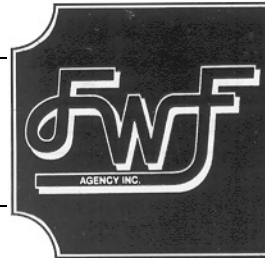


**Request for Proposal  
Accident & Sickness Insurance  
Emergency Service Organization**



103 COLLEGE PARK PLAZA  
JOHNSTOWN, PA 15904  
262-9833  
800-544-6680  
**YOUR INSURANCE NEEDS**

PROPOSALS ARE VALID FOR 45 DAYS

**GENERAL INFORMATION**

Name of Organization: \_\_\_\_\_

Policy Anniversary Date: \_\_\_\_\_ Proposal Needed By: \_\_\_\_\_

Address (include County): \_\_\_\_\_

Total number of emergency responses in the past twelve months: \_\_\_\_\_  
 \*Please supply a call-log if available.  
 Total Fire \_\_\_\_\_  
 Total Rescue \_\_\_\_\_  
 Total EMS \_\_\_\_\_

Population Served on a First Call basis: \_\_\_\_\_

Total number of Volunteers, including Juniors and Auxiliary Members: \_\_\_\_\_

Total number of Career (Paid) Personnel: \_\_\_\_\_

Is coverage for Career (Paid) Personnel to be included in this proposal?  Yes  No  
 Are all Career (Paid) Personnel currently covered by Workers Compensation Insurance?  Yes  No  
 Are all Volunteers currently covered by Workers Compensation Insurance?  Yes  No  
 Is there a full-time Safety Officer (paid or volunteer)?  Yes \_\_\_\_\_ (name)  No

**ACCIDENT & SICKNESS PROGRAM BENEFITS**

**Core Benefits**

	<u>PLAN I</u>	<u>PLAN II</u>	<u>PLAN III</u>	<u>PLAN IV</u>	<u>PLAN V</u>
Accidental Death & Dismemberment	\$10,000	\$25,000	\$50,000	\$100,000	\$150,000
Sickness Death Benefit	\$10,000	\$25,000	\$50,000	\$100,000	\$150,000
Permanent Physical Impairment	\$10,000	\$25,000	\$50,000	\$100,000	\$150,000
Burn Disfigurement Benefit	\$10,000	\$25,000	\$50,000	\$100,000	\$150,000
Family Expense Benefit	\$10,000	\$10,000	\$10,000	\$10,000	\$10,000
Family Education Benefit	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000
(choose one)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blanket Medical Expense	\$10,000	\$25,000	\$50,000	\$100,000	\$150,000
(choose one)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weekly Disability Benefit (Week 1- 4 / Week 5 +)	\$100 / \$200	\$200 / \$400	\$300 / \$600	\$400 / \$800	\$600/\$1200
(choose one)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## ACCIDENT & SICKNESS PROGRAM BENEFITS (continued)

### Additional Core Benefits (automatically included)

- 24-Hour Accidental Death & Dismemberment: up to \$10,000
- Athletics and Special Events – Injury Only
  - Medical Expense Benefit: up to \$1,000
  - Total Disability Benefit: up to \$200 per week for up to 52 weeks
- HIV Benefit: 100% of the Principal Sum \*Not available in New York
- HIV Infection Prevention Benefit: up to \$3,500 \*Not available in New York
- Physical Assault Benefit – Injury only: \$5,000
- Day Care Expense Benefit – Injury or Sickness: up to \$30 per day for up to 26 weeks
- Permanent Physical Impairment Education Benefit – Injury only: up to 35% of the Principal Sum, not to exceed \$20,000
- Continuation of Coverage Benefit: up to \$500 per month for up to 18 months, not to exceed \$6,000

### Optional Benefit Riders (indicate the benefits that are to be included)

Career Personnel Rider (Career Personnel receive same benefits as Volunteers):	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Weekly Hospital Indemnity Rider (up to \$300 per week for up to 104 weeks):	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• If Yes, how much per week? <input type="checkbox"/> \$100 <input type="checkbox"/> \$200 <input type="checkbox"/> \$300		
Additional Weekly Disability Rider (up to \$300 – applies to 1 <sup>st</sup> week only):	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• If Yes, how much? <input type="checkbox"/> \$100 <input type="checkbox"/> \$200 <input type="checkbox"/> \$300		
Auxiliary Member Benefit Rider*:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• If Yes, how much?	AD&D Benefit <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$25,000	
Medical Expense <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000		
Weekly Disability <input type="checkbox"/> \$100 <input type="checkbox"/> \$150 <input type="checkbox"/> \$200		
Full Auxiliary Rider* (Auxiliary Members receive same benefits as Volunteers):	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Organized Team Sports Rider:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• If Yes, provide the following:		
Number of Members	Softball/Baseball: _____	Bowling/Golf: _____
AD&D Benefit	<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$25,000	<input type="checkbox"/> \$50,000
Medical Expense	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$5,000	<input type="checkbox"/> \$10,000
Medical Expense Deductible	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100	
Weekly Disability	<input type="checkbox"/> \$100 <input type="checkbox"/> \$150 <input type="checkbox"/> \$200	<input type="checkbox"/> \$250 <input type="checkbox"/> \$300
Elimination period	<input type="checkbox"/> none <input type="checkbox"/> 7 days	
Duration of Benefit	<input type="checkbox"/> 26 weeks <input type="checkbox"/> 52 weeks	

\* Note: The Auxiliary Member Benefit Rider and the Full Auxiliary Rider are mutually exclusive. Either one may be included, but not both.

## **PARTICIPATING ORGANIZATION SIGNATURE AND STATE FRAUD STATEMENTS**

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### **APPLICABLE IN NEW JERSEY - NEW JERSEY FRAUD STATEMENT**

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

### **APPLICABLE IN NEW YORK - NEW YORK FRAUD STATEMENT**

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.

**THE UNDERSIGNED WARRANTS THAT HE/SHE HAS MADE A GOOD FAITH EFFORT TO ASCERTAIN COMPLETE AND ACCURATE ANSWERS TO THE QUESTIONS SET FORTH IN THIS DOCUMENT AND THAT THE INFORMATION PROVIDED IN THIS DOCUMENT, INCLUDING ANY ATTACHMENTS, IS TRUE AND ACCURATE AND COMPLETE TO THE BEST OF THEIR KNOWLEDGE AND BELIEF.**

**ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD AN 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.**

**Applicant:** \_\_\_\_\_  
(signature) (title)

**Date:** \_\_\_\_\_

**Insurance Agent:** \_\_\_\_\_  
(signature)

**Date:** \_\_\_\_\_

## **INSURANCE AGENT INFORMATION**

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NOTE: THE FOLLOWING INFORMATION MUST BE COMPLETED IN ORDER FOR US TO QUOTE!

Producer _____	CSR or other contact _____
Name of Agency _____	
Agency Address _____	
Agent's License Number _____	
Phone _____	Fax _____