183 Leader Heights Road
P.O. Box 2726, York, PA 17405
800.233.1957 | Fax: 717.747.7022
VFIS.com

Return completed application to your
Regional Director or submissions@vfis.com

APPLICATION

PROPERTY & CASUALTY / ACCIDENT & SICKNESS / BENEFITS

GENERAL INFORMATION

Date of Application: Date Proposal Needed By:

Current Carrier: Expiration Date:

Legal Name of Organization:

(List all legal entities and other organizations that are to be Named Insureds.)

Mailing Address:

Street or PO Box | City | County | State | Zip Code

FEIN: Website:

Contact Information:

	First Name	MI	Last Name	Phone	Email
Primary:					
Inspection:					

What is your Legal Status?	Independent Department /Not-for-Profit	Municipally Owned	**Are you Incorporated?**	Yes
	For-Profit Organization	Tax District		No

What is your type of Operation?			
	Fire Department / District	First Responder	Search & Rescue Team
	Fire Department / District with Ambulance	Hospital EMS *	911 Emergency Dispatch *
	Ambulance Corps	Relief Association	Training School *
	Rescue Squad	County / State Association *	Haz Mat Team *
	Other (Describe:)		
	* Call VFIS for assistance.		

What is the size of your Organization?			
	Number of Paid Employees Full-Time:		Employees are considered Full time if regularly scheduled 35 or more hours per week.
	Number of Paid Employees Part-Time:		
	Number of Volunteers:		
	Number of Publicly Elected (trustees,commissioners or directors):		

What is your Estimated Response Activity?		# Responses
	Fire and other non-medical runs:	
	Emergency medical or first responder medical runs:	
	Non-emergency transports:	

Highest Level of Service Provided?	Non-Medical (EMS assist)	BLS	ALS

Do you have Workers' Compensation?				
	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	

ACCIDENT & SICKNESS
Supplemental Application

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

Current Carrier: Date Proposal Needed By:

Number of locations with emergency operations? Population of area served on a first call basis:

Do you operate an ambulance? Yes No

Does your organization perform medical evaluations meeting the requirements of NFPA 1582 or OSHA CFR 29 910.134 Respiratory Protection Standard? Yes No

Does your organization have a Safety Officer meeting the requirements of NFPA 1500 and/or NFPA 1521? Yes No

Do you want to cover: Volunteers only Paid Personnel only Both Volunteers and Paid Personnel

Indicate number of Members based on the following classifications:	
Volunteer Members Include unpaid members, paid per call and part-time members averaging less than 25 hours per week.	**Career Members** Members who average 25 hours or more employment per week (hourly or salary).
Active Volunteers One who receives no compensation or is paid per call.	Full-Time Paid Employees One who averages 25 hours or more a week (hourly or salary).
Part-Time Paid Employees One who averages less than 25 hours a week, has no set number of hours a week, or receives an hourly rate per call.	Administrative Personnel Paid Employee whose job description does not include emergency response or training.
Auxiliary Members Junior Members Trustees, Commissioners, Directors	Illinois and Ohio Please complete Supplement for Membership Classification. Contact the VFIS Regional Director for additional information.

Who is covered by Workers' Compensation? Volunteers Paid Personnel

Volunteers are covered for: Disability? Medical? Both?

Specify Carrier:

Provide Medical Expense Benefits: *(Check appropriate box.)*

	Volunteers	Paid Personnel
Excess of Workers' Compensation		
Primary *(first dollar)*		
Not Applicable		

THREE YEAR LOSS HISTORY ***(attach loss runs when available)***				
Date	Type	Paid	Reserved	Total Incurred

Benefit Limits:

AD&D/Loss of Life ($20,000-500,000)	Weekly Indemnity ($100 - $1,000) First 28	After 28	Medical Expense ($2,500 - $100,000)
___	___	___	___
___	___	___	___
___	___	___	___

Weekly Hospital Benefit	Yes	No		
First Week Total Disability Benefit	Yes	No		
Coordinated 28 Day Total Disability Benefit*	$	Volunteer	$	Career
Transition Benefit	Yes	No – Volunteer	Yes	No – Career
Extended Total Disability Benefit	Yes	No – Volunteer	Yes	No – Career
Long-Term Total Disability Benefit *	Yes	No – Volunteer	Yes	No – Career
Weekly Injury Perm. Impairment Benefit COLA	Yes	No – Volunteer	Yes	No – Career
Long-Term Total Disability Benefit COLA *	Yes	No – Volunteer	Yes	No – Career
Extra Expense Benefit	Yes	No – Volunteer	Yes	No – Career
Special Events Rider	Yes	No – **Contact your Underwriter for quote information.**		

Not available in all states.

Billing Schedule: Annual **Semi-Annual Installments** ***($1,500 minimum premium; Not available in MA, RI or WA.)***

Florida Only: Yes No – Florida Statutory Death Benefits per Title X, Chapter 112.191(a), (b) and (c).

League Sports Rider Yes No

Type of Sport: Number of participants:

Start date: Length of season:

	AD&D Benefit	Accident Medical Expense	Weekly Accident Indemnity
Option #1	$5,000	$5,000	$100
Option #2	$10,000	$10,000	$200

24-Hour Accident Benefit – Injury Only** *AD&D for Covered Activities AND Off-Duty Activities*	**OR**	**Off-Duty Accident Benefit – Injury Only**** *AD&D for Off-Duty Activities Only*
$ ($10,000 - $50,000) *(This limit cannot exceed the primary AD&D limit.)*		*$ ($10,000 - $50,000)* *(This limit cannot exceed the primary AD&D limit.)*

Specify class and number of persons on roster for 24-Hour or Off-Duty benefits.

Active Volunteers — Trustees, Commissioners or Directors

Part-Time Paid Employees — Administrative Personnel

Auxiliary Members — Full-Time Paid Employees

Junior Members

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

Name of Producing Agency:

Agency's Address:

Agency's Phone: (   )

Applicant's signature: ______________________ **Title**: **Date**:

Agent's signature: ______________________ **Date:**

County Rated Accident and Sickness Supplemental Application

(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: First Call Population:
3. Does this entity operate an ambulance? Yes No
4. Number of calls annually: Fire EMS:
5. Do you want to cover volunteers only paid employees only both volunteers and paid employees
6. Total number of: Volunteers Auxiliary Members Administrative Personnel
   Trustees Jr. Members Part-time paid employees Full-time paid employees
7. Are all volunteers covered by Workers' Compensation? Yes No N/A
8. Are paid employees covered by Workers' Compensation? Yes No N/A
9. Provide Medical Expense for volunteers: Excess of Workers' Comp Primary (First Dollar) N/A
10. Provide Medical Expense for paid employees: Excess of Workers' Comp Primary (First Dollar) N/A

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

1. Department Name:
2. Number of Locations: First Call Population:
3. Does this entity operate an ambulance? Yes No
4. Number of calls annually: Fire EMS:
5. Do you want to cover volunteers only paid employees only both volunteers and paid employees
6. Total number of: Volunteers Auxiliary Members Administrative Personnel
   Trustees Jr. Members Part-time paid employees Full-time paid employees
7. Are all volunteers covered by Workers' Compensation? Yes No N/A
8. Are paid employees covered by Workers' Compensation? Yes No N/A
9. Provide Medical Expense for volunteers: Excess of Workers' Comp Primary (First Dollar) N/A
10. Provide Medical Expense for paid employees: Excess of Workers' Comp Primary (First Dollar) N/A

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

1. Department Name:
2. Number of Locations: First Call Population:
3. Does this entity operate an ambulance? Yes No
4. Number of calls annually: Fire EMS:
5. Do you want to cover volunteers only paid employees only both volunteers and paid employees
6. Total number of: Volunteers Auxiliary Members Administrative Personnel
   Trustees Jr. Members Part-time paid employees Full-time paid employees
7. Are all volunteers covered by Workers' Compensation? Yes No N/A
8. Are paid employees covered by Workers' Compensation? Yes No N/A
9. Provide Medical Expense for volunteers: Excess of Workers' Comp Primary (First Dollar) N/A
10. Provide Medical Expense for paid employees: Excess of Workers' Comp Primary (First Dollar) N/A