SCHEDULE OF COVERAGES

Policyholder: VFIS TRUST

Policy Number:

Participating Organization:

Augusta County Firemen's Association Inc
PO Box 590
4801 Lee Hwy
Verona, VA 24482-0590

Policy Effective Date:

Term: 3 Year

Policy Expiration Date:

Premium: $ 115,569

This summary of coverage provides only those following benefits that have a specified amount entered opposite the name of the benefit. Benefits that are followed by entry of the word "none" are not provided.

PART	COVERAGE	AMOUNT OF INSURANCE
I.	**Loss of Life Benefits**	
	A. Accidental Death Benefits	
	(i) Accidental Death Indemnity Benefit	$ 50,000
	(ii) Seat Belt Benefit Amount	$ 5,000
	B. Illness Loss of Life Benefit	$ 50,000
	C. Dependent Benefit Amount (Per Dependent Child)	$ 10,000
	D. Spousal Support Benefit Amount	$ 5,000
	E. Memorial Benefit Amount	$ 2,000
II.	**Lump Sum Living Benefits**	
	A. Accidental Dismemberment Principal Sum	$ 50,000
	B. Vision Impairment Benefit	$ 50,000
	C. Optional Permanent Physical Impairment Principal Sum - Injury Only	$ 50,000
	D. Cosmetic Disfigurement Resulting From Burns Principal Sum	$ 50,000
	E. HIV Positive Benefit	$ 50,000
III.	**Weekly Income Benefits**	
	A. Total Disability Benefit	
	(1) Total Disability Weekly Income Benefit (first 28 days)	$ 500
	(2) Total Disability Maximum Weekly Amount (after 28 days)	$ 900
	(3) Total Disability Minimum Weekly Amount	$ 125
	B. Partial Disability Benefit	
	(1) Partial Disability Weekly Income Benefit (first 28 days)	$ 250
	(2) Partial Disability Maximum Weekly Amount (after 28 days)	$ 450
	(3) Partial Disability Minimum Weekly Amount	$ 63
IV.	**Occupational Retraining Benefit Maximum Amount**	$ 20,000
V.	**Weekly Permanent Physical Impairment Benefit**	
VI.	**Optional Weekly Permanent Physical Impairment COLA Benefit**	[X] Yes [ ] No
VII.	**Medical Expense Benefits**	
	A. Medical Expense Maximum Amount	$ 50,000
	Medical Expense Benefit Options	
	1. Excess of Workers' Compensation or No-Fault Auto Insurance Benefits	[ ]
	2. Excess of Workers' Compensation, No-Fault Auto Insurance and Other Group Insurance.	[ ]
	3. Primary Medical Expense Benefit	[X]
	B. Cosmetic/Plastic Surgery Maximum Amount	$ 10,000
	C. Post Traumatic Stress Disorder Maximum Amount	$ 10,000
	D. Critical Incident Stress Management Maximum Amount (Per Covered Activity)	$ 2,500
	E. Family Expense Benefit	$ 100
VIII.	**Optional Benefits**	
	A. Weekly Hospital Indemnity Benefit	$ none
	B. Additional Disability Weekly Benefit	$ none
	C. 24 Hour Accidental Death and Dismemberment Benefit	$ none
	D. Non-Covered Activity Accidental Death and Dismemberment Benefit	$ none

Additional Participating Organizations/Policyholders:

Co # 2 Deerfield - Rescue # 2 Deerfield
Co # 3 Middlebrook
Co # 4 Churchville - Rescue #4 Churchville
Co # 5 Weyers Cove
Co # 6 Verona
Co # 7 Stuarts Draft
Co # 8 Craigsville
Co # 9 Dooms
Co #10 Augusta County
Co #11 Preston L Yancey
Co #14 Swope
Co #18 New Hope
Co #19 Wilson
Co #21 Mt Solon
Rescue # 6 Stuarts Draft
Rescue #16 Craigsville-Augusta Springs
Waynesboro First Aid Crew

ACCIDENT/SICKNESS CLAIM REPORT

Please Complete and Mail To:

Augusta County Fire-Rescue
Attn: Minday Craun
P.O. Box 590
Verona, VA 24482

PLEASE COMPLETE THIS FORM IN FULL FOR PROMPT SERVICE.

NOTE: IMPORTANT STATE INFORMATION ON REVERSE SIDE

DATE OF THIS REPORT______________

TO BE COMPLETED BY INJURED PERSON

Home Telephone No. (AC)______________
Work Telephone No. (AC)______________

Name______________________________ Soc. Sec. No.______________

Home Address______________________ City__________ State________ Zip__________

Date of Accident or Organization's Activity______________ Year: _____ Occurred__________ am pm

Date of Birth__________ Sex_____ Weight__________ Height__________ Marital Status__________

Full-Time/Regular Occupation______________ Income: Weekly__________ Yearly__________

Name and address of full-time employer______________________________

Employer Telephone No.:______________ Length of employment in this work:______________

Please completely answer the next three questions:

1. What activity were you involved in when injured or became ill?

2. How did accident or sickness occur?

3. What is your injury or sickness?

Give date of first day of full-time occupation missed due to above accident and sickness ______________

Give date you were able to return to work ______________

Attending Physician's Name, Address and Telephone Number ______________

Name and Address of Hospital ______________

Dates Hospitalized

From __________ ______ Year

To __________ ______ Year

AUTHORIZATION TO DOCTOR, HOSPITAL, CLINIC, OR WORKERS' COMPENSATION CARRIER TO RELEASE MEDICAL INFORMATION

Please furnish VFIS, Inc. with information they may request regarding details of my past medical history and physical condition. A photostatic copy of this authorization shall be considered as valid as the original. Your help is greatly appreciated.

______________ ______________ ______________

Signature of Injured Member or Next of Kin | Relationship | Date

TO BE COMPLETED BY OFFICIAL OF NAMED INSURED ORGANIZATION (must be other than Injured Person)

- Was the injured person a member of your organization at the time of the above described incident? Yes No
- If claimant is a member of organization, please circle type of member: junior adult auxiliary (Circle one)
- Was the injured person engaged in an authorized activity of your organization at the time of injury or commencement of sickness? Yes No
- Name and Address of Insured Organization
- Policy Number______________
- Organization Telephone Number______________
- Home Telephone Number of Official Signing Below______________

I certify that the above is true.

- Signed ______________ • Title ______________ • Date ______________

VFIS®

Beneficiary Designation for Accident & Sickness Policy

Complete this block each time this form is used—Please Print

Name of Organization ______________________________ State __________

Member's /Employee's Name ______________________________

Member's Date of Birth ______________ Date Member Joined Organization ______________

Complete, sign and date this block if you wish to name or change your beneficiary.

I hereby designate the following beneficiary(ies) with respect to amounts payable as indemnity for loss of life under the referenced Accident & Sickness Policy and hereby revoke any designation of beneficiary thereunder heretofore made by me. I direct that any amounts payable under said policy to my beneficiary(ies) named below be paid to those of Primary Beneficiary who survive me, otherwise to those surviving in Contingent Beneficiary, in proportion to the percentages listed.

Primary (Please refer to back of form for examples)
Beneficiary: Name ______________ Relationship ________ Date of Birth________ Share________%

Name ______________ Relationship ________ Date of Birth________ Share________%

Contingent
Beneficiary: Name ______________ Relationship ________ Date of Birth________ Share________%

Name ______________ Relationship ________ Date of Birth________ Share________%

If none of the above-named beneficiaries are living at the time of my death, I direct that payment be made in accordance with the terms of the policy. I reserve the right to revoke or change this designation.

Signature______________________________ **Date** ______________

This form should be retained in the files of your department or organization and reviewed and updated on a regular basis.

C01:008A

VFIS®

Beneficiary Designation for Accident & Sickness Policy

Complete this block each time this form is used—Please Print

Name of Organization ______________________________ State __________

Member's /Employee's Name ______________________________

Member's Date of Birth ______________ Date Member Joined Organization ______________

Complete, sign and date this block if you wish to name or change your beneficiary.

I hereby designate the following beneficiary(ies) with respect to amounts payable as indemnity for loss of life under the referenced Accident & Sickness Policy and hereby revoke any designation of beneficiary thereunder heretofore made by me. I direct that any amounts payable under said policy to my beneficiary(ies) named below be paid to those of Primary Beneficiary who survive me, otherwise to those surviving in Contingent Beneficiary, in proportion to the percentages listed.

Primary (Please refer to back of form for examples)
Beneficiary: Name ______________ Relationship ________ Date of Birth________ Share________%

Name ______________ Relationship ________ Date of Birth________ Share________%

Contingent
Beneficiary: Name ______________ Relationship ________ Date of Birth________ Share________%

Name ______________ Relationship ________ Date of Birth________ Share________%

If none of the above-named beneficiaries are living at the time of my death, I direct that payment be made in accordance with the terms of the policy. I reserve the right to revoke or change this designation.

Signature______________________________ **Date** ______________

This form should be retained in the files of your department or organization and reviewed and updated on a regular basis.

C01:008A

American Alternative Insurance Corporation

Statutory Home Office: 1013 Centre Road • Wilmington, DE 19805
Administration Office: 555 College Road East • Princeton, NJ 08543-5241 • (800) 305-4954
Administered by: VFIS • 183 Leader Heights Road • York, PA 17402 • (800) 233-1957 • www.vfis.com

A Division of Glatfelter Insurance Group

COMMON POLICY DECLARATIONS

Named Insured and Mailing Address:
AUGUSTA COUNTY
P O BOX 590
VERONA VA 24482

Policy Number: VFIS-TR-2053019-01/000
Renewal of: VFIS-TR-2053019-00

Policy Period: From 0
To
at 12:01 AM Standard Time at your mailing address shown above

Type of Entity: EMERGENCY SERVICE ORGANIZATION
Business Description: EMERGENCY SERVICE ORGANIZATION

This policy consists of the following coverage parts:		Premium
Property	$	27,136.00
Crime	$	1,630.00
Portable Equipment	$	8,644.00
Auto	$	81,355.00
General Liability	$	18,669.00
Management Liability	$	12,692.00
Taxes / Fees / Surcharges:	$	
Estimated Total Premium:	$	150,126.00

The policy premium is payable on the dates and in the amounts shown below:
04/15/2008 $150,126.00

Policy Number
VFIS-TR-2053019-01/000

SCHEDULE OF NAMED INSURED(S)

Named Insured AUGUSTA COUNTY

Effective Date: 04-15-08
12:01 A.M., Standard Time

Agency Name VFIS

DEERFIELD VALLEY RESCUE

WEYERS CAVE VOLUNTEER FIRE COMPANY

CHURCHVILLE VOLUNTEER FIRE DEPARTMENT

MT SOLON VOLUNTEER FIRE COMPANY AND RESCUE

MIDDLEBROOK VOLUNTEER FIRE DEPARTMENT

STUARTS DRAFT VOLUNTEER FIRE COMPANY

CRAIGSVILLE VOLUNTEER FIRE DEPARTMENT

DOOMS VOLUNTEER FIRE DEPARTMENT

PRESTON L YANCEY VOLUNTEER FIRE COMPANY

SWOOPE VOLUNTEER FIRE COMPANY

NEW HOPE VOLUNTEER FIRE DEPARTMENT

STAUNTON-AUGUSTA FIRST AID AND RESCUE

DEERFIELD VALLEY VOLUNTEER FIRE DEPARTMENT

VERONA VOLUNTEER FIRE DEPARTMENT

WILSON VOLUNTEER FIRE COMPANY

STUARTS DRAFT RESCUE SQUAD

CRAIGSVILLE-AUGUSTA SPRINGS FIRST AID

WAYNESBORO FIRST AID CREW

CHURCHVILLE RESCUE

AUGUSTA COUNTY FIRE DEPARTMENT

AUTOMOBILE LOSS NOTICE

DATE (MM/DD/YYYY)

AGENCY	PHONE (A/C, No, Ext):	COMPANY	NAIC CODE:	MISCELLANEOUS INFO (Site & location code)	
		POLICY NUMBER	POLICY TYPE	REFERENCE NUMBER	CAT #
FAX (A/C, No):	E-MAIL ADDRESS:				
CODE:	SUB CODE:	EFFECTIVE DATE	EXPIRATION DATE	DATE OF ACCIDENT AND TIME AM PM	PREVIOUSLY REPORTED YES NO
AGENCY CUSTOMER ID:					

INSURED

NAME AND ADDRESS	SOC SEC # OR FEIN:
RESIDENCE PHONE (A/C, No)	BUSINESS PHONE (A/C, No, Ext)

CONTACT

CONTACT INSURED

NAME AND ADDRESS		WHERE TO CONTACT
		WHEN TO CONTACT
RESIDENCE PHONE (A/C, No)	BUSINESS PHONE (A/C, No, Ext)	

LOSS

LOCATION OF ACCIDENT (Include city & state)	AUTHORITY CONTACTED:	VIOLATIONS/CITATIONS
	REPORT #:	
DESCRIPTION OF ACCIDENT (Use separate sheet, if necessary)		

POLICY INFORMATION

BODILY INJURY (Per Person)	BODILY INJURY (Per Accident)	PROPERTY DAMAGE	SINGLE LIMIT	MEDICAL PAYMENT	OTC DEDUCTIBLE	OTHER COVERAGE & DEDUCTIBLES (UM, no-fault, towing, etc)
LOSS PAYEE					COLLISION DED	

UMBRELLA/ EXCESS	UMBRELLA	EXCESS	CARRIER:	LIMITS:	AGGR	PER CLAIM/OCC	SIR/ DED

INSURED VEHICLE

VEH #	YEAR	MAKE:	BODY TYPE:	PLATE NUMBER	STATE
		MODEL:	V.I.N.:		

OWNER'S NAME & ADDRESS	RESIDENCE PHONE (A/C, No):
	BUSINESS PHONE (A/C, No, Ext):
DRIVER'S NAME & ADDRESS (Check if same as owner)	RESIDENCE PHONE (A/C, No):
	BUSINESS PHONE (A/C, No, Ext):

RELATION TO INSURED (Employee, family, etc.)	DATE OF BIRTH	DRIVER'S LICENSE NUMBER	STATE	PURPOSE OF USE	USED WITH PERMISSION? YES NO

DESCRIBE DAMAGE	ESTIMATE AMOUNT	WHERE CAN VEHICLE BE SEEN?	WHEN CAN VEH BE SEEN?	OTHER INSURANCE ON VEHICLE

PROPERTY DAMAGED VEHICLE? YES NO

DESCRIBE PROPERTY (If auto, year, make, model, plate #)	OTHER VEH/PROP INS? YES NO	COMPANY OR AGENCY NAME:
		POLICY #:

OWNER'S NAME & ADDRESS	RESIDENCE PHONE (A/C, No):
	BUSINESS PHONE (A/C, No, Ext):
OTHER DRIVER'S NAME & ADDRESS (Check if same as owner)	RESIDENCE PHONE (A/C, No):
	BUSINESS PHONE (A/C, No, Ext):

DESCRIBE DAMAGE	ESTIMATE AMOUNT	WHERE CAN DAMAGE BE SEEN?

INJURED

NAME & ADDRESS	PHONE (A/C, No)	PED	INS VEH	OTH VEH	AGE	EXTENT OF INJURY

WITNESSES OR PASSENGERS

NAME & ADDRESS	PHONE (A/C, No)	INS VEH	OTH VEH	OTHER (Specify)

REMARKS (Include adjuster assigned)			
REPORTED BY	REPORTED TO	SIGNATURE OF INSURED	SIGNATURE OF PRODUCER

NOTE: IMPORTANT STATE INFORMATION ON REVERSE SIDE

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PROPERTY LOSS NOTICE

DATE (MM/DD/YYYY)

AGENCY	PHONE (A/C, No, Ext):	MISCELLANEOUS INFO (Site & location code)	DATE OF LOSS AND TIME	AM / PM	PREVIOUSLY REPORTED: YES / NO

POLICY TYPE	COMPANY AND POLICY NUMBER	NAIC CODE	POLICY DATES
PROP/ HOME	CO:		EFF:
	POL:		EXP:
FLOOD	CO:		EFF:
	POL:		EXP:
WIND	CO:		EFF:
	POL:		EXP:

FAX (A/C, No): E-MAIL ADDRESS:

CODE: SUB CODE:

AGENCY CUSTOMER ID

INSURED

NAME AND ADDRESS OF INSURED	DATE OF BIRTH
	SOC SEC # OR FEIN:
RESIDENCE PHONE (A/C, No)	BUSINESS PHONE (A/C, No, Ext)
NAME AND ADDRESS OF SPOUSE (IF APPLICABLE)	DATE OF BIRTH
	SOC SEC # OR FEIN:

CONTACT

CONTACT INSURED

NAME AND ADDRESS OF INSURED	
RESIDENCE PHONE (A/C, No)	BUSINESS PHONE (A/C, No, Ext)
WHERE TO CONTACT	WHEN TO CONTACT

LOSS

LOCATION OF LOSS	POLICE OR FIRE DEPT TO WHICH REPORTED
KIND OF LOSS: FIRE, THEFT, LIGHTNING, HAIL, FLOOD, WIND, OTHER (explain)	PROBABLE AMOUNT ENTIRE LOSS

DESCRIPTION OF LOSS & DAMAGE (Use separate sheet, if necessary)

POLICY INFORMATION

MORTGAGEE

NO MORTGAGEE

HOMEOWNER POLICIES SECTION 1 ONLY (Complete for coverages A, B, C, D & additional coverages. For Homeowners Section II Liability Losses, use ACORD 3.)

A. DWELLING	B. OTHER STRUCTURES	C. PERSONAL PROPERTY	D. LOSS OF USE	DEDUCTIBLES	DESCRIBE ADDITIONAL COVERAGES PROVIDED
					ON

COVERAGE A. EXCLUDES WIND

SUBJECT TO FORMS (Insert form numbers and edition dates, special deductibles)

FIRE, ALLIED LINES & MULTI-PERIL POLICIES (Complete only those items involved in loss)

ITEM	SUBJECT OF INSURANCE	AMOUNT	% COINS	DEDUCTIBLE	COVERAGE AND/OR DESCRIPTION OF PROPERTY INSURED
	BLDG CNTS				
	BLDG CNTS				
	BLDG CNTS				

SUBJECT TO FORMS (Insert form numbers and edition dates, special deductibles)

FLOOD POLICY	BUILDING:	DEDUCTIBLE:	ZONE	PRE FIRM	DIFF IN ELEV	FORM TYPE	GENERAL	CONDO
	CONTENTS:	DEDUCTIBLE:		POST FIRM			DWELLING	

WIND POLICY	BUILDING	DEDUCTIBLE	CONTENTS	ZONE	FORM TYPE	GENERAL / DWELLING	CONDO

REMARKS/OTHER INSURANCE (List companies, policy numbers, coverages & policy amounts)/NY ONLY: PREVIOUS ADDRESS OF INSURED & WIFE'S MAIDEN NAME

CAT #	FICO #	ADJUSTER ASSIGNED	ADJUSTER #	DATE ASSIGNED

REPORTED BY	REPORTED TO	SIGNATURE OF INSURED	SIGNATURE OF PRODUCER

NOTE: IMPORTANT STATE INFORMATION ON REVERSE SIDE

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GENERAL LIABILITY NOTICE OF OCCURRENCE/CLAIM

DATE (MM/DD/YYYY)

AGENCY | PHONE (A/C, No, Ext):

FAX (A/C, No): | E-MAIL ADDRESS:

CODE: | SUB CODE:

AGENCY CUSTOMER ID:

NOTICE OF OCCURRENCE | NOTICE OF CLAIM | DATE OF OCCURRENCE AND TIME | AM | PM | DATE OF CLAIM | PREVIOUSLY REPORTED | YES | NO

EFFECTIVE DATE | EXPIRATION DATE | POLICY TYPE | OCCURRENCE | CLAIMS MADE | RETROACTIVE DATE

COMPANY | NAIC CODE: | MISCELLANEOUS INFO (Site & location code)

POLICY NUMBER | REFERENCE NUMBER

INSURED

NAME AND ADDRESS | SOC SEC # OR FEIN:

RESIDENCE PHONE (A/C, No) | BUSINESS PHONE (A/C, No, Ext)

CONTACT

CONTACT INSURED

NAME AND ADDRESS | WHERE TO CONTACT | WHEN TO CONTACT

RESIDENCE PHONE (A/C, No) | BUSINESS PHONE (A/C, No, Ext)

OCCURRENCE

LOCATION OF OCCURRENCE (include city & state) | AUTHORITY CONTACTED

DESCRIPTION OF OCCURRENCE (Use separate sheet, if necessary)

POLICY INFORMATION

COVERAGE PART OR FORMS (Insert form #s and edition dates)

GENERAL AGGREGATE	PROD/COMP OP AGG	PERS & ADV INJ	EACH OCCURRENCE	FIRE DAMAGE	MEDICAL EXPENSE	DEDUCTIBLE	PD / BI

UMBRELLA/ EXCESS | UMBRELLA | EXCESS | CARRIER: | LIMITS: | AGGR | PER CLAIM/OCC | SIR/ DED

TYPE OF LIABILITY

PREMISES: INSURED IS | OWNER | TENANT | OTHER: | TYPE OF PREMISES

OWNER'S NAME & ADDRESS (If not insured) | OWNERS PHONE (A/C, No, Ext):

PRODUCTS: INSURED IS | MANUFACTURER | VENDOR | OTHER: | TYPE OF PRODUCT

MANUFACTURER'S NAME & ADDRESS (If not insured) | MANUFACT PHONE (A/C, No, Ext):

WHERE CAN PRODUCT BE SEEN?

OTHER LIABILITY INCLUDING COMPLETED OPERATIONS (Explain)

INJURED/PROPERTY DAMAGED

NAME & ADDRESS (Injured/Owner) | PHONE (A/C, No, Ext)

AGE | SEX | OCCUPATION | EMPLOYER'S NAME & ADDRESS | PHONE (A/C, No, Ext)

DESCRIBE INJURY | FATALITY | WHERE TAKEN | WHAT WAS INJURED DOING?

DESCRIBE PROPERTY (Type, model, etc) | ESTIMATE AMOUNT | WHERE CAN PROPERTY BE SEEN? | WHEN CAN PROPERTY BE SEEN?

WITNESSES

NAME & ADDRESS	BUSINESS PHONE (A/C, No, Ext)	RESIDENCE PHONE (A/C, No)

REMARKS

REPORTED BY | REPORTED TO | SIGNATURE OF INSURED | SIGNATURE OF PRODUCER

NOTE: IMPORTANT STATE INFORMATION ON REVERSE SIDE

© ACORD CORPORATION 1986

Vehicle Accident/Loss Investigation Report

(*This is not a claim form*)

Fire Department ______________________ Date ______________

Address ______________________

Name of Driver ______________________ Vehicle ID/Unit Number ______________

Type of Vehicle ______________________

Date Driver Last Certified On Above Vehicle ______________________

Date of Accident ______________ Time ______________ Date Reported ______________

Location of Accident ______________________

Roadway

- ☐ Straight ______
- ☐ Curve ______
- ☐ On Grade ______
- ☐ Level ______
- ☐ Hillcrest ______
- ☐ Dry ______
- ☐ Wet ______
- ☐ Muddy ______
- ☐ Snowy ______
- ☐ Icy ______
- ☐ Oily ______

- ☐ 2-lane
- ☐ 3-lane
- ☐ 4-lane
- ☐ Divided
- ☐ Rural
- ☐ Other ______
- ☐ Lanes marked
- ☐ Lanes unmarked
- ☐ No road detects
- ☐ Holes, ruts, etc.
- ☐ Loose material
- ☐ Other

Accident Occurred:

- ☐ At station
- ☐ Responding to emergency
- ☐ At emergency scene
- ☐ Returning from emergency
- ☐ Training
- ☐ Convention or parade
- ☐ Other ______
- ☐ Sleet

Type of Loss

- ☐ Personal injury
- ☐ Property damage
- ☐ Vehicle damage

Weather

- ☐ Clear
- ☐ Rain
- ☐ Snow
- ☐ Fog
- ☐ Other ______

Description Of Accident ______________________

____

____

____

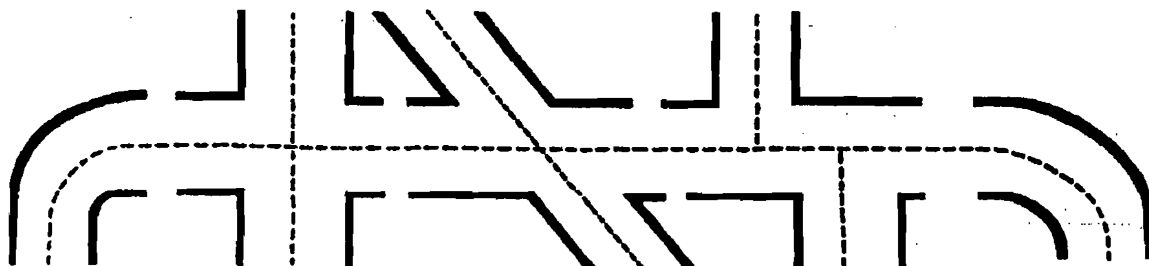
____

____

Motor Vehicle Diagram

Complete the following diagram showing direction and positions of automobiles involved, designating clearly point of contact.

Indicate North ↑



-over-

Safety Analysis

What acts, failures to act and/or conditions contributed most directly to this accident? (Immediate Cause)

____
____
____
____
____

What are the basic or fundamental reasons for the existence of these acts and/or conditions? (Fundamental Cause)

____
____
____
____
____

What action has or will be taken to prevent recurrence? Place "X" by items completed.

____
____
____
____
____

Safety Supervisor's Comments ___________________________
____
____
____
____
____
____

Driver's Signature ______________________ Date ______________

Supervisor's Signature ______________________ Date ______________

Safety Supervisor's Signature ______________________ Date ______________

Safety Analysis

What acts, failures to act and/or conditions contributed most directly to this accident? (Immediate Cause)

____

____

____

____

____

What are the basic or fundamental reasons for the existence of these acts and/or conditions? (Fundamental Cause)

____

____

____

____

____

What action has or will be taken to prevent recurrence? Place "X" by items completed.

____

____

____

____

____

Safety Supervisor's Comments ______________________________

____

____

____

____

____

____

Driver's Signature ______________________ Date ______________

Supervisor's Signature ______________________ Date ______________

Safety Supervisor's Signature ______________________ Date ______________

Vehicle Accident/Loss Investigation Report

(This is not a claim form)

Fire Department ______________________ Date ______________

Address ____

Name of Driver ______________________ Vehicle ID/Unit Number ______________

Type of Vehicle ______________________

Date Driver Last Certified On Above Vehicle ______________________

Date of Accident ______________ Time ______________ Date Reported ______________

Location of Accident ____

Roadway

- ☐ Straight ______
- ☐ Curve ______
- ☐ On Grade ______
- ☐ Level ______
- ☐ Hillcrest ______
- ☐ Dry ______
- ☐ Wet ______
- ☐ Muddy ______
- ☐ Snowy ______
- ☐ Icy ______
- ☐ Oily ______
- ☐ 2-lane
- ☐ 3-lane
- ☐ 4-lane
- ☐ Divided
- ☐ Rural
- ☐ Other ______
- ☐ Lanes marked
- ☐ Lanes unmarked
- ☐ No road defects
- ☐ Holes, ruts, etc.
- ☐ Loose material
- ☐ Other

Accident Occurred:

- ☐ At station
- ☐ Responding to emergency
- ☐ At emergency scene
- ☐ Returning from emergency
- ☐ Training
- ☐ Convention or parade
- ☐ Other ______
- ☐ Sleet

Type of Loss

- ☐ Personal injury
- ☐ Property damage
- ☐ Vehicle damage

Weather

- ☐ Clear
- ☐ Rain
- ☐ Snow
- ☐ Fog
- ☐ Other ______

Description Of Accident ____

____

____

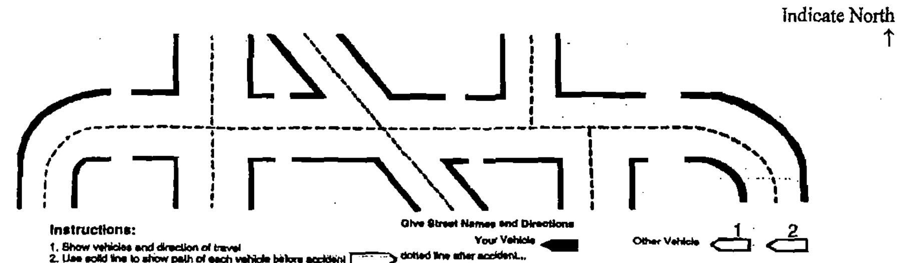
____

____

____

Motor Vehicle Diagram

Complete the following diagram showing direction and positions of automobiles involved, designating clearly point of contact.



-over-