VFIS OF CANADA
A Division of CVIS, Inc.
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ACCIDENT & SICKNESS FACTFINDER

Date: _____ Current Insurer: _____ Date proposal needed by: _____

Full Legal Name(s): _____
(Include all legal entities to be covered, such as municipalities, fire districts, etc.)

Mailing Address: _____
Street or PO Box City/town Province Postal Code

Person completing: _____ (____) _____
Name Title Telephone Number

E-mail: _____ Are you a profit or non-profit organization? ☐ Profit ☐ Non-Profit

Fire/EMS – Complete for all personnel to be covered during the policy term:

1st Call Population: _____ Number of stations? _____ Do you operate an ambulance? ☐ Yes ☐ No

Number of paid full-time personnel (paid 25 hours or more weekly): _____

Number of active volunteer and call personnel (not paid or paid for 25 or fewer hours weekly): _____

Estimated number of emergency calls per year: Fire _____ Rescue/EMS _____

Is Workers' Comp provided for all: Volunteers: ☐ Yes ☐ No ☐ N/A Career: ☐ Yes ☐ No ☐ N/A

General:

Please attach copies of benefit schedule and 5-year loss report for your current policy. Indicate benefit levels desired:

	AD&D/Loss of Life ($10,000 - $500,000)	Weekly Indemnity ($100 - $1,000) First 28	Weekly Indemnity After 28	Medical Expense ($2,500 - $200,000)
Quote 1				
Quote 2				

Name of Producing Agency: _____

Agency's Address: _____

Agency's Phone: (____)_____ Agency's Fax: (____)_____

Producer's signature: _____ **Date**: _____

The undersigned is an authorized representative of the applicant and certifies the information provided to obtain this coverage is accurate to the best of their knowledge, this includes any applications, locations schedules, valuation statements, loss history information and engineering reports.

Applicant's signature: _____ **Title**: _____ **Date**: _____