



PROPERTY/CASUALTY INSURANCE APPLICATION
UTAH

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

REAL AND PERSONAL PROPERTY (CONTINUED)

Type 1-Frame - Buildings where the exterior walls are wood or other combustible materials including construction where combustible materials are combined with other materials such as brick veneer, stone veneer, wood iron-clad, stucco on wood.

Type 2-Joisted Masonry - Buildings where the exterior walls are constructed of masonry materials such as adobe, brick, concrete, gypsum block, hollow concrete block, stone, tile or similar materials and where the floors and roof are combustible.

Type 3-Non-Combustible - Buildings where the exterior walls and the floors and roof are constructed of, and supported by metal, asbestos, gypsum or other non-combustible materials.

Type 4-Masonry Non-Combustible - Buildings where the exterior walls are constructed of masonry materials as described in Code 2, with the floors and roof of metal or other non-combustible materials.

Type 5-Modified Fire Resistive - Buildings where the exterior walls and the floors and roof are constructed of masonry or fire resistive material with a fire resistance rating of one hour or more but less than two hours.

Type 6-Fire Resistive - Buildings where the exterior walls and the floors and roof are constructed of masonry or fire resistive materials having a fire resistance rating of not less than two hours.

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

Please indicate if Blanket Coverage is desired Building Only Contents Only Building & Contents Combined

Are there any other buildings on the location(s) for which coverage is not requested? _____

Indicate the desired Property Deductible: \$500 \$1000 \$2500 \$5000 Other _____

Please list names and addresses of any mortgagees or loss payees for each location:

Loc. No.	Type	Name and Address
	<input type="checkbox"/> MTG <input type="checkbox"/> LP	
	<input type="checkbox"/> MTG <input type="checkbox"/> LP	
	<input type="checkbox"/> MTG <input type="checkbox"/> LP	

Do you currently have a wind/hail or named storm deductible? Yes No

If yes, what amount? \$ _____ or percentage _____ %

FLOOD AND EARTHQUAKE COVERAGE

\$1,000,000 flood and earthquake coverage at each location will be quoted. If flood and earthquake limits exceed \$1,000,000 at any one location, please indicate the limits needed at each such location.

Loc. No.	Flood Limit	Earthquake Limit

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

Do you carry NFIP coverage at any location? Yes No

If yes, please provide locations and limits: _____

GENERAL LIABILITY

Desired coverage:

Limits of Liability (Occurrence Form Only): \$1,000,000 Each Occurrence/\$3,000,000 Aggregate
 \$1,000,000 Each Occurrence/\$10,000,000 Aggregate

Fire legal limit: \$ _____

Med pay limit: \$ _____

* Depending on the type of organization (i.e. Associations, Dispatch Centers, etc.) ESIP may not be able to offer a \$10,000,000 aggregate

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)					
•					
•					
TOTAL					

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

OTHER PROPERTY

Description	Amount of Insurance
_____	\$ _____
_____	\$ _____
_____	\$ _____

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

AUTOMOBILE LIABILITY

Indicate the desired coverage below:

- \$ _____ Auto Liability
- \$ _____ Medical Payments
- \$ _____ OBEL (Applies only in NY)
- \$ _____ PIP / No-Fault (Medical Expense Benefits – Applies Only in PA)
- \$ _____ Additional PIP (Increased Medical Expense Benefits – Applies Only in PA)
- \$ _____ Uninsured Motorists/Underinsured Motorists B.I. Stacking Non-Stacking (if applicable)
- \$ _____ Uninsured Motorists/Underinsured Motorists P.D.

A single deductible will apply to emergency vehicles, service vehicles, trailers and antiques.

Please indicate the desired deductible for these vehicles: \$500 \$1000 \$2500 \$5000

Please indicate the desired deductible for all private passenger type vehicles (PPT's):

- Comprehensive \$250 \$500 \$1000 \$2000 \$3000
- Collision \$250 \$500 \$1000 \$2000 \$3000

Is Automatic Increase coverage desired? Yes No

If yes, by how much should the Agreed Values be increased annually? 3% 6% 9% 12%

Does the organization check MVRs? Yes - all members Yes - drivers only No

Do you check MVRs annually? Yes No

Do you require annual driver training? Yes No

Do you have driver selection criteria? Yes No

Do autos have black box or event recorders? Yes No

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): _____ \$ _____
(1st prior year)
 Carrier(s): _____ \$ _____
(2nd 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

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.

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: _____



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.



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"/> \$600
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): _____

\$ _____
(1st prior year)

Carrier(s): _____

\$ _____
(2nd prior year)

APPLICATION SIGNATURES & STATE FRAUD STATEMENTS

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.

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: _____