Steve Valencia
Athena Insurance and Financial Services
P.O. Box 390, Pine Grove CA 95665
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USFDins.com
Return completed application to
S Valencia steve@athenainsurance.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	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
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5. Do you want to cover ☐ volunteers only ☐ paid employees only ☐ both volunteers and paid employees
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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

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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

Alabama Fraud Warning

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 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.

Delaware Fraud Warning

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.

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.

Kansas Fraud Warning

Any person who commits a fraudulent insurance act is guilty of a crime and may be subject to restitution, fines and confinement in prison. A fraudulent insurance act means an act committed by 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 or insurance agent or broker, any written statement as part of, or in support of, an application for insurance, or the rating of an insurance policy, or a claim for payment or other benefit under an insurance policy, which such person knows to contain materially false information concerning any material fact thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

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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 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.

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.

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 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 Warning

All Types of Insurance: 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 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.

Vermont Fraud Warning

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 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.

West Virginia 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.

Your signature below acknowledges that you have read the General Fraud Warning Notice and the Sta te 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**: ____________

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