Beaver Dam / Littlefield Fire District

630 N. Hwy 91 Beaver Dam, AZ. 86432
PH:928-347-5114 Fax: 928-347-5273

Application

(Please Print) Date:_____

Name:_____ Social Security:_____
Address:_____ Phone #_____ Cell_____
_____

Date of Birth:_____ Drivers Lic State:_____ No.#_____

Do you have any restrictions on your driver's license? □ No □ Yes

If so, what?_____

Do you have any physical / medical limitations ? □ No □ Yes

Heart Condition: □ No □ Yes Fear of heights: □ No □ Yes

Disable injuries or limitations: □ No □ Yes If so, What:_____

Other:_____

Hours Available for call out: □ Anytime

Days_____

Night_____

Previous Experience or Training:_____

_____
_____

Applicants Signature:_____

Please attach any applicable certifications.

183 Leader Heights Road
P.O. Box 2726
York, PA 17405
(800) 233-1957 or (717) 741-0911
www.vfis.com

BENEFICIARY DESIGNATION FORM

This form may be used for multiple Policies when designating the same beneficiary. Use a separate form when designating different beneficiaries for each Policy.

Indicate one of the following:

☐ New Insured ☐ Beneficiary Change ☐ Name Change: From: _____

Complete all of the following information:

Policyholder Name and Policy Number(s) *(Emergency Service Organization Name)*

■	Accident & Sickness	**Policyholder**	Beaver Dam/Littlefield Fire District	**Policy Number**	
☐		**Policyholder**		**Policy Number**	
☐		**Policyholder**		**Policy Number**	
☐		**Policyholder**		**Policy Number**	
☐	**Other**				
☐	**Other**				

Last Name:	**First Name:**	**MI:**
Date of Birth:	**Date of Membership:**	**Social Security Number:** / /

I hereby designate the following beneficiary(ies) to receive any death benefit proceeds payable under the policies checked above. If this form represents a change of beneficiary, the present beneficiary designation(s) are terminated and the following designation(s) made:

BENEFICIARY DESIGNATION – Primary Class ☐ **Mark if additional beneficiaries are listed on a separate paper and attached.** **(Name, address, phone number and/or email address of beneficiaries)**	**Relationship to Insured**	**Date of Birth**	**Percent** (Must equal 100%)
BENEFICIARY DESIGNATION – Contingent Class **(Name, address, phone number and/or email address of beneficiaries)**	**Relationship to Insured**	**Date of Birth**	**Percent** (Must equal 100%)

MINOR OR ESTATE AS BENEFICIARY: If death occurs and a minor child (a person under the age of majority) or your estate is designated as beneficiary, it may be necessary to have a guardian or legal representative appointed before any death benefit can be paid. This could mean legal expenses for the beneficiary and possible delay in the payment of any death benefit. Please take this into consideration when designating your beneficiary.

Insured's Signature: _____ Date: _____

Sample wording for Beneficiary Designations

Class	Relationship to Insured	Percent
One Beneficiary of a class Jane Ann Jones	 Spouse	 100%
Two or more Beneficiaries of a class: Arthur Leo Jones Grace Hays Jones	 Father Mother	 50% 50%
Unnamed Children: Children of the Named Insured		 Split Equally
Unequal distribution: Grace Hays Jones Mary Jones Ford William Roger Jones	 Mother Sister Brother	 50% 25% 25%
Insured's Estate	Executors or Administrators of the Insured's Estate	

This form should be retained by the Policyholder with a copy to the insured.

* Primary Beneficiary is the person(s) who will receive the insurance proceeds.
** Contingent Beneficiary is the person(s) who will receive the insurance proceeds if the primary beneficiary is not alive at your death.

Annual Medical Statement of Personnel

NOTE: This form is designed to provide the individual in charge of all personnel a complete history of physical status as of the date indicated without the need for expensive physical examinations. It is recommended that the form be completed on an annual basis by all drivers of emergency vehicles as well as other employees. If any of the questions are answered "YES," be sure the answer is fully explained.

Questions:

Name: _____

Address: _____

City & State: _____ Zip: _____

Full Time Occupation: _____

Name of Organization: _____

Position/Title: _____

Social Security No. _____

What is your Valid State Operators Plate No. _____

1. Birth Date: Month: _____ Day: _____ Year: _____

		Yes	No
2. Eyesight:			
a.	Have you lost use of either eye? _____ R _____ L	☐	☐
b.	Is peripheral (side) vision restricted?	☐	☐
c.	Are you color blind?	☐	☐
d.	Do you have, or have you ever had, cataracts?	☐	☐
e.	Are actual deficiencies corrected by glasses or contact lenses?	☐	☐
f.	Date of last eye examination: _____		
3. Hearing:			
a.	Do you have difficulty hearing normal conversation level?	☐	☐
b.	Do you use a hearing aid?	☐	☐
4. Diabetes:			
a.	Have you ever been treated for diabetes?	☐	☐
b.	Describe current medication and dosage, if any, and method of administration under "remarks."		
c.	Date of latest blood sugar test: _____		
5. Heart:			
a.	Have you ever been treated for heart disease?	☐	☐
b.	Describe condition: _____		
c.	Describe current medication and dosage, if any, under "remarks."		
d.	Do you have a pacemaker?	☐	☐
e.	Date of last treatment or check-up: _____		
6. Epilepsy:			
a.	Have you ever been treated for epilepsy?	☐	☐
b.	If "Yes," when was your last seizure? _____		
c.	Describe current medication and dosage, if any, under "remarks."		

Remarks:

NOTE: If any questions is answered, "YES," give particulars below. For medical histories, underline the item and identify by referring to question number and letter. Give dates, symptoms, duration, treatment results, names and addresses of doctors, hospitals, etc.

Questions:

	Yes	No
7. Blood Pressure:		
a. Have you ever been treated for high blood pressure? ..... a.	☐	☐
b. If "Yes," when were you treated? ..... b.	_____	
c. What was your last reading? ..... c.	_____	
d. Describe current medication and dosage, if any, under "remarks."		
8. Limbs:		
a. Have you lost an arm or leg? ..... a.	☐	☐
b. Have you lost the use of an arm or leg? ..... b.	☐	☐
c. Does vehicle have special controls? ..... c.	☐	☐
d. If "Yes" to any of the above, describe under "remarks."		
9. Miscellaneous:		
a. Have you ever had, or been treated for, Convulsions? ..... a.	☐	☐
b. If "Yes," give date of last treatment and describe current medication and dosage, if any, under "remarks."		
c. Have you ever had any Fainting Spells? ..... c.	☐	☐
d. If "Yes," give date of last treatment and describe current medication and dosage, if any, under "remarks."		
e. Have you ever had, or been treated for, Loss of Equilibrium? .... e.	☐	☐
f. If "Yes," give date of last treatment and describe current medication and dosage, if any, under "remarks."		
g. Have you ever been treated for Alcohol or Drug Abuse? ..... g.	☐	☐
h. If "Yes," give date of last treatment and describe current medication and dosage, if any, under "remarks."		
i. Have you ever been treated for Mental Illness? ..... i.	☐	☐
j. If "Yes," give date of last treatment and describe current medication and dosage, if any, under "remarks."		
10. What is the date of your last physical examination?	_____	
11. Are there any restrictions posted on your vehicle operator's license?	☐	☐
12. Are you under the care of a physician for any condition not mentioned above which may affect your ability to operate a motor vehicle?	☐	☐

13. When and for what purpose, did you last consult a doctor?

_____

_____

14. Full Name, address and telephone number of your personal physician.

Name: _____

Address: _____

City & State: _____ **Zip:** _____

Remarks:

The answers to the above are complete, accurate, and true to the best of my knowledge.

_____ _____

Signature of Person Named Above **Date**