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FACTFINDER

PROPERTY & CASUALTY / ACCIDENT & SICKNESS / BENEFITS

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: _____

Inspection and Insurance Contact Name: _____

Phone: (____) _____ E-mail: _____

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 (Please complete the attached County Rated A&S Supplement)
☐ 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

No

☐ Blanket Contents☐ \$5,000

Premises #	Item #	Building Occupied As:	Owner or Tenant?	Total Area of Building (including all floors)	Street Address City, State County, Zip Code

Premises #	Item #	Amount of Insurance (Show 100% replacement cost values. In the building amount, include the values of towers, sirens, antennas, etc. wherever located)		Protection Class	Construction Code *	Sprinkler System Y / N	Mortgagee Name and Address
		Building	Contents (\$5,000 minimum)				

7 – heavy timber joisted masonry
8 – superior noncombustible
9 – superior masonry noncombustible

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:

<input type="checkbox"/> \$300,000 occ. / \$1,000,000 agg.	<input type="checkbox"/> \$5,000 Medical Expense (standard)
<input type="checkbox"/> \$500,000 occ. / \$1,000,000 agg.	<input type="checkbox"/> \$10,000 Medical Expense
<input type="checkbox"/> \$1,000,000 occ. / \$2,000,000 agg.	
<input type="checkbox"/> \$1,000,000 occ. / \$3,000,000 agg.	
<input type="checkbox"/> \$1,000,000 occ. / \$10,000,000 agg. (aggregate limit does not apply to each named insured with this option)	

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 storage tanks? ☐ Yes ☐ No

(If yes, and you'd like pollution liability coverage, please complete Supplement D. Note that VFIS does not offer pollution liability coverage for underground storage tanks.)

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

Do you sponsor a Junior Firefighter program (or explorer post)? ☐ Yes ☐ No

If yes, are criminal background checks done on leaders? ☐ Yes ☐ No

If yes, do you have written rules stating that one leader should never be alone with a junior member? ☐ Yes ☐ No

CRIME ☐ **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 criminal background checks done on persons who regularly handle money? ☐ 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? \$ _____

Note: If you are requesting a bond that exceeds \$4,000,000 in limits, please provide us with your most current financial statement.

Below, please indicate the entity to be covered by the bond. If more than eight entities are to be covered, please include additional information in the "Wrap-Up" section of this Factfinder - page 13.

<input type="checkbox"/> Employee Dishonesty – Blanket (for use with non-governmental entities) Limit: \$ _____	Covered Entities: <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
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<input type="checkbox"/> Public Employee Dishonesty – Blanket (for use with governmental entities) Limit: \$ _____ Faithful Performance: <input type="checkbox"/> Yes <input type="checkbox"/> No	Covered Entities: <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
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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).

<input type="checkbox"/> Name or Position Schedule Bond			
Name or Position	Covered Entity (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
			<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 Employee Dishonesty and a Name or Position Schedule bond. Is the Name or Position Schedule bond intended to be:

- ☐ Primary
☐ Specific excess over the Employee Dishonesty

Note: Forgery or Alteration, Computer Fraud and Identity Fraud Expense are coverage extensions that are only available if Employee Dishonesty was requested.

<input type="checkbox"/> Forgery or Alteration Limit: <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$250,000 <input type="checkbox"/> \$500,000 <input type="checkbox"/> \$1,000,000 Other: \$ _____	Covered Entities: _____ _____ _____ _____ _____ _____ _____
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<input type="checkbox"/> Computer Fraud Limit: <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$100,000 * \$10,000 limit is included automatically for any insured that purchases blanket employee dishonesty or blanket public employee dishonesty coverage of \$10,000 or more.	Covered Entities: _____ _____ _____ _____ _____ _____ _____
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<input type="checkbox"/> Identity Fraud Expense Limit: <input type="checkbox"/> \$25,000 * \$10,000 limit is included automatically for any insured that purchases blanket employee dishonesty or blanket public employee dishonesty coverage of \$10,000 or more.	Covered Entities: _____ _____ _____ _____ _____ _____ _____
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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:

☐ Add'l Insured / Lessor ☐ Loss Payee

Vehicle # _____

Name _____

Address _____

City / State / Zip _____

☐ Add'l Insured / Lessor ☐ Loss Payee

Vehicle # _____

Name _____

Address _____

City / State / Zip _____

☐ Add'l Insured / Lessor ☐ Loss Payee

Vehicle # _____

Name _____

Address _____

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.

***If trailer, please provide load capacity in lieu of GVW.**

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 ☐ \$2,500 ☐ \$5,000

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 10.

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

☐ \$1,000,000 each offense or wrongful act / \$10,000,000 aggregate (aggregate limit does not apply to each named insured with this option)

☐ 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.

Cyber Liability and Privacy Crisis Management Expense – Coverage C and D of Management Liability

Cyber Liability protects you when claims are made against you for monetary damages arising out of an electronic information security event.

The limit for Each Electronic Information Security Event will be the same as the Management Liability each offense or wrongful act limit, subject to the Management Liability aggregate.

Privacy Crisis Management Expense reimburses for expenses you incur as a result of a privacy crisis management event first occurring during the policy period. This first party coverage is intended to provide professional expertise in the identification and mitigation of a privacy breach while satisfying Federal and State statutory requirements.

☐ \$50,000 each privacy event / \$50,000 aggregate automatically included

☐ \$100,000 each privacy event / \$100,000 aggregate

☐ \$250,000 each privacy event / \$250,000 aggregate

☐ Yes ☐ No Do you have current firewall management software installed on your computer network?

☐ Yes ☐ No Do you have current antivirus management software installed on your computer network?

☐ Yes ☐ No Do you have a written security and privacy policy?

Cyber Liability and Privacy Crisis Management Expense Comments: _____

EXCESS LIABILITY ☐ 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: _____

Agent's Signature: _____

Applicant's Signature: _____

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): _____

If you have never placed business with us before, please provide the person responsible for agency/brokerage licensing and contracting:

- Contact's Name: _____
- Contact's Email: _____
- Contact's direct phone: _____

PLEASE READ CAREFULLY --- GENERAL FRAUD WARNING NOTICE

Any person who knowingly and with intent to defraud any insurance company or another 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 the person to criminal and civil penalties.

STATE-SPECIFIC FRAUD WARNING NOTICES

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.

Maryland Fraud Warning

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

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.

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: _____

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 and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

Pennsylvania Fraud Warning

All 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 subjects such person to criminal and civil penalties.

Motor Vehicle Insurance: Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any 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.

Washington 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.

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: _____

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 averages 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 looks to the insured for their primary source of income and averages 25 hours or more employment per week, whether hourly or salaried. These hours may be in a set rotation or in varying shifts from week to week.

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? ☐ Yes ☐ No

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

Does your organization provide EMS Service beyond First Aid? ☐ Yes ☐ No

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
☐ Excess of Group Insurance

☐ Primary (first dollar)
☐ Not applicable

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

☐ Excess of Workers' Compensation
☐ Excess of Group Insurance

☐ Primary (first dollar)
☐ 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 - \$500,000)	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	\$290	\$290	\$75,000 (Indiana Year 2009 Statutory)

Is coverage desired for these options?

Extended Total Disability Benefit *	<input type="checkbox"/> Yes	<input type="checkbox"/> No – Volunteer Coverage Only
Weekly Injury Perm. Impairment Benefit COLA	<input type="checkbox"/> Yes	<input type="checkbox"/> No – Volunteer Coverage Only
Additional First Week Indemnity	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Special Events Rider *	<input type="checkbox"/> Yes	<input type="checkbox"/> No – Call your Underwriter for quote information
Weekly Hospital Indemnity	<input type="checkbox"/> Yes	<input type="checkbox"/> No

League Sports Rider	<input type="checkbox"/> Yes <input type="checkbox"/> No									
Type of Sport: _____	Number of participants: _____									
Start date: _____	Length of season: _____									
	<table> <tr> <th>AD&D Benefit</th> <th>Accident Medical Expense</th> <th>Weekly Accident Indemnity</th> </tr> <tr> <td><input type="checkbox"/> Option #1 \$5,000</td> <td>\$5,000</td> <td>\$100</td> </tr> <tr> <td><input type="checkbox"/> Option #2 \$10,000</td> <td>\$10,000</td> <td>\$200</td> </tr> </table>	AD&D Benefit	Accident Medical Expense	Weekly Accident Indemnity	<input type="checkbox"/> Option #1 \$5,000	\$5,000	\$100	<input type="checkbox"/> Option #2 \$10,000	\$10,000	\$200
AD&D Benefit	Accident Medical Expense	Weekly Accident Indemnity								
<input type="checkbox"/> Option #1 \$5,000	\$5,000	\$100								
<input type="checkbox"/> Option #2 \$10,000	\$10,000	\$200								

FL Statutory Benefit Rider ☐ Yes ☐ No – Florida Only (Illegal Loss of Life - \$150,000 additional)

* Not available in all states

24-Hour Benefit (AD&D for covered & non-covered activities) **	
<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____ (\$10,000-\$50,000) Not exceeding AD&D amount selected
Non-Covered/Off-Duty Activity (AD&D only for non-covered activities) **	
<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____ (\$10,000-\$50,000) Not exceeding AD&D amount selected
Do you want to cover:	<u>Specify number on roster</u>
Active Volunteers <input type="checkbox"/>	_____
Career Members <input type="checkbox"/>	_____
Auxiliary Members <input type="checkbox"/>	_____
Junior Members <input type="checkbox"/>	_____
Trustees, Commissioners or Director: <input type="checkbox"/>	_____

**** 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 Signature: _____

County Rated Accident & 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: Fire: _____ EMS: _____
6. Do you want to cover ☐ volunteers only ☐ paid employees only ☐ both volunteers and paid employees
7. Total number volunteers: _____ Part-time paid employees: _____ Full-time paid employees: _____
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: Fire: _____ EMS: _____
6. Do you want to cover ☐ volunteers only ☐ paid employees only ☐ both volunteers and paid employees
7. Total number volunteers: _____ Part-time paid employees: _____ Full-time paid employees: _____
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: Fire: _____ EMS: _____
6. Do you want to cover ☐ volunteers only ☐ paid employees only ☐ both volunteers and paid employees
7. Total number of volunteers: _____ Part-time paid employees: _____ Full-time paid employees: _____
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 20 FOR THE FOLLOWING ITEMS

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 _____

Gross Floor Area (include all floors except basement)

1st fl. _____ sq ft. + 2nd fl _____ sq ft. + 3rd fl _____ sq ft = Total Sq Ft.

Building Perimeter – Indicate approximate perimeter by each floor in feet

1st fl. _____ feet + 2nd fl _____ feet + 3rd fl _____ feet = Total Perimeter

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 ☐

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: _____

Indicate the ISO Construction 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 _____ %

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: _____

Risk Control Use Only
Insured Amount

of Stories

Total Area

Perimeter

Design Quality

Economy 1 _____

Average 2 _____

Superior 3 _____

Premium 4 _____

Premium+ 5 _____

Architectural Fees

☐ 0% ☐ 3% ☐ 5% ☐ 7%

Occupancy/Name Change

- ☐ 8402 _____ ☐ Fire Station
☐ 7110 _____ ☐ Social Hall
☐ 6506 _____ ☐ Garage
☐ 6505 _____ ☐ Storage
☐ 4210 _____ ☐ Office
☐ 2100 _____ ☐ Amb Bldg.
☐ Other (occ): _____
☐ Other (NC): _____

Story Heights

Construction Type

1. Frame _____ %
 2. Masonry _____ %
 3. Pre-Engineered _____ %
 4. Steel Frame _____ %
 5. Pro. Steel Frame _____ %
 6. Reinforced Concrete _____ %

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) (SS) _____ "Y" or %

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

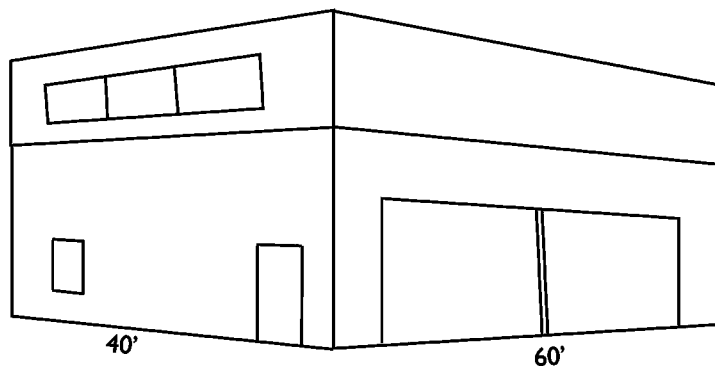
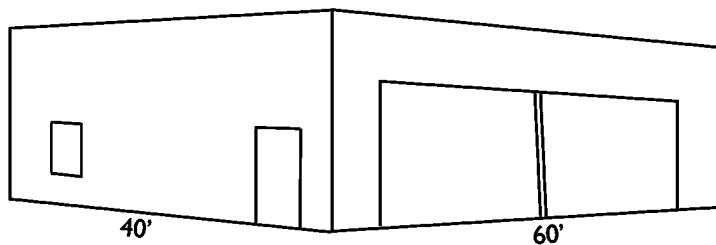
ATTACH PHOTOS AND PROVIDE DIAGRAM OF THE BUILDING ON PAGE 21

Gross Floor Area - (include all floors except basement)

Examples

1 Story Building

$$40' \times 60' = 2,400 \text{ sq. ft.}$$



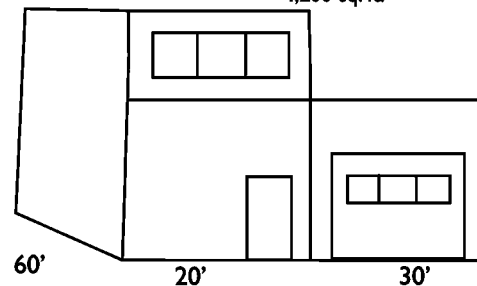
Partial 2 Story Building

$$1\text{st } 60' \times 20' = 1,200 \text{ sq. ft.}$$

$$2\text{nd } 60' \times 20' = 1,200 \text{ sq. ft.}$$

$$1\text{st } 60' \times 30' = 1,800 \text{ sq. ft.}$$

$$4,200 \text{ sq. ft.}$$



2 Story Building

$$40' \times 60' = 2,400 \text{ sq. ft.}$$

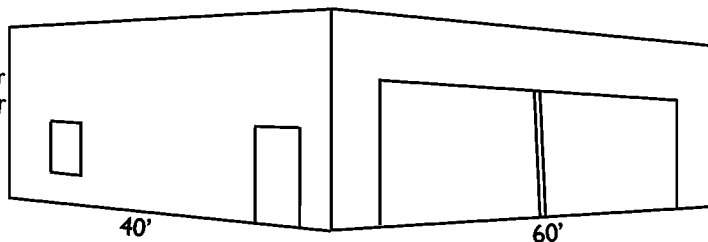
$$40' \times 60' = 2,400 \text{ sq. ft.}$$

$$4,800 \text{ sq. ft.}$$

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

1 Story Building

$$60' + 40' + 60' + 40' = 200 \text{ ft. perimeter}$$

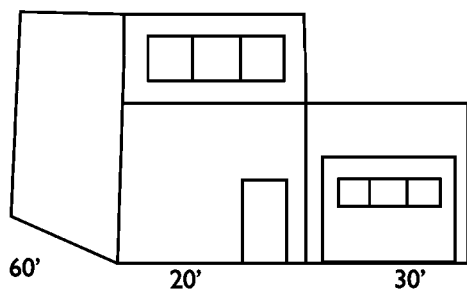


Partial 2 Story Building

$$1\text{st} = 20' + 60' + 20' + 30' + 60' + 30' = 220 \text{ ft. perimeter}$$

$$2\text{nd} \quad 20' + 60' + 20' + 60' = 160 \text{ ft. perimeter}$$

$$380 \text{ ft. total}$$

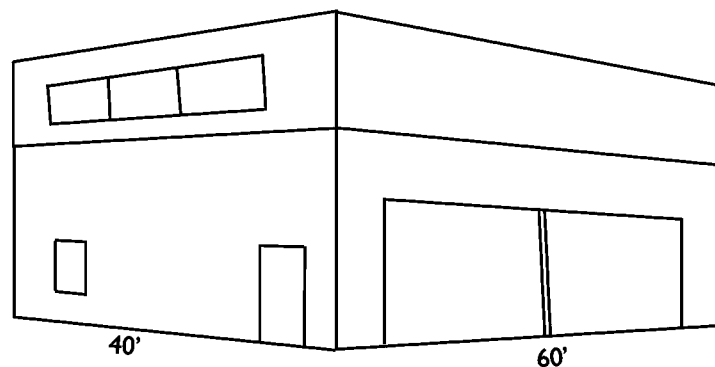


2 Story Building

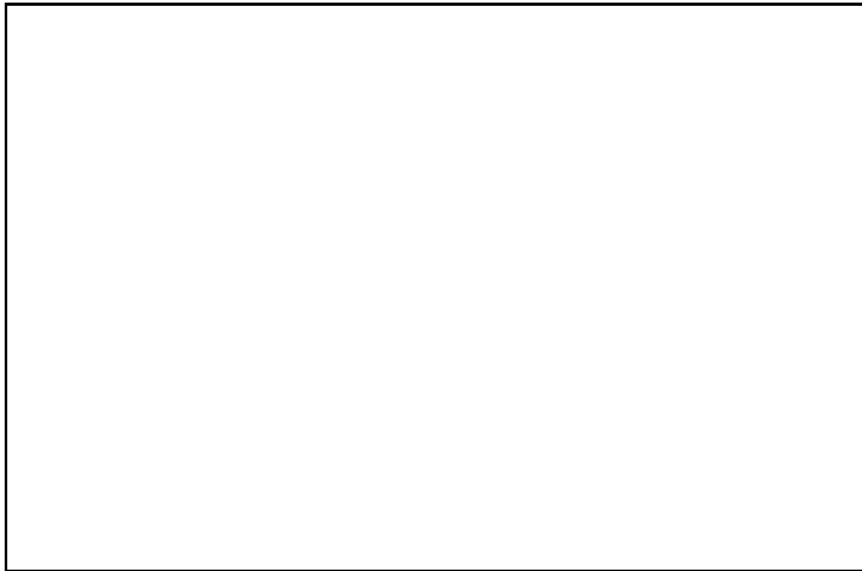
$$1\text{st} = 60' + 40' + 60' + 40' = 200 \text{ ft. perimeter}$$

$$2\text{nd} = 60' + 40' + 60' + 40' = 200 \text{ ft. perimeter}$$

$$400 \text{ ft. total}$$



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
 - ☐ \$1,000,000 / \$10,000,000 (aggregate limit does not apply to each named insured with this option)
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: _____

POLLUTION LIABILITY – ABOVE GROUND STORAGE TANKS (Supplement D)

Legal Name: _____

Mailing Address: _____

1. Address / location of tank? _____
2. What was the date of installation? _____
Was the tank new at installation? ☐ Yes ☐ No
If no, what is the age of the tank? _____
3. What is being stored in the tank? _____
4. What is the maximum tank capacity in gallons? _____
5. What is the distance in feet to nearest adjoining property? _____
6. What is the distance in feet to surface water (lakes, rivers, streams, etc.) or wells? _____
What is the surface water? _____
7. What material is the tank constructed of? _____
8. Does the AST have any secondary containment safeguards? ☐ Yes ☐ No
If yes, please explain: _____
9. Does the insured routinely monitor the tank to insure they are not leaking? ☐ Yes ☐ No
If yes, how frequently? _____
10. Do employees, volunteers know and follow release reporting, investigation and confirmation procedures?
☐ Yes ☐ No
11. Physical protection - Is there a vehicle barrier in place to prevent collision? ☐ Yes ☐ No
Is the tank properly grounded with lightning protection? ☐ Yes ☐ No
12. Security protection from vandalism – fencing, lighting etc.? ☐ Yes ☐ No
If yes, please explain: _____
13. Is there any mechanical or electrical equipment attached to the AST such as an electric generator?
☐ Yes ☐ No
If yes, call your VFIS Underwriter for assistance.

Tank # _____ of _____

A photo(s) of the tank as it appears on the premises is required as part of this submission.

SPECIALTY BENEFITS

(Supplement E)

GROUP TERM LIFE ☐ **Yes** ☐ **No**

Data Required: Census data including member's name, and date of birth.

Proposed Effective Date for the Plan: _____

Basic Face Amount including Basic AD&D: \$ _____

Covered Activity AD&D (from 100% – 200%): _____ %

Reduction Schedule: ☐ Standard Reduction (50% at age 70)
(Please check one) ☐ None
 ☐ Other (explain) _____

Type of Organization: ☐ Volunteer ☐ Career ☐ Combination (Volunteer/Career)

GROUP LONG TERM DISABILITY - CAREER ☐ **Yes** ☐ **No**

Data Required: Census data including member's name, date of birth, and annual salary.

Proposed Effective Date for the Plan: _____

CRITICAL ILLNESS ☐ **Yes** ☐ **No**

Proposed Benefits:	Critical Illness (Covered Illness – Cancer Heart Attack and Stroke)	AD&D	Aggregate Limit (per covered accident)
<input type="checkbox"/> Option 1	\$10,000	\$10,000	\$500,000
<input type="checkbox"/> Option 2	\$20,000	\$10,000	\$500,000
<input type="checkbox"/> Option 3	\$30,000	\$10,000	\$500,000

Number of Eligible Persons: _____

Agent's Signature: _____

Applicant's Signature: _____