BENEFITS BY McNeil&Co.

NEW YORK 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

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

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	$
Permanent Physical Impairment – Injury	$10,000	$25,000	$50,000	$100,000	$150,000	$ same
Burn Disfigurement	$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: $					

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 Safety Device Benefit	25% of Principal Sum
Post-Traumatic Stress Disorder	$20,000
Family Expense Benefit	$25,000
Family Education Benefit (Spouse/Child)	$25,000
Plastic Surgery	$10,000
Physical Assault Benefit	50% of Principal Sum
Day Care Expense Benefit	up to $100 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	up to $750 per month, not to exceed $18,000
Residence and Vehicle Adaptation Expense	$15,000
Survivor (Child, Spouse or Domestic Partner, Elder)	10% of Principal Sum, not to exceed $10,000
Critical/Traumatic Incident Stress Management Team	$20,000

Optional Benefits (select the optional benefits to be included)

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

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