

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:

Primary:

First Name MI Last Name Phone Email

Inspection:

First Name MI Last Name Phone Email

What is your Legal Status?

Independent Department /Not-for-Profit
For-Profit Organization

Municipally Owned
Tax District

Are you Incorporated? Yes
No

What is your type of Operation?

Fire Department / District
Fire Department / District with Ambulance
Ambulance Corps
Rescue Squad
Other (Describe: _____)
* Call VFIS for assistance.

First Responder
Hospital EMS *
Relief Association
County / State Association *
Search & Rescue Team
911 Emergency Dispatch *
Training School *
Haz Mat Team *

What is the size of your Organization?

Number of Paid Employees Full-Time:

Number of Paid Employees Part-Time:

Number of Volunteers:

Number of Publicly Elected (trustees, commissioners or directors):

Employees are considered Full time if regularly scheduled 35 or more hours per week.

What is your Estimated Response Activity?

Fire and other non-medical runs:

Emergency medical or first responder medical runs:

Non-emergency transports:

Responses

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	Career Members
Include unpaid members, paid per call and part-time members averaging less than 25 hours per week.	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 <i>(first dollar)</i>		
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)		Medical Expense (\$2,500 - \$100,000)
	First 28	After 28	
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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:	
	<u>AD&D Benefit</u>	<u>Accident Medical Expense</u> <u>Weekly Accident Indemnity</u>
Option #1	\$5,000	\$5,000 \$100
Option #2	\$10,000	\$10,000 \$200

24-Hour Accident Benefit – Injury Only**	OR	Off-Duty Accident Benefit – Injury Only**
AD&D for Covered Activities AND Off-Duty Activities		AD&D for Off-Duty Activities Only
\$ (\$10,000 - \$50,000)		\$ (\$10,000 - \$50,000)
(This limit cannot exceed the primary AD&D limit.)		(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
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9. Provide Medical Expense for volunteers: Excess of Workers' Comp Primary (First Dollar) N/A
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