

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 <input type="checkbox"/> Building & Contents <input type="checkbox"/> Portable Fire/EMS Equipment <input type="checkbox"/> Other Inland Marine <input type="checkbox"/> Public & Professional Liability <input type="checkbox"/> Apparatus – Fire Service Vehicles & Ambulance <input type="checkbox"/> Excess policy: Submit Acord Application
Special Instructions	

Applicant Information

Name (First Named Insured)	Mailing Address of First Named Insured
Website	Other Named Insureds
Reason(s) for any Other Named Insureds	
Year Entity Began Operations	FEIN Number

Fire Chief/EMS Administrator

Governing Board Contact

Name	Name
E-mail Address	E-mail Address
Primary Phone	Primary Phone
Secondary Phone	Secondary Phone

Form of Organization

Is the organization a governmental subdivision?

- Fire Department Only Fire & EMS Combined
 EMS Only

- Yes No

How is your Emergency Response Organization authorized to operate?

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

Total Number of Employees/Volunteers

- Full-time Paid (35 or more hours per week) _____ Part time paid (35 or less hours per week) _____
 Paid per call _____ Rate paid per call _____
 Paid-on-Call _____ Daily Rate _____
 What is the total annual payroll? _____ Non-paid volunteers _____

Insured

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"/> Automobile Limit of Liability Comp Ded: \$ _____ Coll Ded: \$ _____		
<input type="checkbox"/> Umbrella/Excess Liability Limit of Liability \$ _____		\$
Total Premium _____		\$

LOSS HISTORY

Enter all claims other than workers comp for five (5) prior years or attach loss runs Check here if none
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
				\$	\$	<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

ADDITIONAL INTERESTS

PROPERTY INTERESTS	LIABILITY INTERESTS
1. Type of Interest:	1. Type of Interest:
Item of Interest:	Item of Interest/Reason of Interest:
Name:	Name:
Address:	Address:
City: State: ZIP:	City: State: ZIP:
2. Type of Interest:	2. Type of Interest:
Item of Interest:	Item of Interest/Reason of Interest:
Name:	Name:
Address:	Address:
City: State: ZIP:	City: State: ZIP:
3. Type of Interest:	3. Type of Interest:
Item of Interest:	Item of Interest/Reason of Interest:
Name:	Name:
Address:	Address:
City: State: ZIP:	City: State: ZIP:

Note: For Automobile Additional Interests - see page 12.

FirePAK Property

All locations: If building limit is \$100,000 or more, complete a Marshall Swift 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 Marshall Swift valuation.

Street Address (use legal description only if no street or E911 address exists)		Location #	
County	City	State	Zip Code
Occupancy (if more than one, show % of each)			
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
				<input type="checkbox"/> Basement <input type="checkbox"/> Slab <input type="checkbox"/> Crawl Space
Construction Type				
<input type="checkbox"/> Frame/Wood Combustible	<input type="checkbox"/> Joisted Masonry/Masonry	<input type="checkbox"/> Non-Comb Pre-Engineered Metal	<input type="checkbox"/> Masonry Non-Comb Steel Frame	
<input type="checkbox"/> Modified Fire Resistive Protected Steel Frame	<input type="checkbox"/> Fire Resistive Reinforced Concrete Frame			
Year Installed/Updated				
Plumbing	Electrical	Heating/AC System	Pressure Boiler	
Year Last Inspected	Roof Construction Type <i>(ex: asphalt shingle, metal, slate, membrane)</i>		Year Roof Installed	
Electrical:	Heating:			
Fire Protection System: <input type="checkbox"/> Yes <input type="checkbox"/> No				

Other exposures: Complete if applicable

Cooking: Is there a kitchen? Yes No Is the kitchen available for use by the general public? Yes No
 If yes, type of cooking equipment? Commercial Range Domestic Range Gas or Electric Griddle Deep Fat Fryer

How often is the kitchen used?	Average number of persons served?
	%
Halls/Meeting Rooms	
Is there a community meeting area in fire station? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, size of meeting area:
How often used?	Used for events other than meeting? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, describe events & users:	
Receipts from rental of hall / meeting room:	

Housing	
Is there any housing of personnel in the building? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, sleeping quarters for how many individuals?
Average number on duty 24/7 basis:	
Other Structures	
Are there any structures at this location you do NOT want to insure? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please describe:	
Optional Property Coverages	
Earthquake: <input type="checkbox"/> Yes <input type="checkbox"/> No	

If yes, building & business personal property limit – limit desired: \$ _____ Deductible: _____

Flood: Yes No

Note: Flood Coverage is limited to \$1,000,000 per policy and \$1,000,000 Annual Aggregate

If yes, Building & Business Personal Property – Limit desired \$ _____

1. Distance to nearest body of water (river, lake, creek) _____

2. Type of body of water: River Lake Creek

3. Name of the body of water? _____

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

5. Has the property ever been threatened with flooding? Yes No If yes, when: _____

6. Have flood waters ever been within 100 yards of the property? Yes No If yes, when: _____

7. Is the property protected by a levee? Yes No

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

a. Please outline plan details or attach a copy of the plan.

Additional Coverages		Additional Coverages	
Additional Property limits (Optional)	Provided	Increase To:	Location #
Employee Dishonesty*	\$ 25,000		
Accounts Receivable	\$100,000		
Money and Securities*	\$25,000		
Outdoor Property	\$100,000		
Computers Software, Telephone Systems	\$250,000		
Valuable Papers & Records – Cost of Research	\$100,000		

**If increased limits are desired for *Employee Dishonesty or *Money and Securities, please complete Acord 141 Crime Section 2000 application.*

Indicate the reason for the need for higher limits:

For additional locations please add additional copies of FirePAK property form.

For more than 1 location you must complete and provide page 3 and 4.

FirePAK General Liability / Professional Liability

Limit of Liability			
\$ _____ each occurrence	\$ _____ aggregate		
Operations			
1. Population Served by Your Organization on a First Alarm Basis <i>(not including mutual aid)</i>	2. Total Annual Calls		
Is the population served a resort or high tourist area: <input type="checkbox"/> Yes <input type="checkbox"/> No Population during tourist season: _____	Please enter the total number of annual calls for each operation of your entity: Fire calls <input type="text"/> Search & Rescue calls <input type="text"/> HazMat calls <input type="text"/> Total EMS <input type="text"/> EMS non-emergency <input type="text"/> EMS emergency <input type="text"/> Non-medical calls <input type="text"/> Transports <input type="text"/> Controlled Burns <input type="text"/>		
3. HazMat Calls (complete only if applicable)			
Level of certification of department: _____			
Types of materials cleaned: _____			
Describe what the department does for HazMat cleanup: _____			
4. EMS Operations (complete if applicable)			
What certification level has your entity been awarded by your state? _____			
Is a licensed physician utilized as your Medical/EMS Director? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Below, please provide the "Number" of rostered members who are Certified in each of the EMS categories. Count individuals only once, at their highest EMS individual certification level.			
CPR:	Emergency Rescue Tech:	EMT D:	
First Responder:	Nurses:	EMT Basic:	
First Responder - Defib:	Non-EMT Drivers:	EMT Intermediate:	
First Responder - Advanced:	Administrators (non-certified):	EMT Paramedic:	
Crash Injury Management Tech:	EMT A:	Physicians Assistants:	
5. Search and Rescue Operations (complete if applicable)			
Describe the types of search and rescue operations conducted by the entity. _____			
6. Are there any other operations performed by the applicant?			
<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please describe those operations. _____			
7. Junior Firefighter Program (Explorer program) (complete if applicable)			
Do you have a program? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, attach copy of standard operating guidelines.			
What are participants allowed to do? _____			
Number of participants? _____	Age of participants? _____		
8. Does your organization maintain formal education and training programs?			
<input type="checkbox"/> Yes <input type="checkbox"/> No			
9. Are your employees/volunteers covered for Workers Compensation Insurance?			
<input type="checkbox"/> Yes <input type="checkbox"/> No			
10. Does your organization sell subscriptions for service?			
<input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, does the organization respond to all calls for emergency service: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Within its service area without regard to whether the caller/victim is a subscriber: <input type="checkbox"/> Yes <input type="checkbox"/> No			
11. Does your organization own any vacant land? <i>If "Yes," please list number of acres.</i>			
<input type="checkbox"/> Yes <input type="checkbox"/> No # Acres: _____			
Does your organization own any vacant buildings? If "Yes," please list address <input type="checkbox"/> Yes <input type="checkbox"/> No # _____			

12. Fund Raising – Sponsored Events (Optional Coverage)

Our liability policy does not cover certain fund raising or sponsored events unless they are specifically added to the policy and a premium charged. We will insure the following events for an additional premium. These surveys can be obtained from your state director (if applicable) or your CWG agent.

Event	Number of Times Held Annually	Event	Number of Times Held Annually
Archery Contest		Haunted House	
Circus/Carnival		Horse Pull	
Concerts		Motorized Land Vehicle events Describe:	
Festival/Fair		Watercraft Describe:	
Fireworks Display (sponsor only)		Other Describe:	
Fireworks (detonation) Cost of Fireworks: \$ _____		Other Describe:	

* Bounce House/Amusement Rides are not eligible for coverage

Total annual receipts from all fund raising activities? _____

13. Liquor Liability (Optional Coverage)

- a. Will you furnish alcoholic beverages for a charge or where a liquor license or permit is required? Yes No
- b. Annual receipts _____
- c. Do you permit alcohol on the premises or at sponsored functions, but do not sell it? Yes No
- d. If a rental hall, do you provide bartenders to serve alcohol supplied by others? Yes No
- e. If alcohol is consumed or sold on premises, please describe procedures in place to manage or monitor consumption?

- g. Is Liquor Liability Coverage needed: Yes No

14. 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.

Do you need this coverage? Yes No

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

15. Management Liability – (Optional Coverage)

- a. Limit of Liability \$ _____ each wrongful act \$ _____ aggregate.
- b. Deductible \$1,000 \$2,500 \$5,000
- c. Do you currently have Claims-Made Management Liability Coverage: Yes No
- d. Do you want Prior Acts Coverage? Yes No
- e. Will you purchase an extended reporting period from their current Claims-Made insurer? Yes No
- f. Does the applicant have knowledge of any incidents which would cause a person to believe that a claim or suit might result? Yes No
- g. 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? If yes, please explain.
 - Any disciplinary action by any regulatory agency or association? Yes No
 - Any administrative proceeding charging violation of federal or state regulation? Yes No
 - Any criminal actions? Yes No
 - Any lawsuits related to the operation of the entity? Yes No
- h. Number of trustees, commissioners or directors: _____
- i. Are the directors elected, appointed or other? Please specify: _____

Employment Practices Liability (Optional Coverage)

Limit of Insurance (check one): \$500,000/1,000,000 \$1,000,000/2,000,000 \$2,000,000/4,000,000

Deductible (check one): \$1,000 \$2,500 \$5,000

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

Do you want Prior Acts Coverage? Yes No

EMPLOYEE DATA

	Full Time (35 or more hours)	Part Time (less than 35 hours)	Non-Paid Volunteers or Paid Per Call
# of Employees/Volunteers Now			
# of Employees/Volunteers A Year Ago			
# 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			

GENERAL INFORMATION

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

2. Do you secure references on job candidates? Yes No

3. Do you have an Employment Handbook for all employees?
 a. 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

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

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

6. Do you have a clearly written policy against discrimination?
 a. Is annual training conducted for all employees and/or volunteers? Yes No

7. Do you have a clearly written policy against sexual harassment?
 a. Is annual training conducted for all employees and/or volunteers? Yes No

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

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

Please explain any "No" answers to questions 1-9.

10. Are you aware of any fact, situation, or circumstance which may result in an Employment Practices Liability claim? If yes, attach a detailed explanation. Yes No

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

Please explain any "Yes" answers to questions 10 and 11.

Automobile Liability

- 1. Limit of Liability \$ _____ Each occurrence
- 2. Medical Payments \$ _____ Each Person
- 3. PIP/No Fault \$ _____ (applicable states only)
- 4. Uninsured Motorist Coverage: Yes No If yes, limit \$ _____
- 5. Underinsured Motorists: Yes No If yes, limit \$ _____

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

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

- 6. Comprehensive deductible options: \$500 \$1,000 \$2,500 \$5,000
- 7. Collision deductible options: \$500 \$1,000 \$2,500 \$5,000
- 8. Does your organization check MVR's? Yes No If yes: All members Drivers only
- 9. What is the selection criteria for new drivers? _____
- 10. Please describe driver training program. _____
- 11. How often are drivers required to update their training? _____
- 12. Have any vehicles been converted from a previous use (oil tankers, military vehicles, delivery vans, etc.)? Yes No
 - a. If yes, indicate vehicle number(s) _____
 - b. If yes, is there a water tank on the vehicle? Yes No
 - c. Please list the entity that performed the conversion: _____
- 13. Does the applicant repair the vehicles of other? Yes No
 - If yes, please answer:
 - a. Types of vehicles repaired? _____
 - b. Values of vehicles repaired? _____
 - c. Receipts from repair work? _____
- 14. 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: _____
- 15. Are any vehicles on loan from forestry service or other governmental agencies? Yes No
 - If yes, please identify vehicle: _____

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 a DV:

1. The age of the vehicle.
2. The Actual Cash Value and Replacement Cost of the vehicle.
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.

OPTIONAL: INFLATION INCREASE. For vehicles valued on a DV, we will automatically increase that value each quarter, by the percentage that you choose. The options are **0%**, **.50%** (2% annually), **1.0%** (4% annually),

(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	<p>AMBULANCE (Advanced Life Support):</p> <p>ALS Ambulance is designed to transport or support a transport vehicle with specialized medical equipment as specified by a governing authority.</p> <ul style="list-style-type: none"> • 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).
5B	<p>AMBULANCE (Basic Life Support):</p> <p>BLS Ambulance is designed to transport patients/victims and equipped as specified by a governing authority.</p> <ul style="list-style-type: none"> • Examples of equipment carried could be: resuscitation devices, oxygen therapy devices, suction equipment, splints, first aid supplies, etc.
6	ANTIQUA: Vehicle used for display or in parades
7	BRUSH: Off the road unit used to control brush/ground fires
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 Any vehicle valued over \$250,000 please also complete UW 00 91

Unit #	Year	Make	Model	VIN/Serial #	Type of Apparatus	Garaging Location #
Ex.	2005	Chevy	Howe	7777778888999	1000 gpm pumper	Loc 1
Use Code	Value Code	Insurable Value	Comp Deductible	Collision Deductible	Quarterly Inflation %	Garaging Location #
1	DV	\$250,000	\$500	\$1,000	0%	
Unit #	Year	Make	Model	VIN/Serial	Type of Apparatus	Garaging Location
1						
Use Code	Value Code	Insurable Value	Comp Deductible	Collision Deductible	Quarterly Inflation %	
Unit #	Year	Make	Model	VIN/Serial	Type of Apparatus	Garaging Location
2						
Use Code	Value Code	Insurable Value	Comp Deductible	Collision Deductible	Quarterly Inflation %	
Unit #	Year	Make	Model	VIN/Serial	Type of Apparatus	Garaging Location
3						
Use Code	Value Code	Insurable Value	Comp Deductible	Collision Deductible	Quarterly Inflation %	
Unit #	Year	Make	Model	VIN/Serial	Type of Apparatus	Garaging Location
4						
Use Code	Value Code	Insurable Value	Comp Deductible	Collision Deductible	Quarterly Inflation %	
Unit #	Year	Make	Model	VIN/Serial	Type of Apparatus	Garaging Location
5						
Use Code	Value Code	Insurable Value	Comp Deductible	Collision Deductible	Quarterly Inflation %	
Unit #	Year	Make	Model	VIN/Serial	Type of Apparatus	Garaging Location
6						
Use Code	Value Code	Insurable Value	Comp Deductible	Collision Deductible	Quarterly Inflation %	
Unit #	Year	Make	Model	VIN/Serial	Type of Apparatus	Garaging Location
7						
Use Code	Value Code	Insurable Value	Comp Deductible	Collision Deductible	Quarterly Inflation %	
Unit #	Year	Make	Model	VIN/Serial	Type of Apparatus	Garaging Location
8						
Use Code	Value Code	Insurable Value	Comp Deductible	Collision Deductible	Quarterly Inflation %	
Unit #	Year	Make	Model	VIN/Serial	Type of Apparatus	Garaging Location
9						
Use Code	Value Code	Insurable Value	Comp Deductible	Collision Deductible	Quarterly Inflation %	

Unit #	Year	Make	Model	VIN/Serial	Type of Apparatus	Garaging Location
10						
Use Code	Value Code	Insurable Value	Comp Deductible	Collision Deductible	Quarterly Inflation %	
Unit #	Year	Make	Model	VIN/Serial	Type of Apparatus	Garaging Location
11						
Use Code	Value Code	Insurable Value	Comp Deductible	Collision Deductible	Quarterly Inflation %	
Unit #	Year	Make	Model	VIN/Serial	Type of Apparatus	Garaging Location
12						
Use Code	Value Code	Insurable Value	Comp Deductible	Collision Deductible	Quarterly Inflation %	
Unit #	Year	Make	Model	VIN/Serial	Type of Apparatus	Garaging Location
13						
Use Code	Value Code	Insurable Value	Comp Deductible	Collision Deductible	Quarterly Inflation %	

If additional insurable vehicles need to be listed, please copy the previous page and add the page to your submission.

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

Unit #	<input type="checkbox"/> Loss Payee	<input type="checkbox"/> Additional Insured
Name of Loss Payee/Additional Insured		
Address		
City	State	Zip
Unit #	<input type="checkbox"/> Loss Payee	<input type="checkbox"/> Additional Insured
Name of Loss Payee/Additional Insured		
Address		
City	State	Zip
Unit #	<input type="checkbox"/> Loss Payee	<input type="checkbox"/> Additional Insured
Name of Loss Payee/Additional Insured		
Address		
City	State	Zip
Unit #	<input type="checkbox"/> Loss Payee	<input type="checkbox"/> Additional Insured
Name of Loss Payee/Additional Insured		
Address		
City	State	Zip
Unit #	<input type="checkbox"/> Loss Payee	<input type="checkbox"/> Additional Insured
Name of Loss Payee/Additional Insured		
Address		
City	State	Zip

If additional Loss Payees need to be listed, please copy this page and add the page to your submission.

Insured

Inland Marine Coverage Part

Please provide REPLACEMENT COST VALUES for all equipment/items to be insured.

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

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

(1) Value Carried On Each Vehicle Same As Vehicle # Shown on Page 10-11	Equipment Value Per Vehicle	(1) Total	\$
1	\$	(2) Pagers, Base Radio, Communications & Electronic Gear	\$
2	\$		
3	\$	(3) Individual "Turnout/Breakout Gear"	\$
4	\$		
5	\$	(4) All other remaining items not in 1, 2, or 3 above	\$
6	\$		
7	\$	(5) EMS Medical Equipment [if not shown in # (1) above]	\$
8	\$		
9	\$	Equipment Grand Total If more than 10 vehicles, copy this page and attach.	\$
10	\$		

Items May Be Included In Property Coverage

Description	Location: Street Address/Legal Description, City, ST	Deductible	Replacement Cost Value
Radio Tower		\$	\$
Antenna & Accessories		\$	\$
Outdoor Bell		\$	\$
Siren		\$	\$
Other (Describe)	Complete Description, Serial #, Etc.	Deductible	Replacement Cost Value
		\$	\$
		\$	\$
		\$	\$
		\$	\$
		\$	\$
		\$	\$
		\$	\$

Watercraft

	Year	Make/Model	Length/HP	Serial #	Insured Replacement Value
Hull					\$
Motor					\$
Trailer					\$
Equipment					\$

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

Snowmobile					
	Year	Make/Model	Length/HP	Serial #	Insured Replacement Value
Snowmobile					\$
Trailer					\$
Equipment (Detachable items including sleds)					\$

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

All-Terrain Vehicle					
	Year	Make/Model	Length/HP	Serial #	Insured Replacement Value
ATV					\$
Trailer					\$
Equipment (Detachable items including sleds)					\$

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

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 INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS THE PERSON TO CRIMINAL AND CIVIL PENALTIES. (Not applicable in CO, KS, MA, MN, NE, OH, OK, OR, VT, or WA; IN LA, ME, TN, AND VA, INSURANCE BENEFITS MAY ALSO BE DENIED).

IN CO, 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.

IN KS, ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY FOR PERSONAL OR COMMERCIAL INSURANCE, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY FOR COMMERCIAL OR PERSONAL INSURANCE WHICH SUCH PERSON KNOWS TO CONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT.

IN MASSACHUSETTS, NEBRASKA, OREGON AND VERMONT, 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.

IN WASHINGTON, IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS.

THE UNDERSIGNED IS AN AUTHORIZED REPRESENTATIVE OF THE APPLICANT AND REPRESENTS THAT REASONABLE ENQUIRY 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



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