



Volunteer Firefighters Blanket Accident Policy

Request for Insurance

Special Risk Life & Health Department

- Hartford Life Insurance Company
- Hartford Fire Insurance Company
- Hartford Life and Accident Insurance Company

1. Name of Policyholder: _____
 Address of Policyholder: _____
 City, State, ZIP Code: _____

Is this an association or countywide organization? Yes. No. If yes, are all companies covered? Yes. No.

2. Name of Organization(s) (name of Fire Department or Company, Ambulance, First-Aid or Rescue Squad) to be covered: _____
 Address of Organization: _____
 City, State, ZIP Code: _____

Is your Organization covered by Worker's Compensation or similar policy? Yes No.

3. Does the city, or village or any Fire Department or Company (Ambulance, First-Aid or Rescue Squad) within the city, town or village carry similar insurance with any other company? Yes. No. If yes, please give the following information for the past three years:

Name of Carrier:	_____	_____	_____
Policy Year:	20 _____	20 _____	20 _____
Total Premium:	\$ _____	\$ _____	\$ _____
Total Incurred Claims:	\$ _____	\$ _____	\$ _____

4. How many fire houses or locations of ambulance, first-aid or rescue squads in the city, town or village are to be covered: _____

List the name, location, number of pieces of apparatus and description of all apparatus for each firehouse or ambulance, first-aid or rescue squad to which this insurance shall apply.

(Attach a separate sheet of paper, if necessary.)

Name	Location	Number of Pieces
_____	_____	_____

(Fire truck, engine or pumper, hose wagon, ladder truck, patrol, ambulance, tournament truck and any other piece of apparatus.)

5. Policy Term: ____ Year(s) Desired Effective Date: _____
 New Business Renewal of Policy Number: _____

Coverage will commence on the desired effective date or on the date the request is accepted by Hartford Life, whichever is later.

Protect yourself against financial loss if injured in the line of duty.

Plan of Coverage (Specify Limits Desired)

Accident Coverages

AD&D Catastrophic Loss
 Principal Sum \$ _____
 Accelerated Benefit \$ **% of AD&D*** _____
Seat Belt Coverage Yes No \$ **\$20,000** _____
Medical Expenses \$ _____
 Deductible \$ _____
Weekly Income \$ _____
 Benefit Period: 2 years; 5 years; to age 65
COLA Yes No

Partial Disability (included with Weekly Income benefit)
 Permanent Total Disability \$ _____

Heart or Circulatory Malfunction
 Principal Sum \$ _____
 Medical Expenses \$ _____
 Deductible \$ _____
 Weekly Income \$ _____
 Benefit Period: 26 weeks; 52 weeks; 104 weeks

Sickness Coverages

Influenza, La Grippe & Pneumonia
 Principal Sum \$ _____
 Medical Expenses \$ _____
 Deductible \$ _____
 Weekly Income \$ _____
 Benefit Period:
 26 weeks; 52 weeks; 104 weeks

Contagious & Infectious Diseases

Principal Sum \$ _____
 Medical Expenses \$ _____
 Deductible \$ _____
 Weekly Income \$ _____
 Benefit Period:
 26 weeks; 52 weeks; 104 weeks

**50% of AD&D up to \$50,000 maximum.*

Other Coverages

Hospital Indemnity
 Accident
 Daily \$ _____
 Accident/Sickness
 Daily Benefit \$ _____

Education Benefit
 Yes Benefit **up to \$5,000**
 Maximum Amount \$ **reimbursed**

Cosmetic Disfigurement From Burns

Benefit Amount \$ _____
 Family Expense
 Benefit Amount **up to \$5,000**
 Yes No **reimbursed**

HIV Positive Benefit Amount \$ _____

Firefighter Auxiliary
 Principal Sum \$ _____
 Medical Expenses \$ _____
 Deductible \$ _____
 Hospital
 Daily Benefit Indemnity \$ _____

Junior Firefighters**
 Principal Sum \$ _____
 Medical Expenses \$ _____
 Deductible \$ _____

***no charge for \$10,000 AD&D and AME.*

Excess coverage is available for all Medical Benefits; contact your reporting office for details.
 (Note: Minimum policy premium is \$375.)

6. Signature of Person Providing Information: _____ Date: _____

Title or Position: _____

7. Agent Name, Address and Agency Code: _____

Signature of Licensed Resident Agent (where required): _____

