

# Fire/EMS PAK® Application



State Director Name (If Applicable): \_\_\_\_\_

State Director Agent Number (If Applicable): \_\_\_\_\_

Originating Agent Name: \_\_\_\_\_

Originating Agent Code Number: \_\_\_\_\_

Today's Date: \_\_\_\_\_ Date Needed: \_\_\_\_\_ Proposed Effective Date: \_\_\_\_\_

**Indicate Coverage to Quote:**

- Building & Contents
- Public & Professional Liability
- Apparatus – Fire Service Vehicles & Ambulance
- Portable Fire/EMS Equipment
- Other Inland Marine
- Excess policy: Submit Acord Application

Special Instructions: \_\_\_\_\_

**Applicant Information**

Named Insured: \_\_\_\_\_

Mailing Address : \_\_\_\_\_

Website: \_\_\_\_\_

Other Named Insureds: \_\_\_\_\_

Reason(s) for any Other Named Insureds: \_\_\_\_\_

Year Entity Began Operations: \_\_\_\_\_

FEIN: \_\_\_\_\_

**Fire Chief/EMS Administrator/Governing Board Contact**

Name: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Form of Organization:  Fire Department Only  Fire & EMS Combined  EMS Only

**How is your Emergency Response Organization authorized to operate?**

- Municipal / City Owned and Controlled
- County Owned and Controlled
- Independent
- Non-Profit Corporation
- For Profit Corporation
- Township
- Fire/EMS District
- Other(describe): \_\_\_\_\_

**Total Number of Members:**

- Full-time Paid (35 or more hours per week) \_\_\_\_\_
- Part time paid (less than 35 hours per week) \_\_\_\_\_
- Volunteers \_\_\_\_\_

**Loss History**

Check here if no losses  
Loss runs required upon binding

Date Of Occurrence	Line	Type/Description Of Occurrence Or Claim	Date Of Claim	Amount Paid	Amount Reserved	Claim Status
_____	_____	_____	_____	\$ _____	\$ _____	<input type="checkbox"/> OPEN <input type="checkbox"/> CLOSED
_____	_____	_____	_____	\$ _____	\$ _____	<input type="checkbox"/> OPEN <input type="checkbox"/> CLOSED
_____	_____	_____	_____	\$ _____	\$ _____	<input type="checkbox"/> OPEN <input type="checkbox"/> CLOSED
_____	_____	_____	_____	\$ _____	\$ _____	<input type="checkbox"/> OPEN <input type="checkbox"/> CLOSED

**Current Insurance Company, Coverage And Premiums**

**X - Coverage Presently Insured**

	Name of Insurer	Annual Premium
<input type="checkbox"/> Property (Building & Contents)	_____	\$ _____
<input type="checkbox"/> Portable Equipment & Other Inland Marine	_____	\$ _____
<input type="checkbox"/> Commercial General & EMS Liability		
Limit of Liability \$ _____	_____	\$ _____
<input type="checkbox"/> Management Liability		
<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-made		
Limit of Liability \$ _____	_____	\$ _____
<input type="checkbox"/> Employment Practices Liability		
<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-made		
Limit of Liability \$ _____	_____	\$ _____
<input type="checkbox"/> Automobile		
Limit of Liability \$ _____		
Comp Ded: \$ _____ Coll Ded: \$ _____	_____	\$ _____
<input type="checkbox"/> Umbrella/Excess Liability		
Limit of Liability \$ _____	_____	\$ _____
	Total Premium	\$ _____

**Additional Interests**

**PROPERTY INTERESTS**

1. Type of Interest: \_\_\_\_\_  
 Item of Interest: \_\_\_\_\_  
 Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

2. Type of Interest: \_\_\_\_\_  
 Item of Interest: \_\_\_\_\_  
 Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

**LIABILITY INTERESTS**

1. Type of Interest: \_\_\_\_\_  
 Item of Interest: \_\_\_\_\_  
 Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

2. Type of Interest: \_\_\_\_\_  
 Item of Interest: \_\_\_\_\_  
 Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

*Note: For Automobile Additional Interests - see Auto Section.*

**FirePAK Property**

**Additional Coverages**

Additional Property limits (Optional)	Provided	Increase To:
Accidental Discharge of Fire Protection Equipment	\$ 25,000	_____
Fine Arts at Market Value	\$ 50,000	_____
Ordinance or Law - Demolition and Increased Cost of Construction	\$ 300,000	_____
Employee Theft*	\$ 50,000	_____
Outdoor Property	\$ 300,000	_____
Computer Equipment including Electronic Data	\$ 250,000	_____

*\*If increased limits are desired for Employee Theft, please complete Acord 141 Crime Section 2000 application.*

Indicate the reason for higher limits: \_\_\_\_\_

All locations: If building limit is \$500,000 or more, complete a CoreLogic COMMERCIAL EXPRESS™ valuation and attach photos. Any building insured on a Guaranteed Replacement Cost basis requires photos of front, side, and back of the building, and a CoreLogic COMMERCIAL EXPRESS™ valuation.

Street Address \_\_\_\_\_ Location # \_\_\_\_\_ Occupancy \_\_\_\_\_  
(use legal description only if no street or E911 address exists)

County \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Building Limit \_\_\_\_\_ Building Personal Property Limit \_\_\_\_\_ Coinsurance % \_\_\_\_\_ Deductible \$ \_\_\_\_\_

**Valuation Provision**

Replacement Cost     Actual Cash Value     Guaranteed Replacement Cost

**Protection Class**    **# of Stories**    **Year Originally Built**    **Total Square Ft. (Area)**    **Sub Floor**  
\_\_\_\_\_    \_\_\_\_\_    \_\_\_\_\_    \_\_\_\_\_     Basement     Slab     Crawl Space

**Construction Type**

Frame/Wood Combustible     Joisted Masonry/Masonry     Non-Comb Pre-Engineered Metal     Masonry Non-Comb Steel Frame  
 Modified Fire Resistive Protected Steel Frame     Fire Resistive Reinforced Concrete Frame

**Year Installed/Updated**

**Plumbing**    **Electrical**    **Heating/AC System**    **Pressure Boiler**  
\_\_\_\_\_    \_\_\_\_\_    \_\_\_\_\_    \_\_\_\_\_

**Roof Construction Type**

(ex: asphalt shingle, metal, slate, membrane)

**Year Roof Installed**

Fire Protection System:     Yes     No

**Other exposures:**

Is there a hall/community meeting area in the fire station or a separate building?     Yes     No

If yes:  
Provide the address(es): \_\_\_\_\_

Describe events and users: \_\_\_\_\_

Provide the square feet of area rented to the public: \_\_\_\_\_

How often is it rented? \_\_\_\_\_

Is there any grease laden cooking?     Yes     No    If yes, is a UL fire suppression system utilized?     Yes     No

**Earthquake/Flood**

Is Earthquake coverage requested?     Yes     No    Deductible:     \$1,000     5%     10%

Is Flood coverage requested?     Yes     No    Deductible:     \$1,000     \$2,500     \$5,000     \$10,000     \$25,000     \_\_\_\_\_%

Note: Flood Coverage is limited to \$1,000,000 per policy and \$1,000,000 Annual Aggregate. (WI is limited to \$500,000.)

Has the property ever experienced flooding?     Yes     No    If yes, when: \_\_\_\_\_    Amount of damage: \$ \_\_\_\_\_

Is the property protected by a levee?     Yes     No

Is there an evacuation plan in place to reduce or avoid property loss?     Yes     No

\* For additional locations, please add additional copies of FirePAK property form.

**FirePAK General Liability / Professional Liability**

**Limit of Liability**

\$ \_\_\_\_\_ each occurrence \$ \_\_\_\_\_ aggregate

**Operations**

**Population Served by Your Organization on a First Alarm Basis** (not including mutual aid): \_\_\_\_\_

**Population during tourist season if applicable:** \_\_\_\_\_

Please enter the total number of annual calls for each operation of your entity:

Fire calls:	EMS calls:	Non-Emergency Transports:
Search & Rescue calls:	HazMat calls:	Controlled Burns:

Is there any sharing of services, property or vehicles with any other entity?  Yes  No

If yes, please describe: \_\_\_\_\_

Hold harmless agreements in place?  Yes  No

Are you or any of your members involved with Community Paramedicine Services?  Yes  No

Are there any other operations performed by the applicant?  Yes  No

If yes, please describe: \_\_\_\_\_

**HazMat Calls (complete only if applicable)**

What is your HazMat certification level? \_\_\_\_\_

Types of materials cleaned: \_\_\_\_\_

Describe your HazMat operations: \_\_\_\_\_

**EMS Operations (complete if applicable)**

Is a licensed physician utilized as your Medical/EMS Director?  Yes  No

Years of experience for: EMS Director/Manager: \_\_\_\_\_ EMS Medical Director: \_\_\_\_\_

Do you audit/review and document the work of all EMS Personnel?  Yes  No

Frequency of review: Weekly Monthly Annually

Do you take disciplinary action for EMS personnel not performing to required standards?  Yes  No

Do you have a maximum number or type of EMS violations that personnel may incur before corrective action is taken?  Yes  No

If yes, please describe: \_\_\_\_\_

Do you transport any imprisoned persons, inmates or detainees?  Yes  No

Do you transport any psychiatric persons?  Yes  No

Do you provide any transport greater than 100 miles?  Yes  No

If yes, please advise the number or percentage of long distance transport: \_\_\_\_\_

What certification level has your entity been awarded by your state? \_\_\_\_\_

Certification levels vary by state. Provide the number of rostered members for each EMS category (or their state equivalent titles). Count individuals only once, at their highest EMS individual certification level.

First Responder:	EMT Basic:
EMT Intermediate:	EMT Advanced Paramedic:

**Search and Rescue Operations (complete if applicable)**

Describe your search and rescue operations: \_\_\_\_\_

**Junior Firefighter or Cadet Program (complete if applicable)**

Do you have a program?  Yes  No If yes, attach copy of cadet operating guidelines.

Number of participants? \_\_\_\_\_ Age range of participants? \_\_\_\_\_

What activities are participants limited to? \_\_\_\_\_

Do you require parents to sign waivers releasing your organization from liability and do the parents and minors understand the risks of your cadet program?  Yes  No

Do you require that all cadets are supervised?  Yes  No

**Special Events:**

Our liability policy does not cover certain fund raising or sponsored events unless they are specifically added to the policy. We will insure the following events (additional premium may apply).

Festival/Fair:	Fireworks Display (Sponsor Only):
Other:	Fireworks Display (Detonation):
Other:	Cost of Fireworks: \$

Bounce House/Amusement Rides are not eligible for coverage. Please advise if these exposures exist:  Yes  No

**Liquor Liability (Optional Coverage)**

Is Liquor Liability Coverage needed:

Yes  No

Are you required to obtain a liquor license or permit to serve alcohol?

Yes  No

Do you possess a current and valid liquor license or permit?

Yes  No

Has your liquor license ever been suspended or revoked? If yes, explain: \_\_\_\_\_

Have you ever been cited for violations of a law/ordinance relating to the sale of alcohol?

Yes  No

If yes, explain: \_\_\_\_\_

Have you incurred any claims for liquor liability during the past three years?

Yes  No

If yes, explain: \_\_\_\_\_

Do you have a written alcohol service policy that is distributed to new and existing persons serving alcohol?

Yes  No

Does the written alcohol service policy include guidance on how to monitor and recognize intoxication?

Yes  No

Are alcohol servers required to sign and acknowledge that they have read, understand, and will comply with the alcohol policy?

Yes  No

Is service delayed or discontinued for customers who show signs of approaching intoxication?

Yes  No

Are transportation arrangements made for customers who appear to be impaired?

Yes  No

Are servers required to ask for identification of all patrons who appear to be 35 years old or younger

Yes  No

Do you post signage clarifying intent to not serve underage patrons?

Yes  No

Is service of alcohol refused to anyone unable to provide legal proof of age?

Yes  No

Is alcohol being served in a controlled area to ensure serving to legally eligible patrons?

Yes  No

Describe the event(s) alcohol is being provided for, including any entertainment:

Yes  No

\_\_\_\_\_  
\_\_\_\_\_

**Cyber Liability**

Is Cyber Liability coverage requested?

Yes  No

If yes, Limit \$ \_\_\_\_\_ Note: If over \$200,000, an additional supplement will be required. Please advise underwriter.

Does the organization have current firewall software installed on their computer network?

Yes  No

Does the organization have current anti-virus software installed on their computer network?

Yes  No

Does the organization have a written privacy and security policy?

Yes  No

**Employers Liability – Stop Gap (Optional Coverage)**

If the insured purchases their Workers' Compensation from a state fund that does not provide Employers Liability Coverage, we can provide this coverage.

Is Stop Gap coverage needed?  Yes  No State \_\_\_\_\_

If yes, specify Limits of Liability \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (Each Employee/Each Accident/ Aggregate Disease)

**Management Liability (Optional Coverage)**

Each Wrongful Act Limit \$ \_\_\_\_\_ Annual Aggregate Limit \$ \_\_\_\_\_

Deductible  \$1,000  \$2,500  \$5,000

Do you currently have Claims-Made Management Liability Coverage?

Yes  No

Do you want Prior Acts Coverage?

Yes  No

Does the entity have a written Policies and Procedures Manual for all its activities?

Yes  No

Does the entity have legal counsel regularly review the manual?

Yes  No

For the following questions, please explain any "Yes" answers in the space provided below.

Has your entity or any director/officer of your entity been the subject of or involved in any of the following in the last five (5) years:

Any disciplinary action, proceedings or charges by any regulatory agency or association?

Yes  No

Any actual or alleged criminal, fraudulent or dishonest acts, errors or omissions?

Yes  No

Any lawsuits relating to the operation of the entity?

Yes  No

Does the applicant have knowledge of any incidents which would cause a person to believe that a claim or suit might result?

Yes  No

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Employment Practices Liability (Complete if Applicable)**

Limit of Insurance: \$ \_\_\_\_\_ Annual Aggregate Limit: \$ \_\_\_\_\_

Retroactive Date if applicable: \_\_\_\_\_

Do you currently have Claims-Made Employment Practices Liability Coverage?  Yes  No

Deductible:  \$2,500  \$5,000

	Full Time (35 or more hours)	Part Time (less than 35 hours)	Volunteers
Number of Employees/Volunteers Now			
Number of Employees/Volunteers 1 Year Ago			
Number Terminated / Laid Off in last 12 months			
% of Employees/Volunteers with Dept. Less Than 12 Months			
% of Employees/Volunteers with Dept. More Than 5 Years			

Do you use an employment application for all your job applicants?  Yes  No

Do you secure references on job candidates?  Yes  No

Do you have an Employment Handbook for all employees?  Yes  No

Are all employees / volunteers required to sign a form that they have been provided with and reviewed a copy of the Employee handbook?  Yes  No

Do you have a specific person that handles all personnel issues?  Yes  No

Do you have job descriptions and expectations clearly written and utilized?  Yes  No

Do you have a clearly written policy against discrimination?  Yes  No

Is annual training conducted for all employees and/or volunteers?  Yes  No

Do you have a clearly written policy against sexual harassment?  Yes  No

Do you seek counsel from an attorney before terminating an employee/volunteer?  Yes  No

Do you have a policy on giving references on former employees/volunteers to others?  Yes  No

Are you aware of any fact, situation, or circumstance which may result in an Employment Practices Liability claim?  Yes  No

Have there been any previous allegations or claims relating to employee termination, harassment, or discrimination?  Yes  No

**Automobile**

**You must include and sign ACORD 61 (if applicable) and ACORD 137 (not the schedule) forms applicable to your state.**

*Note: \$1,000,000 is the maximum Uninsured/Underinsured limit we will write.*

Does your organization order and review MVR's for all members?  Yes  No

Do you provide ongoing driver training to all new and current members?  
How often? \_\_\_\_\_  Yes  No

Do you have standard operating guidelines requiring all members to comply with all motor vehicle laws while responding to calls or conducting operations for your entity?  Yes  No

Do you have standard operating guidelines stating that all members cannot drive or conduct any operations for your entity if under the influence of alcohol or drugs?  Yes  No

Are any active drivers on your roster under the age of 25 or over the age of 70?  
If yes, please provide driver information for each (Name, D.O.B., License Number):  
\_\_\_\_\_  
\_\_\_\_\_

Do you conduct monthly inspections of all vehicles tires to determine proper condition or need of replacement?  
NFPA 1911 requires inspection and that all tires must be replaced every seven years.  Yes  No

Does your organization repair the vehicles of others?  
If yes, please answer:  Yes  No

Types of vehicles repaired? \_\_\_\_\_

Values of vehicles repaired? \_\_\_\_\_

Are any vehicles provided for the personal use of any member of the organization?  Yes  No

If yes, please identify the vehicle and the name of individual to whom it is furnished:

Are any vehicles on loan from forestry service or other governmental agencies?  Yes  No

If yes, please identify vehicle(s): \_\_\_\_\_

Is primary liability coverage for member's personally owned and hired vehicles requested?  Yes  No

**GUIDE FOR APPARATUS, FIRE SERVICE VEHICLES & AMBULANCE**

**1) INSURABLE DOLLAR VALUES**

We insure physical damage for vehicles on either an Actual Cash Value basis (ACV) or a Designated Value (DV) basis. Vehicles that are standard production vehicles such as private passenger cars, pickups, vans and sport utility vehicles will be insured on an ACV basis and you need to tell us the cost new of the vehicle and the 17-digit VIN. If insured on a DV basis, you need to tell us the value that you want to insure on the vehicle.

Other special fire service and EMS vehicles should be insured on a DV basis. You must determine the DV that you want to insure on the vehicle. The DV you decide should be somewhere between the ACV of the vehicle and the cost to replace the vehicle with a new one.

You should choose the DV for each vehicle very carefully. Remember, in case of a loss, most vehicles are repaired, not replaced. However, if the repair cost of a vehicle exceeds 75% of the DV you have chosen, you have the option to not repair and to get another vehicle. The payment for a new vehicle is limited to the DV you have chosen.

Things to consider for DV:

1. The age of the vehicle.
2. The Actual Cash Value and Replacement Cost of the vehicle. Include the value of any permanently installed equipment, such as a loading system (excluding gurneys and cots).
3. What do you want or need to get back if that vehicle has to be replaced?
4. Remember, the higher the DV the more you will pay in insurance premiums and the less likely it is that you will reach the 75% repair cost threshold needed to replace the vehicle.

**(2) VALUE CODE**

CN = Cost New      DV = Designated Value

**(3) USE CODE**

Numeric or Numeric Alpha code to describe the unit and its use.

CODE	DESCRIPTION
1	PUMPER: Firefighting Apparatus per N.F.P.A. 1901
1A	AERIAL LADDER TRUCK: Apparatus with or without pump
1M	MINI PUMPER: Booster or Class A Pump
2	TANKER: Water carrier, with or without pump
2T	Same as #2, but a Tractor-Trailer unit
3	EQUIPMENT/PERSONNEL CARRIER: Truck, step-van, station wagon, pickup, etc. with permanently attached specialized Fire/EMS equipment (other than lights and sirens)
3b	EQUIPMENT/PERSONNEL CARRIER: Converted bus or similar vehicle, with permanently attached specialized Fire/EMS equipment (other than lights, sirens)
4A	RESCUE TRUCK: Heavy
4B	RESCUE TRUCK: Light
5A	AMBULANCE (Advanced Life Support): ALS Ambulance is designed to transport or support a transport vehicle with specialized medical equipment as specified by a governing authority. <ul style="list-style-type: none"> <li>• Examples of such equipment could be, but not limited to: BLS equipment, intravenous equipment, cardiac monitoring equipment, telemetry communicating equipment, drug boxes, trauma kits, shock suits, etc. normally used by Nurses, EMT's and Paramedics (dependent upon certification regulations of your governing authority)</li> </ul>
5B	AMBULANCE (Basic Life Support): BLS Ambulance is designed to transport patients/victims and equipped as specified by a governing authority. <ul style="list-style-type: none"> <li>• Examples of equipment carried could be: resuscitation devices, oxygen therapy devices, suction equipment, splints, first aid supplies, etc.</li> </ul>
6	ANTIQUA: Vehicle used for display or in parades
7	BRUSH: Off the road unit used to control brush/ground fire
8	PRIVATE PASSENGER: Autos, Pickups, Vans, SUV's, without permanently attached specialized Fire/EMS equipment
9	TRAILER: Except for 2T above, any non-motorized unit for any use
10	OTHER: Describe here:

**Vehicle / Trailer Schedule**

<b>Unit #</b>	<b>Year</b>	<b>Make</b>	<b>Model</b>	<b>VIN/Serial</b>	<b>Type of Apparatus</b>	<b>Garaging Location #</b>
1						
<b>Use Code</b>	<b>Value Code</b>	<b>Insurable Value</b>	<b>Comp Deductible</b>	<b>Collision Deductible</b>		
<b>Unit #</b>	<b>Year</b>	<b>Make</b>	<b>Model</b>	<b>VIN/Serial</b>	<b>Type of Apparatus</b>	<b>Garaging Location #</b>
2						
<b>Use Code</b>	<b>Value Code</b>	<b>Insurable Value</b>	<b>Comp Deductible</b>	<b>Collision Deductible</b>		
<b>Unit #</b>	<b>Year</b>	<b>Make</b>	<b>Model</b>	<b>VIN/Serial</b>	<b>Type of Apparatus</b>	<b>Garaging Location #</b>
3						
<b>Use Code</b>	<b>Value Code</b>	<b>Insurable Value</b>	<b>Comp Deductible</b>	<b>Collision Deductible</b>		
<b>Unit #</b>	<b>Year</b>	<b>Make</b>	<b>Model</b>	<b>VIN/Serial</b>	<b>Type of Apparatus</b>	<b>Garaging Location #</b>
4						
<b>Use Code</b>	<b>Value Code</b>	<b>Insurable Value</b>	<b>Comp Deductible</b>	<b>Collision Deductible</b>		
<b>Unit #</b>	<b>Year</b>	<b>Make</b>	<b>Model</b>	<b>VIN/Serial</b>	<b>Type of Apparatus</b>	<b>Garaging Location #</b>
5						
<b>Use Code</b>	<b>Value Code</b>	<b>Insurable Value</b>	<b>Comp Deductible</b>	<b>Collision Deductible</b>		
<b>Unit #</b>	<b>Year</b>	<b>Make</b>	<b>Model</b>	<b>VIN/Serial</b>	<b>Type of Apparatus</b>	<b>Garaging Location #</b>
6						
<b>Use Code</b>	<b>Value Code</b>	<b>Insurable Value</b>	<b>Comp Deductible</b>	<b>Collision Deductible</b>		
<b>Unit #</b>	<b>Year</b>	<b>Make</b>	<b>Model</b>	<b>VIN/Serial</b>	<b>Type of Apparatus</b>	<b>Garaging Location #</b>
7						
<b>Use Code</b>	<b>Value Code</b>	<b>Insurable Value</b>	<b>Comp Deductible</b>	<b>Collision Deductible</b>		
<b>Unit #</b>	<b>Year</b>	<b>Make</b>	<b>Model</b>	<b>VIN/Serial</b>	<b>Type of Apparatus</b>	<b>Garaging Location #</b>
8						
<b>Use Code</b>	<b>Value Code</b>	<b>Insurable Value</b>	<b>Comp Deductible</b>	<b>Collision Deductible</b>		
<b>Unit #</b>	<b>Year</b>	<b>Make</b>	<b>Model</b>	<b>VIN/Serial</b>	<b>Type of Apparatus</b>	<b>Garaging Location #</b>
9						
<b>Use Code</b>	<b>Value Code</b>	<b>Insurable Value</b>	<b>Comp Deductible</b>	<b>Collision Deductible</b>		
<b>Unit #</b>	<b>Year</b>	<b>Make</b>	<b>Model</b>	<b>VIN/Serial</b>	<b>Type of Apparatus</b>	<b>Garaging Location #</b>
10						
<b>Use Code</b>	<b>Value Code</b>	<b>Insurable Value</b>	<b>Comp Deductible</b>	<b>Collision Deductible</b>		

*For additional vehicles, please add additional copies of the Vehicle/Trailer Schedule.*



**For Any Automobile Loss Payee or Additional Insured complete the following:**

Name of Loss Payee/Additional Insured \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Unit # \_\_\_\_\_  Loss Payee  Additional Insured

Name of Loss Payee/Additional Insured \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Unit # \_\_\_\_\_  Loss Payee  Additional Insured

Name of Loss Payee/Additional Insured \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Unit # \_\_\_\_\_  Loss Payee  Additional Insured

**Inland Marine Coverage Part**

Deductible Per One Occurrence:  \$500  \$1,000  \$2,500  \$5,000

**PORTABLE EQUIPMENT:** Defined as "All Firefighting and/or Emergency Medical Equipment and gear not permanently attached to building or vehicles."

Equipment Value Per Vehicle

(Same vehicle # as shown on page 8)

1: \$ _____	(1) Sum of Equipment Value Per Vehicle	\$ _____
2: \$ _____	(2) Pagers, Base Radio, Communications & Electronic Gear	\$ _____
3: \$ _____	(3) Individual "Turnout/Breakout Gear"	\$ _____
4: \$ _____	(4) All other remaining items not in 1,2 or 3 above	\$ _____
5: \$ _____	(5) EMS Medical Equipment if not reported in 1 above	\$ _____
6: \$ _____	<b>Equipment Grand Total</b>	\$ _____
7: \$ _____	If more than 10 vehicles, copy this page and attach.	
8: \$ _____		
9: \$ _____		
10: \$ _____		

Other (Describe)	Complete Description, Serial #, Etc.	Replacement Cost Value	Actual Cash Value
_____	_____	\$ _____	\$ _____
_____	_____	\$ _____	\$ _____
_____	_____	\$ _____	\$ _____
_____	_____	\$ _____	\$ _____

Watercraft	Year	Make/Model	Length/HP	Serial #	Replacement Cost Value	Actual Cash Value
Hull	_____	_____	_____	_____	\$ _____	\$ _____
Motor	_____	_____	_____	_____	\$ _____	\$ _____
Trailer	_____	_____	_____	_____	\$ _____	\$ _____
Equipment	_____	_____	_____	_____	\$ _____	\$ _____

**Snowmobile**

	Year	Make/Model	HP	Serial #	Replacement Cost Value	Actual Cash Value
Snowmobile Trailer	_____	_____	_____	_____	\$ _____	\$ _____
Equipment	_____	_____	_____	_____	\$ _____	\$ _____
(Detachable items including sleds)	_____	_____	_____	_____	\$ _____	\$ _____

**All-Terrain Vehicle**

	Year	Make/Model	HP	Serial #	Replacement Cost Value	Actual Cash Value
ATV	_____	_____	_____	_____	\$ _____	\$ _____
Trailer	_____	_____	_____	_____	\$ _____	\$ _____
Equipment (Detachable items including sleds)	_____	_____	_____	_____	\$ _____	\$ _____

**General 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.

The fraud warnings listed below are applicable in and may be required by the states of CO, IN, MN, and NE. Please review the appropriate fraud warning relevant to the state that you reside in prior to submitting your application and/or filing a claim with us or any other insurer.

**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.

**Indiana:** A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

**Minnesota:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**Nebraska:** 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, may be committing a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

The undersigned is an authorized representative of the applicant and represents that reasonable inquiry has been made to obtain the answers to questions on this application. He/she represents that the answers are true, correct and complete to the best of his/ her knowledge.

State Director

\_\_\_\_\_

Local Agent (Name, Address, Phone Number)

\_\_\_\_\_

CWG Agent Number

\_\_\_\_\_

Applicant Signature Required



\_\_\_\_\_

Local Agent Signature Required



\_\_\_\_\_



| a Berkley Company

Acadia Insurance Company • Continental Western Insurance Company • Firemen's Insurance Company of Washington, D.C.  
Tri-State Insurance Company of Minnesota • Union Insurance Company