete a Dispatch Supplement form.

Highest Level of EMS services provided?

Advanced Life Support  Basic Life Support  No EMS

OPERATIONS (CONTINUED)

Stretcher Information:

Type	Brand			Number Used
X-Frame	<input type="checkbox"/> Ferno	<input type="checkbox"/> Stryker	Other:	
Power Cot	<input type="checkbox"/> Ferno	<input type="checkbox"/> Stryker	Other:	
Bariatric Cot	<input type="checkbox"/> Ferno	<input type="checkbox"/> Stryker	Other:	
Other	<input type="checkbox"/> Ferno	<input type="checkbox"/> Stryker	Other:	

Does your service have a mandatory lift assist policy?  Yes  No

Please indicate the type of straps used to secure patients?  2-point  3-point  5-point

Are all bariatric patients transported using a bariatric cot?  Yes  No

Are two transport teams used to transport all bariatric patients?  Yes  No

Wheelchair Information:  Not Applicable

Do all your wheelchairs meet the WC19 standard?  Yes  No

Do all your wheelchair tie downs and lap belts meet the WC18 standard?  Yes  No

What type of tie downs are utilized for the patient?  4 point  Strap  Docking

Is a wheelchair checklist mandatory for all drivers to utilize?  Yes  No

Are wheelchair reminder stickers inside the vans?  Yes  No

How often are wheelchair van drivers required to complete training?  Annually  Bi-Annually  Remedial  Other \_\_\_\_\_

WATERCRAFT/AIRCRAFT

Does the organization own any watercraft?  Yes  No

If yes, please list below:

Year	Manufacturer	Model	Length	Motor Type	Horsepower	Replacement Cost
			'			\$
			'			\$
			'			\$

Where is the watercraft primarily stored? \_\_\_\_\_

Where is the watercraft principally operated? \_\_\_\_\_

Are watercraft operators required to be licensed?  Yes  No

Do you require annual training for watercraft operators?  Yes  No

Does the organization own or operate any Aircraft?  Yes  No

Does the organization own any unmanned aircraft, commonly known as drones?  Yes  No

Does the organization have any drones with a value over \$25,000?  Yes  No

Are drone operators required to be certified by the FAA?  Yes  No

ERRORS AND OMISSIONS / EMERGENCY SERVICES LIABILITY

Type of coverage currently carried:  Occurrence Form  Claims-Made Form

Was any claim made or suit filed against the organization or any of its members in the past 5 years for Employment Discrimination, Wrongful Termination, Sexual Harassment, Failure to render professional duties (Directors, Officers or Board Members), Employment Related Matters, or Errors or Omission in administration of your benefits program?  Yes  No

Do you have knowledge of any incident in the past 5 years regarding Employment Discrimination, Wrongful Termination, Sexual Harassment, Failure to render professional duties (Directors, Officers or Board Members), Employment Related Matters, or Errors or Omission in administration of your benefits program?  Yes  No

**CYBER LIABILITY**

Does the insured carry Cyber Liability coverage?  Yes  No  
 If yes, what type of coverage is currently carried?  Occurrence  Claims Made (Retro Date: \_\_\_\_\_)  
 Privacy Event Mitigation Expense Limit:  \$50,000  \$100,000  \$250,000  
 What is the organizations total revenue? \$ \_\_\_\_\_

**MISCELLANEOUS LIABILITY**

Does the organization sell subscriptions for service?  Yes  No  
 If yes, does the organization respond to all calls for emergency service within its service area without regard to whether the victim is a subscriber?  
 Yes  No

**OTHER ACTIVITIES /COMMUNITY EVENTS**

N/A

Describe the fund-raising activities of the organization:		# of times per year	Total Annual Receipts
Field Days / Carnivals			
Do you own or rent any Amusement Rides?	<input type="checkbox"/> Own <input type="checkbox"/> Rent		
If Rented, is a Certificate of Insurance obtained from the owner of the rides?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
If Owned, Do you rent any mechanically operated Amusement Rides to others?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Are rides inspected after set-up prior to public use?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, by whom?			
Do you own or rent any Live Animal Rides?	<input type="checkbox"/> Own <input type="checkbox"/> Rent		
If Rented, is a Certificate of Insurance obtained from the owner of the Animals?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you provide Fireworks at the Field Days / Carnival?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, is a certified pyrotechnic professional used?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Bingo	Cost per Card:	Avg. # of Attendees:	
Hall Rental			
Motorized events (e.g. rodeos, poker runs, demolition derby)			
Other Activities Not outlined above: Please Describe			

**LIQUOR LIABILITY**

Is alcohol sold, served or consumed on your premises at any time throughout the year?  Yes  No  
 If yes, please complete and attach a Liquor Supplement.

**PORTABLE EQUIPMENT**

Guaranteed Replacement Cost coverage normally will be provided for all portable equipment used away from the premises for firefighting, emergency medical aid, rescue service, or teaching/training purposes. This equipment will be covered while on premises and while away from the premises, including while in transit, in storage, or in use. **Portable equipment includes boats, motors, and ATV's.**

Desired Deductible:  \$250  \$500  \$1000  \$2500  \$5000



**AUTOMOBILE LIABILITY (Continued)**

In the below Vehicle Schedule

- for emergency vehicles, service vehicles, trailers and antiques, show the desired Agreed Value;
- for all vehicles, show the location where it is usually garaged. Location numbers should correspond to those described in the Property section of this survey.
- GRC valuation is available for vehicles under five years. Please attach original Bill of Sale.

Vehicle Types						
TKR (Tanker or Tender)	LR (Light Rescue-under 10,000 GVW)	PMP (Pumper)	COM (Command)			
P-T (Pumper-Tanker)	MR (Medium Rescue-under 20,000 GVW)	M-P (Mini-Pumper)	ANT (Antique)			
AER (Aerial device-any type)	HR (Heavy Rescue-over 20,000 GVW)	BT (Brush Truck)	HAZ (HazMat)			
ALS (Advanced Life Support)	BLS (Basic Life Support Unit)	TRL (Trailers)	AIR (Air Cascade)			
U/S (Utility or Salvage)	PPT (Private Passenger Type)	FOM (Chemical Foam)				

  

Vehicle Schedule						
Veh. No.	Year	Make, Model, Type	Cost New (PPT's Only)	Agreed Value	VIN (Required)	Loc. No.
1.			\$	\$		
2.			\$	\$		
3.			\$	\$		
4.			\$	\$		
5.			\$	\$		
6.			\$	\$		
7.			\$	\$		
8.			\$	\$		
9.			\$	\$		
10.			\$	\$		
11.			\$	\$		
12.			\$	\$		

If there are any additional vehicles, please attach a Vehicle Schedule Supplement.

Does the organization own or lease any vehicles that are not shown on the Vehicle Schedule of this survey?  Yes  No

If yes, please describe: \_\_\_\_\_

If any vehicles require an Additional Insured or Loss Payee, please list:

Name & Address \_\_\_\_\_ Vehicle # \_\_\_\_\_  A.I.  L.P.

Name & Address \_\_\_\_\_ Vehicle # \_\_\_\_\_  A.I.  L.P.

Name & Address \_\_\_\_\_ Vehicle # \_\_\_\_\_  A.I.  L.P.

**CRIME**

Are there multiple treasuries (departments, districts, associations, etc.) within the organization?  Yes  No

If yes, please fill out a Crime Supplement form for each treasury.

What is your annual revenue? \$ \_\_\_\_\_

Fidelity

Type of Bond:

Commercial Blanket      Limit of Insurance      \$ \_\_\_\_\_

Number of Class I Employees/Volunteers (direct contact with funds)      \_\_\_\_\_

Number of Class II Employees/Volunteers (all others)      \_\_\_\_\_

Position Schedule      Position      Limit of Insurance      Excess over Blanket

\_\_\_\_\_ \$ \_\_\_\_\_  Yes  No

\_\_\_\_\_ \$ \_\_\_\_\_  Yes  No

\_\_\_\_\_ \$ \_\_\_\_\_  Yes  No

\_\_\_\_\_ \$ \_\_\_\_\_  Yes  No



CRIME (CONTINUED)

- Computer Fraud and Funds Transfer \$ \_\_\_\_\_
- Faithful Performance
- Forgery or Alterations Limit of Insurance: \$ \_\_\_\_\_

- Are department computers physically secured?  Yes  No
- Are online login credentials secured?  Yes  No
- Does the department have a credit card or debit card?  Yes  No
- If yes, are card holders authorized to make online purchases?  Yes  No
- Does anyone have access to department accounts from home?  Yes  No
- If so, do they use a department-issued computer, or a personal computer?  Department  Personal
- If they use a department computer, are other household members barred from using it?  Yes  No

Money and Securities

Note: \$50,000 money and securities coverage is provided under the Property Coverage Extensions. If increased limits are needed only to cover special events, describe below:

Event	Date of Event	Limit Needed
_____	_____	\$ _____
_____	_____	\$ _____

General Crime Information

- Are internal account reviews conducted by an individual/committee without access to funds?  Yes  No
- If yes, how often are accounts examined?  Monthly  Quarterly  Semi-Annually  Annually  Other
- When were the accounts last examined? Month/Year \_\_\_\_ / \_\_\_\_
- Are Invoices or Requisitions, Check Registers and Bank Statements cross-checked against each other at reconciliation?  Yes  No
- Do all checks require 2 signatures?  Yes  No
- If No, do checks over a certain amount require 2 signatures?  Yes in excess of: \$ \_\_\_\_\_  No
- Are procedures in place requiring segregation of duties so that no single transaction can be fully controlled from organization to completion by one person?  Yes  No
- Do you prohibit employees who reconcile monthly bank statements from
  - Signing Checks?  Yes  No
  - Making Withdrawals?  Yes  No
  - Handling deposits?  Yes  No
- Do you maintain a list of authorized vendors?  Yes  No
- Do you verify invoices against a corresponding purchase order, receiving report and/or vendor list prior to issuing payment?  Yes  No
- Do you perform reference checks, including criminal history checks, on persons who frequently handle money?  Yes  No

**UMBRELLA AND EXCESS LIABILITY**

Desired Limit of Insurance (maximum \$10 million): \$ \_\_\_\_\_/Occurrence \$ \_\_\_\_\_/Aggregate  
(These limits will apply to Excess Liability and Umbrella Liability)

Please note that the minimum underlying limits are \$1 million per occurrence/\$2 million annual aggregate for Commercial General Liability, and \$1 million CSL for Auto Liability.

Please indicate the following underlying coverage information for Employers Liability. If this information is not provided, Excess Employers Liability coverage will not be included.

Insurer\*: \_\_\_\_\_ Policy Number: \_\_\_\_\_  
 Policy Period: \_\_\_\_\_

Employers Liability (Coverage B) Limits: \$ \_\_\_\_\_ Bodily Injury by Accident (\$100,000 min)  
 \$ \_\_\_\_\_ Bodily Injury by Disease (\$100,000 min)  
 \$ \_\_\_\_\_ BI by Disease Policy Limit (\$500,000 min)

*\*Excess Employers Liability is subject to approval of the insurer providing the underlying coverage.*

**PREMIUM HISTORY**

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

Carrier(s): \_\_\_\_\_ \$ \_\_\_\_\_  
(current year)  
 Carrier(s): \_\_\_\_\_ \$ \_\_\_\_\_  
(1<sup>st</sup> prior year)  
 Carrier(s): \_\_\_\_\_ \$ \_\_\_\_\_  
(2<sup>nd</sup> prior year)

**CLAIMS HISTORY**

Have there been any claims or losses in the last five years:  Yes  No

If yes, please indicate all known claims and losses for the past five years, and any pending incidents that could result in a claim being made against the organization. Include the date of loss, a short description of the claim, the status of the claim (open/closed), and the dollar amounts paid or reserved.\*

DOL	Description	Status	Amount

\*Attach separate pages if needed. Provide the carrier loss runs if available

## **APPLICATION SIGNATURES & STATE FRAUD STATEMENTS**

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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.

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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)*



## Rewards and Incentives for What Matters Most:

### Your Members and Their Families

Creating a Benefits package for your emergency services volunteers recognizes the dangers they bravely face and helps to reward their commitment and sacrifice. We know all too well that unforeseen events can occur during emergencies, despite even our most ambitious safety measures.

By offering a McNeil & Co. Benefits package, you can provide for the financial needs of members who suffer tragic accidents or fatalities, events that can leave families without fathers, mothers, sisters and brothers.

### Protecting families. Promoting loyalty.

You also offer an incentive to **future volunteers, who join with the confidence of knowing there's a financial safety net below them.** With options like our Length of Service Award Program, you can help recruit and retain members with special benefits for their sustained commitment.

Our national program comes with the risk management services and industry expertise you can expect from any McNeil & Co. policy. Support your members with a customized benefits package—and the attention and expertise you can only expect from people who live and breathe the emergency services industry.



MONTANA BLANKET ACCIDENT 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

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 a minimum of 8 hours of safety training annually?
- Require annual physicals for its members?  Have organized health and wellness initiatives (i.e. fitness program)?
- Have and enforce a seatbelt policy?  Have an organized driver training program?
- Utilize an incident command system on every call?  Require annual mask fit tests?
- Have a safe lifting training program?  Have annual blood-borne pathogen training requirements?
- Have power cots?  Have a policy and enforce the use of universal precautions?
- Requires all officers be at least NIMS 200 certified?  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). <i>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.</i>					
Indemnity Benefits	<input type="checkbox"/> Plan 1	<input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 3	<input type="checkbox"/> Plan 4	<input type="checkbox"/> Plan 5	<input type="checkbox"/> 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	<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$75,000 <input type="checkbox"/> Other: \$					
Weekly Disability Benefit (Week 1- 4 / Week 5+)	<input type="checkbox"/> \$100/\$200 <input type="checkbox"/> \$200/\$400 <input type="checkbox"/> \$300/\$600 <input type="checkbox"/> \$400/\$800 <input type="checkbox"/> \$500/\$1,000 <input type="checkbox"/> \$600/\$1,200 <input type="checkbox"/> Other: \$					
Accidental Death & Dismemberment – Other than Covered Activity	<input type="checkbox"/> 24-Hour Coverage (includes Line of Duty) <input type="checkbox"/> Off Duty Coverage <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> Other: \$					
Athletics & Special Events – Injury Only	Medical Expense <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$5,000 Total Disability – Per Week <input type="checkbox"/> \$100 <input type="checkbox"/> \$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):		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Full Auxiliary* (Auxiliary Members will receive same benefits selected for Volunteers):		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Auxiliary Member Benefit*:		<input type="checkbox"/> Yes	<input type="checkbox"/> No
• If Yes, how much?	AD&D Benefit	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$10,000
		<input type="checkbox"/> \$25,000	
	Medical Expense	<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$5,000
		<input type="checkbox"/> \$10,000	
	Weekly Disability	<input type="checkbox"/> \$100	<input type="checkbox"/> \$150
		<input type="checkbox"/> \$200	<input type="checkbox"/> \$250
		<input type="checkbox"/> \$300	<input type="checkbox"/> \$300
Weekly Hospital Indemnity (per week for up to 104 weeks):		<input type="checkbox"/> Yes	<input type="checkbox"/> No
• If Yes, how much per week?		<input type="checkbox"/> \$100	<input type="checkbox"/> \$200
		<input type="checkbox"/> \$300	<input type="checkbox"/> \$400
		<input type="checkbox"/> \$500	<input type="checkbox"/> \$600
Additional Weekly Disability:		<input type="checkbox"/> Yes	<input type="checkbox"/> No
• If Yes, how long?	<input type="checkbox"/> First Week	<input type="checkbox"/> First 4 Weeks	
• If Yes, how much?	<input type="checkbox"/> \$100	<input type="checkbox"/> \$200	<input type="checkbox"/> \$300
		<input type="checkbox"/> \$400	<input type="checkbox"/> \$500
		<input type="checkbox"/> \$600	
Organized Team Sports:		<input type="checkbox"/> Yes	<input type="checkbox"/> No
• If Yes, provide the following:			
Number of Members	Softball/Baseball/Basketball: _____	Bowling/Golf: _____	
AD&D Benefit	<input type="checkbox"/> \$10,000	<input type="checkbox"/> \$25,000	<input type="checkbox"/> \$50,000
Medical Expense	<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$10,000
Medical Expense Deductible	<input type="checkbox"/> \$50	<input type="checkbox"/> \$100	
Weekly Disability	<input type="checkbox"/> \$100	<input type="checkbox"/> \$200	<input type="checkbox"/> \$300
		<input type="checkbox"/> \$400	<input type="checkbox"/> \$500
		<input type="checkbox"/> \$600	
Elimination period	<input type="checkbox"/> none	<input type="checkbox"/> 7 days	
Duration of Benefit	<input type="checkbox"/> 26 weeks	<input type="checkbox"/> 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): \_\_\_\_\_

\$ \_\_\_\_\_ (Please provide a copy of dec page from current policy.)  
(current year)

Carrier(s): \_\_\_\_\_

\$ \_\_\_\_\_  
(1<sup>st</sup> prior year)

Carrier(s): \_\_\_\_\_

\$ \_\_\_\_\_  
(2<sup>nd</sup> prior year)

## **APPLICATION SIGNATURES & STATE FRAUD STATEMENTS**

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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.

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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)*