

FACTFINDER PROPERTY & CASUALTY / ACCIDENT & SICKNESS

GENERAL INFORMATION

Date of Application: _____ Date Proposal Needed By: _____

Current Carrier and Agency: _____ Expiration Date: _____

Type of Organization: Independent Department Municipally Owned Tax District
 Other (Describe: _____)

Full Legal Name: _____
(List all legal entities such as Fire Districts, Fire Companies, Rescue Squads, Auxiliaries and other organizations that are to be Named Insureds.)

Federal Employer Identification Number (FEIN): _____

Organization's Mailing Address: _____
Street or PO Box

City _____ County _____ State _____ Zip Code _____

Organization's fax number: (____) _____ Organization's website: _____

Contact person's name: _____ Title: _____

Day phone: (____) _____ Evening phone: (____) _____ E-mail address: _____

Is this individual (check all that apply): the contact for inspection purposes?
 the contact for education and training purposes?
 the head of the organization?

Is your organization incorporated? Yes No
If No, are you an: Unincorporated Association
 Political Subdivision
 Joint Venture (attach copy of agreement)
 Other (Describe: _____)

If No, are you chartered? Yes No

Is the applicant a for-profit or not-for-profit organization? For-Profit Not-for-Profit

- Type of Department: Fire Department / District
 Fire Department / District with Ambulance
 Ambulance Corps (pre-survey may be required)
 Rescue Squad
 First Responder
 Hospital EMS (pre-survey required; call VFIS for assistance before proceeding)
 Relief Association
 County / State Association
 Search & Rescue Team
 911 Emergency Dispatch (pre-survey required; call VFIS for assistance before proceeding)
 Training School (call VFIS for assistance before proceeding)
 Haz Mat Team (call VFIS for assistance before proceeding)
 Other (Describe: _____)

Population of area served on a first call basis: _____

Number of full-time paid employees: _____

A full-time employee is one who is regularly scheduled to work 35 or more hours a week. These hours may be in a set rotation or in varying shifts from week to week.

Number of part-time paid employees: _____

A part-time employee is one who works less than 35 hours a week, or has no set number of hours a week, or receives an hourly rate per call.

Number of active volunteers: _____

A volunteer performs services without expectation of any compensation.

Number of publicly elected trustees, commissioners or directors: _____

Estimated number of responses per year:

Fire and other non-medical runs. _____

Emergency medical or first responder medical runs. Include number of runs involving medical treatment either at the scene of an emergency or while in transport (or both) _____

Non-emergency transports. _____

Are all volunteers covered by Workers' Compensation? Yes No N/A

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

If No to either of the above, is there an Accident & Sickness policy in force with primary medical benefits of at least \$10,000? Yes No

Premises #	Item #	Year Built	Age of electrical system if more than 35 years old	If more than one entity is insured, to which one is this property assigned?	Occupied 24 hours per day?	Are there any structures at this premises that you <u>don't</u> want to insure? If so, describe them below and make sure their values are not included in the "amount of insurance" requested on the previous page.

Do you want VFIS to estimate the building value for you? Yes No (If Yes, complete Supplement B for each building.)

GENERAL LIABILITY **Yes** **No**

- Limits desired:
- \$300,000 occ. / \$1,000,000 agg. \$5,000 Medical Expense (standard)
 - \$500,000 occ. / \$1,000,000 agg. \$10,000 Medical Expense
 - \$1,000,000 occ. / \$2,000,000 agg.
 - \$1,000,000 occ. / \$3,000,000 agg.

If the Workers' Compensation coverage does not provide Employer's Liability, does the applicant want Employer's Liability coverage as part of the General Liability? Yes No

If yes, show the total annual payroll: \$ _____

If yes, choose limits:

- | | Bodily injury by accident
– each accident | Bodily injury by disease
– policy limit | Bodily injury by disease
– each volunteer or employee |
|--------------------------|--|--|--|
| <input type="checkbox"/> | \$100,000 | \$500,000 | \$100,000 |
| <input type="checkbox"/> | \$500,000 | \$500,000 | \$500,000 |
| <input type="checkbox"/> | \$500,000 | \$1,000,000 | \$500,000 |
| <input type="checkbox"/> | \$1,000,000 | \$1,000,000 | \$1,000,000 |
| <input type="checkbox"/> | \$1,000,000 | \$2,500,000 | \$1,000,000 |

Check all applicable fundraising or social activities that apply and provide the information requested for each:

<input type="checkbox"/>	Carnivals or field days with mechanical amusement rides	Number of days held annually: ____	Are rides operated by an amusement ride contractor? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, does the contractor carry at minimum \$1 million in liability limits? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, does the contractor name this applicant as an Additional Insured and provide them with a COI? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Conventions sponsored	Number of days held annually: ____	
<input type="checkbox"/>	Fireworks sponsored	Number of days held annually: ____	Fireworks are detonated by: <input type="checkbox"/> Qualified outside contractor <input type="checkbox"/> Applicant If detonated by outside contractor, does the contractor carry at minimum \$1 million in liability limits? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, does the contractor name this applicant as an Additional Insured and provide them with a COI? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Bingo	Number of days held annually: ____	
<input type="checkbox"/>	Motorized events <ul style="list-style-type: none"> • tractor pulls • mud bogs • etc. 	Type of event: _____ Number of days held annually: ____	
<input type="checkbox"/>	Hall rentals	Number of days rented annually: ____	Written agreement signed by renter? <input type="checkbox"/> Yes (attach specimen copy) <input type="checkbox"/> No COI obtained if renter is other than an individual? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Social Club	Square footage of club: _____	
<input type="checkbox"/>	Boats greater than 100hp (do not include jet skis or wave runners)	Number: _____	If physical damage is desired please be sure to schedule coverage under portable equipment
<input type="checkbox"/>	Grandstand or bleachers	Number: _____	
<input type="checkbox"/>	Vacant Land	Number of acres: _____	
<input type="checkbox"/>	Other (describe):		

Do all areas of public assembly have emergency lighting? Yes No N/A

Do you participate in any sports activities on a league basis? Yes No

If Yes, do you have an Accident & Sickness policy with a league sports rider (or similar first-party medical coverage for sports activities)? Yes No

Which of the following best describes the organization's use of alcoholic beverages?

- The organization sells alcohol year-round (bar or club)
Show annual gross receipts: \$ _____
License or permit required by the state? Yes No
License or permit obtained? Yes No

- The organization sells alcohol at special events.
Describe event(s): _____
Show annual gross receipts: \$ _____
License or permit required by the state? Yes No
License or permit obtained? Yes No

- The organization permits alcohol on the premises or at sponsored functions, but does not sell it.
- The organization provides bartenders to serve alcohol supplied by others at functions such as the rental of the social hall.
- The organization prohibits alcohol on the premises and at sponsored functions.

Have you entered into any written agreements to have another entity perform fire / EMS / rescue or dispatching services for you?

- Yes No If Yes, please forward a copy of all such contracts.

Do you use paramedics or firefighters that are contracted out to you by a labor leasing firm?

- Yes No If Yes, please forward a copy of all such contracts and answer the following:
Number of employees leased on a full-time basis: _____
Number of employees leased on a part-time basis: _____

Do you have a specially organized hazardous materials response team as part of your organization? Yes No

Do you own or are you responsible for any above-ground or underground storage tanks? Yes No
(If Yes, make sure your tanks are properly insured. VFIS does not offer tank liability coverage.)

What is the organization's level of state certification or licensing?

- Not state certified or licensed
 First Responder
 Basic Life Support
 Advanced Life Support

If "not state certified or licensed" or "first responder" was checked above, describe the highest level of service provided:

- Non-medical only
 Basic Life Support
 Advanced Life Support

BONDS **Yes** **No**

Do checks require at least two signatures?

Yes, in excess of \$ _____ No

Do purchases require the signed approval of two or more people?

Yes, in excess of \$ _____ No

Are bank accounts reconciled by someone not authorized to deposit or withdraw? Yes No

Are financial records audited by outside parties? Yes No

If yes, how often? _____

Does your organization run bingo nights or other games of chance? Yes No

If yes, how often? Annually Monthly Weekly or more often

If yes, approximate annual revenues raised by such gaming? \$ _____

Covered Entity: (if more than one named insured) _____

<input type="checkbox"/> Commercial Blanket Bond (for use with non-governmental entities)	<input type="checkbox"/> Public Employee Blanket Bond (for use with governmental entities)
Limit: \$ _____	Limit: \$ _____
Number of rateable persons (see below): _____	Number of rateable persons (see below): _____
Faithful performance <input type="checkbox"/> Yes <input type="checkbox"/> No	

Faithful performance is not available for non-governmental entities unless it's specifically required in the organization's by-laws, constitution, or resolution (please provide a copy).

Rateable persons consist of:

- commissioners, directors or trustees who perform the duties of a volunteer or employee,
- all officers, and
- other volunteers or employees who handle, have custody of or maintain records of money, securities or other property.

Name or Position Schedule Bond

Name or Position	Entity Covered (if more than one)	Limit	Faithful Performance (governmental entities only)
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

Answer only if you've requested both a Blanket Bond and a Name or Position Schedule Bond. Is the Name or Position Schedule Bond intended to be:

- Primary
- Specific excess over the Blanket Bond

AUTOMOBILE **Yes** **No**

Limit Desired (Combined Single Limit): \$300,000 \$500,000 \$1,000,000

Uninsured / Underinsured Motorists Limit: _____ PIP Limit: _____ Med Pay Limit: _____

Deductibles: Comprehensive \$250 \$500 \$1,000 Optional Deductibles: Comprehensive \$250 \$500 \$1,000
Collision \$250 \$500 \$1,000 Collision \$250 \$500 \$1,000

Rental Reimbursement: Yes No Applicable vehicle numbers: _____ Amount per day: _____ Number of days: _____

Are there any vehicles the organization does not own, but which are furnished for the organization's regular use? Yes No

If Yes, be sure they're listed in the schedule on the following page, and provide the owner's information below as an additional insured / lessor.

Have any vehicles been converted from a previous use (oil tankers, military vehicles, delivery vans, etc.)? Yes No

If Yes, indicate vehicle number(s): _____

If Yes, is there a water tank on the vehicle? Yes No

Does the applicant have any Garage Liability or Garagekeeper's exposure (for example, repairing the vehicles of others)? Yes No

Indicate any additional interest here:

<input type="checkbox"/> Add'l Insured / Lessor <input type="checkbox"/> Loss Payee	<input type="checkbox"/> Add'l Insured / Lessor <input type="checkbox"/> Loss Payee	<input type="checkbox"/> Add'l Insured / Lessor <input type="checkbox"/> Loss Payee
Vehicle # _____	Vehicle # _____	Vehicle # _____
Name _____	Name _____	Name _____
Address _____	Address _____	Address _____
City / State / Zip _____	City / State / Zip _____	City / State / Zip _____

NOTE: VFIS will not quote both optional deductibles and optional agreed values.

NOTE: Agreed value coverage is available as an option for private passenger vehicles less than five years old (not available in MA). Please indicate in the schedule on the next page if this is to be quoted. Otherwise, ACV will be quoted for private passenger vehicles.

VEH #	YEAR	MAKE	DESCRIPTION (MODEL / TYPE)	VEHICLE CLASS (below)	SERIAL NUMBER (VIN)	GVW	AGREED VALUE	OPTIONAL AGREED VALUE	Garaged at Premises #	TERR.
EX.	2004	Freightliner	1000 GPM Pumper	PR	1HTLFTVL6KH666870	40,000	\$250,000	\$350,000	3	045
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

- If you have unique names or numbers to identify your vehicles (for example, Truck 55), we can include them on the policy for your convenience. Just provide them in the DESCRIPTION column above the model/type.
- If there is more than one Named Insured, please tell us which one is responsible for each vehicle. Just write in an abbreviation or other appropriate identifier in the GARAGED AT column above the premises number.

VEHICLE CLASSES

PR	Pumper (regular)	BV	Brush Vehicle	RTH	Heavy Rescue Truck	ANTQ	Antique	CF	Chemical and Foam Unit
PLDH	Pumper with large diameter hose	AD	Aerial Device	ALS	Advanced Life Support Ambulance	SNOW	Snowmobile	AC	Air Cascade Unit
T	Tanker	QR	Quint (regular)	BLS	Basic Life Support Ambulance	TRL	Trailer	S	Salvage Truck
PT	Pumper/Tanker	QLDH	Quint with large diameter hose	FR	First Responder Vehicle	SERV	Non-emergency vehicle (give "original cost new" in the "agreed value" column)	PPT	Chief's Car
MP	Mini-Pumper	RTL	Light Rescue Truck	HM	Hazardous Materials Vehicle	TOUR	Tournament Vehicle	BUS	Bus

PORTABLE EQUIPMENT **Yes** **No**

Indicate the type of coverage needed: Blanket Scheduled Blanket and Scheduled

Choose a deductible: \$250 \$500 \$1,000

For blanket coverage, you must complete the "Vehicle Class" column on the vehicle schedule. Account for all vehicles owned by the organization or furnished to the organization for regular use. Use the codes defined on page 9.

For scheduled coverage, please provide the following for each item insured. Attach a separate sheet if necessary.

Item Number	Description	Serial Number	Unit Value	Quantity

MANAGEMENT LIABILITY **Yes** **No**

Choose limits: \$300,000 each offense or wrongful act / \$1,000,000 aggregate \$1,000,000 each offense or wrongful act / \$2,000,000 aggregate
 \$500,000 each offense or wrongful act / \$1,000,000 aggregate \$1,000,000 each offense or wrongful act / \$3,000,000 aggregate

Claims made basis

Does the applicant have knowledge of any incidents which would cause a reasonable person to believe that a claim or suit might result? Yes No If Yes, please give complete details, including date:

Occurrence basis

Please indicate whether the applicant:

- is currently insured on an occurrence basis for Management Liability coverage, or
- does not currently carry Management Liability coverage, or
- will purchase an extended reporting period from their current claims made carrier when they move their coverage to VFIS.

Does the organization have a personnel (human resources) administrator? Yes No

Does the organization have written policies and procedures covering the following areas?

Hiring or applying for membership	<input type="checkbox"/> Yes <input type="checkbox"/> No	Discipline	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dismissal	<input type="checkbox"/> Yes <input type="checkbox"/> No	Promotions	<input type="checkbox"/> Yes <input type="checkbox"/> No
Discrimination	<input type="checkbox"/> Yes <input type="checkbox"/> No	New employee / volunteer orientation	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sexual Harassment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Performance evaluation	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

IMPORTANT NOTE: When coverage is bound, a completed and signed Supplement C will be required if coverage is on a claims made basis. Consider getting the appropriate signature now.

UMBRELLA / EXCESS **Yes** **No**

Indicate limits: \$ _____ occurrence / \$ _____ aggregate

Note: Underlying limits of \$1,000,000 are required.

Coverage desired over: General Liability Management Liability Automobile Liability
(Check all that apply)

WRAP-UP INFORMATION

Any special information the underwriter should know? If available, include the current premiums and attach loss runs for the past four years.

Answer in all states except Missouri: Has the applicant's insurance program been cancelled or non-renewed by another carrier? Yes No If Yes, please provide details:

Name of producing agency: _____

Agency's address: _____

Agency's phone: () _____ Agency's fax: () _____

Agency's e-mail address: _____

If you are not licensed as a broker, are you a property / casualty agent? Yes No

Name and email address of producer or CSR (for contact purposes): _____

Arkansas Fraud Warning

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado Fraud Warning

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Florida Fraud Warning

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky Fraud Warning

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Louisiana Fraud Warning

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maine Fraud Warning

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

New Hampshire Statement of Residency

To procure automobile insurance, I hereby attest that I am, and each named insured is, a resident of the State of New Hampshire. I understand that if I falsely claim for myself or any named insured to be a resident of the State of New Hampshire, I am subject to prosecution, imprisonment of up to one year, a fine of \$2,000 and the denial of coverage for any loss, not occurring in New Hampshire, under the automobile insurance policy for which I am applying. I also understand that this statement will be relied upon in connection with future renewals of the automobile insurance policy for which I am applying, and that it is my responsibility to inform my insurance company before my next renewal after I or any named insured ceases to be a New Hampshire resident and that I will be subject to the penalties listed above if I fail to do so.

New Jersey Fraud Warning

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New Mexico Fraud Warning

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

New York Fraud Warning

Automobile Insurance: Any person who knowingly and with intent to defraud any insurance company or other person files an application for commercial insurance or a statement of claim for any commercial or personal insurance benefits containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who, in connection with such application or claim, knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the Department of Motor Vehicles or an insurance company, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed \$5,000 and the value of the subject motor vehicle or stated claim for each violation.

Other Types of Insurance: 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 \$5,000 and the stated value of the claim for each such violation.

Ohio Fraud Warning

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma Fraud Warning

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon Fraud Warning

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents materially false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

Pennsylvania Fraud Warning

Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any materially false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and payment of a fine of up to \$15,000.

Tennessee Fraud Warning

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Virginia Fraud Warning

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits. READ YOUR POLICY. THE POLICY OF INSURANCE FOR WHICH APPLICATION IS BEING MADE, IF ISSUED, MAY BE CANCELLED WITHOUT CAUSE AT THE OPTION OF THE INSURER AT ANY TIME IN THE FIRST 60 DAYS DURING WHICH IT IS IN EFFECT AND AT ANY TIME THEREAFTER FOR REASONS STATED IN THE POLICY.

Washington Fraud Warning

All applications for insurance must contain a statement, permanently affixed to the application, that clearly states in substance: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Applicant's signature: _____ Title: _____ Date: _____

Producer's signature: _____ Date: _____

ACCIDENT & SICKNESS

(Supplement A)

Important Note: If quoting A&S only, pages 1 and 2 of this application must be completed

Current Carrier: _____ Date Proposal Needed By: _____

Population of area served on a first call basis: _____

Number of locations with emergency operations? _____

Do you operate an ambulance? Yes No

Number of active volunteers: _____

Number of part-time paid employees: _____

A part-time employee is one who works less than 25 hours a week, or has no set number of hours a week, or receives a dollar amount per call.

Number of full-time paid employees: _____

A full-time employee is one who is regularly scheduled to work 25 or more hours a week. These hours may be in a set rotation or in varying shifts from week to week.

IMPORTANT - Number of members age 65 and over responding to emergency calls: _____

Illinois only:

Part-time personnel (include members paid per call if more than 25 hours per week): _____

Full-time / collective bargaining members: _____

Does your organization perform medical evaluations meeting the requirements of NFPA 1582 or OSHA CFR 29 1910.134 Respiratory Protection Standard?

Does your organization have a Safety Officer meeting the requirements of NFPA 1500 and/or NFPA 1521?

Does your organization provide EMS Service beyond First Aid?

Are all volunteers covered by Workers' Compensation? Yes No N/A

If Yes, are they covered for: Disability? Medical? Both?

If Yes, please specify carrier: _____

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

Do you want Medical Expense Benefits for volunteers to be:

- Excess of Workers' Compensation Primary (first dollar)
 Excess of Group Insurance Not applicable

Paid career (or full-time / collective bargaining) to be:

- Excess of Workers' Compensation Primary (first dollar)
 Excess of Group Insurance Not applicable

NOTE: If your volunteers or paid employees are covered by Workers' Compensation, the Medical Expense option is limited to "Excess of Workers' Compensation."

Do you want to cover: volunteers only paid employees only both volunteers and paid employees

THREE YEAR LOSS HISTORY (attach loss run if available)				
Date	Type	Paid	Reserved	Total Incurred

Do you want a: 1 year policy? 3 year pre-paid policy? 3 year annual installment policy?

Indicate limits desired:

AD&D / Loss of Life (\$20,000 - \$250,000)	Weekly Indemnity (\$100 - \$1,000)		Medical Expense (\$2,500 - \$100,000)
	First 28	After 28	
<input type="checkbox"/> _____	_____	_____	_____
<input type="checkbox"/> _____	_____	_____	_____
<input type="checkbox"/> _____	_____	_____	_____
<input type="checkbox"/> \$150,000	\$250	\$250	\$75,000 (Indiana Year 2000 Statutory)

Is coverage desired for these options?

- Cost of Living Adjustment for Weekly PPI Benefit Yes No – Volunteer Coverage Only
- Additional First Week Indemnity Yes No
- Special Events Rider * Yes No – **Call your Underwriter for quote information**
- Hospital Indemnity Yes No
- League Sports Rider Yes No
- Type of Sport: _____ Number of participants: _____ Length of season: _____
- AD&D Benefit \$ _____ Accident Medical Expense \$ _____ Weekly Accident Indemnity \$ _____
- Optional Supplementary Benefits Package Yes No – New York Only
- FL Statutory Benefit Rider Yes No – Florida Only (Illegal Loss of Life - \$150,000 additional)

* Not available in all states

*24-Hour Benefit Rider (AD&D for covered & non-covered activities)
 Yes No \$ _____ (\$10,000-\$50,000) Not exceeding AD&D life amount selected

*Non-Covered Activity Rider (AD&D only for non-covered activities)
 Yes No \$ _____ (\$10,000-\$50,000) Not exceeding AD&D life amount selected

Do you want to cover: Specify number on roster

Active Volunteers _____

Career Members _____

Auxiliary Members _____

Junior Members _____

Trustees, Commissioners or Directors: _____

***Coverage cannot be bound without a copy of the insured's roster indicating the members covered for this benefit.**

If this is a county quotation, complete attached county supplement on page 15.

Name of Producing Agency: _____

Agency's Address: _____

Agency's Phone: (____) _____ Agency's Fax: (____) _____

Producer Signature: _____

County Rated Accident And Sickness Supplement
(Photocopy this page if more than three departments)

For each department that is to be covered, complete the following questions:

1. Department Name: _____
2. Number of Locations: _____
3. Population on a First Call Basis: _____
4. Does this entity operate an ambulance? Yes No
5. Number of calls on an annual basis: _____
6. Do you want to cover volunteers only paid employees only both volunteers and paid employees
7. Total number of active volunteers (include volunteers paid per call): _____
8. Are all volunteers covered by Workers' Compensation? Yes No N/A
9. Do you want Medical Expense Benefits for volunteers to be Excess of Workers' Compensation Primary (First Dollar)
 Excess of Group Insurance N/A
10. Total number of paid employees: _____
11. Are paid employees covered by Workers' Compensation? Yes No N/A
12. Do you want medical Expense Benefits for paid employees Excess of Workers' Compensation Primary (First Dollar)
 Excess of Group Insurance N/A

NOTE: If your volunteers or paid employees are covered by Workers' Compensation, the Medical Expense option is limited to "Excess of Workers' Compensation".

For each department that is to be covered, complete the following questions:

1. Department Name: _____
2. Number of Locations: _____
3. Population on a First Call Basis: _____
4. Does this entity operate an ambulance? Yes No
5. Number of calls on an annual basis: _____
6. Do you want to cover volunteers only paid employees only both volunteers and paid employees
7. Total number of active volunteers (include volunteers paid per call): _____
8. Are all volunteers covered by Workers' Compensation? Yes No N/A
9. Do you want Medical Expense Benefits for volunteers to be Excess of Workers' Compensation Primary (First Dollar)
 Excess of Group Insurance N/A
10. Total number of paid employees: _____
11. Are paid employees covered by Workers' Compensation? Yes No N/A
12. Do you want medical Expense Benefits for paid employees Excess of Workers' Compensation Primary (First Dollar)
 Excess of Group Insurance N/A

NOTE: If your volunteers or paid employees are covered by Workers' Compensation, the Medical Expense option is limited to "Excess of Workers' Compensation".

For each department that is to be covered, complete the following questions:

1. Department Name: _____
2. Number of Locations: _____
3. Population on a First Call Basis: _____
4. Does this entity operate an ambulance? Yes No
5. Number of calls on an annual basis: _____
6. Do you want to cover volunteers only paid employees only both volunteers and paid employees
7. Total number of active volunteers (include volunteers paid per call): _____
8. Are all volunteers covered by Workers' Compensation? Yes No N/A
9. Do you want Medical Expense Benefits for volunteers to be Excess of Workers' Compensation Primary (First Dollar)
 Excess of Group Insurance N/A
10. Total number of paid employees: _____
11. Are paid employees covered by Workers' Compensation? Yes No N/A
12. Do you want medical Expense Benefits for paid employees Excess of Workers' Compensation Primary (First Dollar)
 Excess of Group Insurance N/A

NOTE: If your volunteers or paid employees are covered by Workers' Compensation, the Medical Expense option is limited to "Excess of Workers' Compensation".

VFIS BUILDING VALUATION FORM
(Photo of Building Must Accompany Completed Form)
(Supplement B)

Submitted by _____ Date _____
 Policy # _____ Location # _____
 Insured _____
 Mailing Address _____
 City _____ State _____ Zip _____

Location Address _____
 City _____ State _____ Zip _____

Current Insured Amount \$ _____
 List the Year(s) when built _____
SEE EXAMPLE ON PAGE 18 FOR THE FOLLOWING ITEMS

Risk Control Use Only
Insured Amount

Indicate the **number** of stories (not including basement)
 1 story 1 ½ stories 2 stories Other _____
 Indicate the **height** of each story (check all that apply) 10' 12' 14' 16' 18'
 Other _____

of Stories

Total Area

Gross Floor Area (include all floors except basement)
 1st fl. _____ sq ft. + 2nd fl _____ sq ft. + 3rd fl _____ sq ft = Total Sq Ft.

Perimeter

Building Perimeter – Indicate approximate perimeter by each floor in feet
 1st fl. _____ feet + 2nd fl _____ feet + 3rd fl _____ feet = Total Perimeter

Design Quality

Economy 1 _____

Average 2 _____

Superior 3 _____

Premium 4 _____

Premium+ 5 _____

Indicate Design Quality

1. **Economy** – plain bldg. design; interiors plain or unfinished; minimal plumbing & electric

2. **Average** – most common design for type bldg. – basic design limited trim & ornamentation

3. **Superior** – complex roof lines; moderate ornamentation; good interior finishes & fixtures

4. **Premium** – individually designed with high cost materials & workmanship

Architectural Fees
 0% 3% 5% 7%

Indicate how building occupancy is best described (check all that apply)

Apparatus room only – small office, storage, restrooms

Apparatus room – office meeting room, kitchenette

Apparatus room – office training rooms, kitchen, sleeping quarters

Social hall; kitchen; restrooms

Office Building

Other – Describe: _____

Occupancy/Name Change

8402 _____ Fire Station

7110 _____ Social Hall

6506 _____ Garage

6505 _____ Storage

4210 _____ Office

2100 _____ Amb Bldg.

Other (occ): _____

Other (NC): _____

Story Heights _____

Indicate the ISO Constructions Class by %. Must total 100%

Class 1 Frame _____ %

Class 2 Masonry (Joisted Masonry) _____ %

Class 3 Noncombustible (Butler Style) _____ %

Class 4 Masonry Noncombustible _____ %

Class 5 Modified Fire Resistive: < 2 hrs fire rating _____ %

Class 6 Fire Resistive: > 2 hrs fire rating _____ %

Construction Type

1. Frame _____ %

2. Masonry _____ %

3. Pre-Engineered _____ %

4. Steel Frame _____ %

5. Pro. Steel Frame _____ %

6. Reinforced Concrete _____ %

Basement Information

Basement, Unfinished _____ sq ft

Basement, Partially Finished _____ sq ft

Basement, Finished _____ sq ft

How is the basement occupied? Storage Office Social Hall Garage

Other (describe): _____

Basement depth or story height 6' 8' 10' 12' 14' 16' 18'

Other: _____

Basement Type

(0101) sq. ft.

(0103) sq. ft.

Basement Occ. _____

Depth _____ ft.

Wall Opening _____ %

Building Exterior					
Wall Type	% of Wall	Risk Control Use Only	Wall Type	% of Wall	Risk Control Use Only
Brick, on studs	%	B ____%	Siding, metal/vinyl, on studs	%	U ____%
Brick, on masonry	%	C ____%	Siding, metal/vinyl, on girts	%	V ____%
Brick, solid (12")	%	D ____%	Siding, metal/vinyl, on masonry	%	W ____%
Brick, solid (24")	%	F ____%	Siding, wood, on studs	%	X ____%
Concrete, block	%	G ____%	Siding, wood, on masonry	%	Y ____%
Concrete, block, Split Face	%	H ____%	Stone, on frame	%	Z ____%
Concrete, poured-in-place	%	I ____%	Stone, on masonry	%	AA ____%
Concrete, pre-cast panels	%	J ____%	Stone, solid (12")	%	BB ____%
EIFS, on studs (Dryvit)	%	N ____%	Stucco, on studs	%	EE ____%
EIFS, on masonry (Dryvit)	%	O ____%	Stucco, on masonry	%	FF ____%
Insulated sandwich panel	%	R ____%	None		

Mechanicals

Heating Systems	% of system	Risk Control Use Only	Heating Systems	% of system	Risk Control Use Only
Boiler & piping only	%	A ____%	Steam or hot water w/radiators	%	G ____%
Electric baseboard or wall unit	%	B ____%	Steam or hot water w/unit heaters	%	H ____%
Forced hot air	%	C ____%	Thru-wall units	%	I ____%
Gas, oil or electric suspended unit heaters	%	D ____%	Ventilation only	%	J ____%
Heat pump	%	E ____%	None	%	K ____%
Rooftop unit	%	F ____%			

Cooling Systems	% of system	Risk Control Use Only	Cooling Systems	% of system	Risk Control Use Only
Chilled H2O w/air handlers	%	A ____%	Rooftop unit	%	F ____%
Chilled H2O w/fan coil units	%	B ____%	Thru wall units	%	G ____%
Evaporative coolers	%	C ____%	Unit AC – air cooled	%	H ____%
Forced cool air	%	D ____%	Unit AC – H2O cooled	%	I ____%
Heat pump	%	E ____%	None	%	J ____%

Fire Protection Systems (Indicate "Y" or Percent of Square Footage Covered)

Sprinkler System – automatic fire sprinkler system (SS) _____ **"Y" or %**

Manual Fire Alarm System – manual fire alarm system includes pull stations with either a horn or bell, or a light. (FAS) _____ **"Y" or %**

Automatic Fire Detection System – automatic fire detection system includes a smoke and/or fire detection system that activates the fire alarm system (AFD) _____ **"Y" or %**

Elevators

Passenger Elevator _____ **# of Elevators**

Freight Elevator _____ **# of Elevators**

Building Condition – (please check box which best describes current condition of building)

Excellent – new; like new; very well maintained; no signs of needed maintenance or repair **(1)**

Good – well maintained; some minor deterioration is visible **(2)**

Average – building shows normal wear and tear **(3)**

Poor – definite deterioration; obvious lack of maintenance and upkeep **(4)**

Very Poor – approaching unsound condition **(5)**

(Risk Control Use Only) Effective Age or Depreciation % _____

Mezzanines – by type and square footage

Finished mezzanine (3075) _____ sq. ft. (3075)

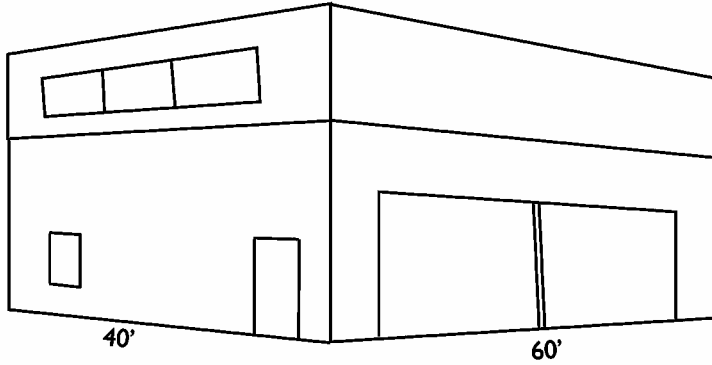
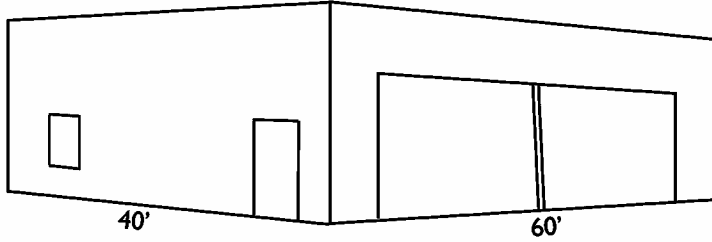
Partially finished mezzanine (3076) _____ sq. ft. (3076)

Unfinished mezzanine (3077) _____ sq. ft. (3077)

ATTACH PHOTOS AND PROVIDE DIAGRAM OF THE BUILDING ON PAGE 19

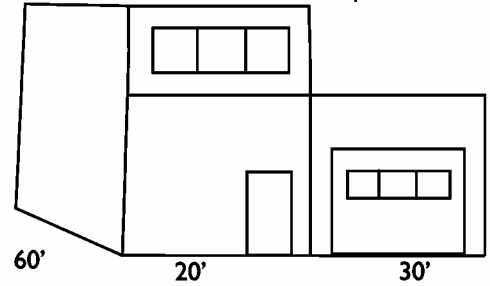
Gross Floor Area - (include all floors except basement)
Examples

1 Story Building
 $40' \times 60' = 2,400$ sq. ft.



Partial 2 Story Building

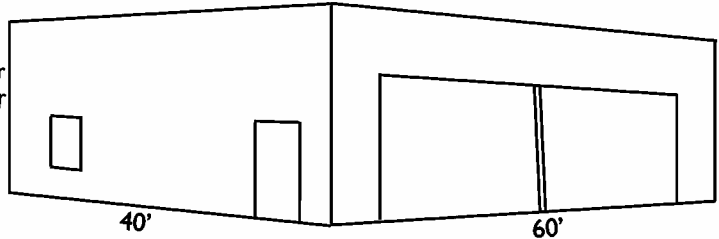
1st $60' \times 20' = 1,200$ sq. ft.
 2nd $60' \times 20' = 1,200$ sq. ft.
 1st $60' \times 30' = 1,800$ sq. ft.
4,200 sq. ft.



2 Story Building
 $40' \times 60' = 2,400$ sq. ft.
 $40' \times 60' = 2,400$ sq. ft.
4,800 sq. ft.

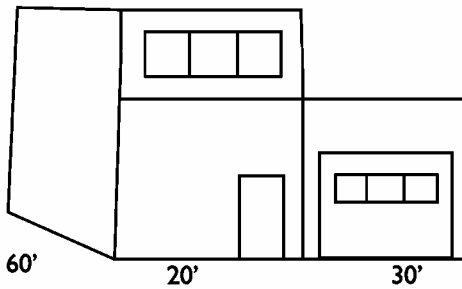
Building Perimeter - Indicate approximate perimeter by each floor in ft.

1 Story Building
 $60' + 40' + 60' + 40' = 200$ ft. perimeter



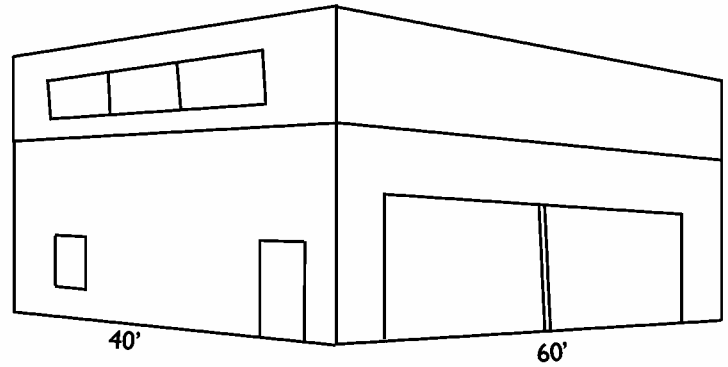
Partial 2 Story Building

1st = $20' + 60' + 20' + 30' + 60' + 30' = 220$ ft. perimeter
 2nd = $20' + 60' + 20' + 60' = 160$ ft. perimeter
380 ft. total

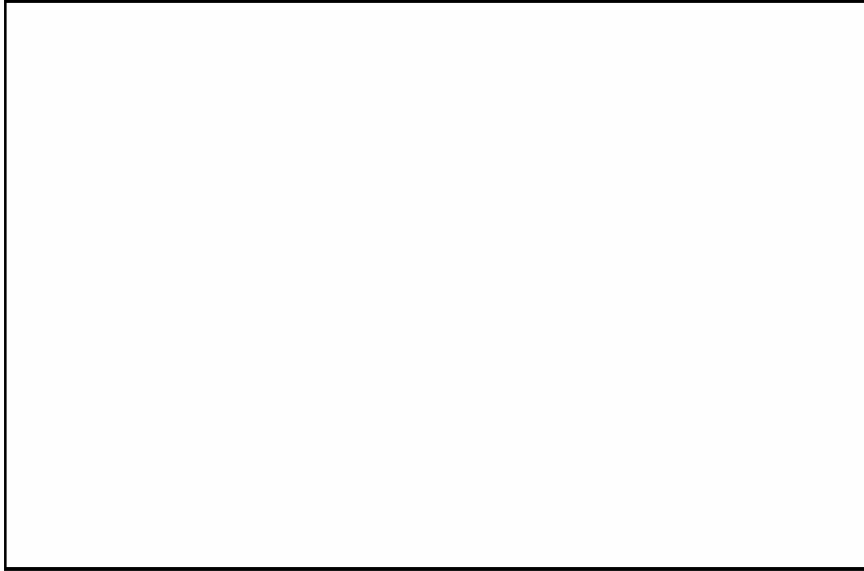


2 Story Building

1st = $60' + 40' + 60' + 40' = 200$ ft. perimeter
 2nd = $60' + 40' + 60' + 40' = 200$ ft. perimeter
400 ft. total



Diagram



Attach Photos

“CLAIMS-MADE” MANAGEMENT LIABILITY APPLICATION
(Supplement C)

1. Legal name of applicant: _____
2. Address: _____
3. Desired effective date of coverage: _____
4. Limits of liability requested (cannot be greater than the General Liability limit):
 - \$300,000 each offense or wrongful act / \$1,000,000 aggregate
 - \$500,000 / \$1,000,000
 - \$1,000,000 / \$2,000,000
 - \$1,000,000 / \$3,000,000
5. Does the applicant have knowledge of any incidents which would cause a reasonable person to believe that a claim or suit might result? Yes No
If Yes, please give complete details, including date: _____

6. Name of person designated to receive any and all notices from the company or agent concerning this insurance:

COVERAGE CANNOT BECOME EFFECTIVE PRIOR TO THE DATE THIS SIGNED APPLICATION IS APPROVED BY THE COMPANY.

THE APPLICANT ACCEPTS NOTICE THAT ANY POLICY WHICH MAY BE ISSUED AND ANY RENEWALS THEREOF WILL APPLY ON A “CLAIMS MADE” BASIS.

The applicant agrees that in the event they become aware of any fact which would serve to alter any answer previously given to one or more of the foregoing questions, they will so advise the agent. The applicant further agrees that based on such revised information, the agent may revise or withdraw any quotation previously given.

The undersigned, being authorized by and acting on behalf of the applicant, declares that to the best of his / her knowledge and after having made proper inquiry, the responses to the foregoing are true and that no facts have been suppressed or any material facts misstated. The applicant further agrees that this application shall be the basis of any policy issued. The application is valid for 90 days from the date it is signed.

Agent's Signature: _____ Applicant's Signature: _____

Address: _____ Title: _____

City / State / Zip: _____ Date: _____

APPLICABLE TO NEW YORK ONLY:

The **CLAIMS MADE** policy covers only claims:

- (1) actually made against the insured while the policy remains in effect, or
- (2) arising from incidents reported to the insurer while the policy remains in effect.

All coverage provided by the policy ceases upon the termination of the policy, except for the automatic (basic) extended reporting period coverage, unless the insured purchases additional (supplemental) extended reporting period coverage.

The automatic (basic) extended reporting period is 90 days. The additional (supplemental) extended reporting period is unlimited, with any period of time less than that being at the insured's option.

The applicant should be aware that there are potential coverage gaps that may arise upon expiration of the applicable (either basic or supplemental) extended reporting period. For example, there is no coverage for a claim made after the applicable extended reporting period terminates unless the incident giving rise to such claim was reported to the insurance company prior to the termination of the applicable extended reporting period.

There is no separate premium charge for the basic extended reporting period. The premium for the supplemental extended reporting period is 50% of the annual premium for the last policy.

If the applicant is changing from an occurrence policy to a claims made policy, the receipt of information from the insurer describing the limited scope of coverage and potential coverage gaps inherent in claims made forms is acknowledged.

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.

Agent's Signature: _____

Applicant's Signature: _____

Address: _____

Title: _____

City / State / Zip: _____

Date: _____