



New York Volunteer Firefighters Blanket Accident Policy Request for Insurance

Special Risk Life & Health Department

- Hartford Life Insurance Company
- Hartford Fire 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, town 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.

(Cont.)

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

Plan of Coverage (Specify Limits Desired)

AD&D Catastrophic Loss: Principal Sum.....\$ _____
 Medical Expenses\$ _____
 Deductible\$ _____
 Accident Weekly Income\$ _____

Benefit Period: 2 years; 5 years; to age 65

COLA: Yes No

Partial Disability (included with Weekly Income benefit)

Permanent Total Disability\$ _____

Other Coverages

Additional Benefit for Loss of Life (included at no charge)\$ _____ \$2,000

Benefit for Additional Covered Conditions: Principal Sum\$ _____

 Medical Expenses.....\$ _____

 Deductible\$ _____

 Weekly Income\$ _____

 Benefit Period: 26 weeks; 52 weeks; 104 weeks

Hospital Indemnity: Accident Daily Benefit\$ _____

Accident/Sickness Daily Benefit\$ _____

Education Benefit: Yes No Maximum Amount\$ up to \$5,000 reimbursed

Seat Belt Coverage: Yes No\$ \$20,000

Cosmetic Disfigurement From Burns: Benefit Amount\$ _____

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

Firefighter Auxiliary Principal Sum\$ _____

 Medical Expenses.....\$ _____

 Deductible\$ _____

 Hospital Indemnity Daily Benefit\$ _____

*Junior Firefighters Principal Sum\$ _____

 Medical Expenses.....\$ _____

 Deductible\$ _____

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

(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): _____

