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
ACCIDENT & SICKNESS

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 website: _____ E-mail address: _____

Contact person's name: _____ Title: _____

Day phone: (____) _____ Cell #: (____) _____

Is your organization incorporated? ☐ Yes ☐ No For-profit or Not-For-Profit? ☐ For-Profit ☐ Not-for-Profit

If No, are you an: ☐ Unincorporated Association ☐ Political Subdivision
☐ Joint Venture *(attach copy of agreement)* ☐ Other (Describe: _____)

If No, are you chartered? ☐ Yes ☐ No

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

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

Estimated number of responses per year:

_____ Fire and other non-medical runs	_____ Non-emergency transports
_____ 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.	

Department Type:

☐ Fire Department / District	☐ Search & Rescue Team
☐ Fire Department / District with Ambulance	☐ County / State Association *(Please complete the attached County Rated A&S Supplement)*
☐ Ambulance Corps *(pre-survey may be required)*	☐ 911 Emergency Dispatch *(pre-survey required; call VFIS for assistance before proceeding)*
☐ Rescue Squad	☐ Training School *(call VFIS for assistance before proceeding)*
☐ First Responder	☐ Haz Mat Team *(call VFIS for assistance before proceeding)*
☐ Relief Association	☐ Hospital EMS *(pre-survey required; call VFIS for assistance before proceeding)*
☐ Other: (Describe: _____)	

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	Weekly Indemnity ($100 - $1,000) 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: (____) _____ Agency's Fax: (____) _____

Agent's E-mail Address: _____

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: _____ 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
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   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

FRAUD WARNING NOTICE – PLEASE READ CAREFULLY

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 act, which is a crime, and may subject such person to criminal and civil penalties.

Alabama	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.
Arkansas	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.
California	For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
Colorado	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.
District Of Columbia	WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
Florida	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.
Kansas	Any person who knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance that such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.
Kentucky	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	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	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.
Maryland	Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
Minnesota	A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
New Jersey	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	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	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.
Ohio	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	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	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, may be guilty of a fraudulent act, which may be a crime, and may subject such person to criminal and civil penalties.
Pennsylvania	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 subjects such person to criminal and civil penalties.
Rhode Island	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.
Tennessee	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.
Vermont	Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.
Virginia	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.
Washington	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.
West Virginia	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.

Your signature below acknowledges that you have read the General Fraud Warning Notice and the State Specific Fraud Warning Notice that applies to your state of domicile.

The undersigned is an authorized representative of the applicant and certifies the information provided to obtain this coverage is accurate to the best of their knowledge; this includes any applications, locations schedules, valuation statements, loss history information and engineering reports.

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

Agent's signature: _____ **Date:** _____