



UTAH 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). 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	<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	<input type="checkbox"/> \$25,000
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 TO UTAH APPLICANTS: Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.

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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: \_\_\_\_\_