



## 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: \_\_\_\_\_

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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:**

<b>Policyholder Name and Policy Number(s)</b> <i>(Emergency Service Organization Name)</i>	
<input type="checkbox"/> _____ <b>Policyholder</b> _____	<b>Policy Number</b> _____
<input type="checkbox"/> _____ <b>Policyholder</b> _____	<b>Policy Number</b> _____
<input type="checkbox"/> _____ <b>Policyholder</b> _____	<b>Policy Number</b> _____
<input type="checkbox"/> _____ <b>Policyholder</b> _____	<b>Policy Number</b> _____
<input type="checkbox"/> <b>Other</b> _____	
<input type="checkbox"/> <b>Other</b> _____	

<b>Last Name:</b> _____	<b>First Name:</b> _____	<b>MI:</b> _____
<b>Date of Birth:</b> _____	<b>Date of Membership:</b> _____	<b>Social Security Number:</b> /    /

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:

<b>BENEFICIARY DESIGNATION – Primary Class</b>	<b>Relationship to Insured</b>	<b>Date of Birth</b>	<b>Percent</b> <small>(Must equal 100%)</small>
<input type="checkbox"/> <b>Mark if additional beneficiaries are listed on a separate paper and attached.</b> <b>(Name, address, phone number and/or email address of beneficiaries)</b>			
<b>BENEFICIARY DESIGNATION – Contingent Class</b>	<b>Relationship to Insured</b>	<b>Date of Birth</b>	<b>Percent</b> <small>(Must equal 100%)</small>
<b>(Name, address, phone number and/or email address of beneficiaries)</b>			

**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

<b>Class</b>	<b>Relationship to Insured</b>	<b>Percent</b>
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. \_\_\_\_\_

### 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.

**1. Birth Date:** Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_

**2. Eyesight:**

**Yes No**

- a. Have you lost use of either eye? \_\_\_\_\_ R \_\_\_\_\_ L..... a.
- b. Is peripheral (side) vision restricted? ..... b.
- c. Are you color blind? ..... c.
- d. Do you have, or have you ever had, cataracts? ..... d.
- e. Are actual deficiencies corrected by glasses or contact lenses?. e.
- f. Date of last eye examination: ..... f. \_\_\_\_\_

**3. Hearing:**

- a. Do you have difficulty hearing normal conversation level? ..... a.
- b. Do you use a hearing aid? ..... b.

**4. Diabetes:**

- a. Have you ever been treated for diabetes?..... a.
- b. Describe current medication and dosage, if any, and method of administration under "remarks."
- c. Date of latest blood sugar test:..... c. \_\_\_\_\_

**5. Heart:**

- a. Have you ever been treated for heart disease? ..... a.
- b. Describe condition: ..... b. \_\_\_\_\_
- c. Describe current medication and dosage, if any, under "remarks."
- d. Do you have a pacemaker?..... d.
- e. Date of last treatment or check-up:..... e. \_\_\_\_\_

**6. Epilepsy:**

- a. Have you ever been treated for epilepsy? ..... a.
- b. If "Yes," when was your last seizure? ..... b. \_\_\_\_\_
- c. Describe current medication and dosage, if any, under "remarks."

**Questions:**

**Remarks:**

- 7. Blood Pressure:**
- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| a. Have you ever been treated for high blood pressure? .....        | <input type="checkbox"/> | <input type="checkbox"/> |
| b. If "Yes," when were you treated? .....                           | _____                    |                          |
| c. What was your last reading? .....                                | _____                    |                          |
| d. Describe current medication and dosage, if any, under "remarks." |                          |                          |
- 8. Limbs:**
- |  |                          |                          |
|--|--------------------------|--------------------------|
| a. Have you lost an arm or leg? .....                      | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Have you lost the use of an arm or leg? .....           | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Does vehicle have special controls? .....               | <input type="checkbox"/> | <input type="checkbox"/> |
| d. If "Yes" to any of the above, describe under "remarks." |                          |                          |
- 9. Miscellaneous:**
- |   |                          |                          |
|---|--------------------------|--------------------------|
| a. Have you ever had, or been treated for, Convulsions? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? ....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 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: \_\_\_\_\_

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

\_\_\_\_\_  
Signature of Person Named Above

\_\_\_\_\_  
Date