CHUBB®

Federal Insurance Company

Special Risk Insurance Application

Section I Policyholder Information

Name of Policyholder: CITY OF MARSHALL

Address 344 W MAIN ST

City MARSHALL **State** MN **Zip Code** 56258

Phone Number:

Contact Name:

Effective Date: 02/01/2023

Policy Number: SPEC-IM-EN

INSURANCE REQUESTED

A) CLASS OF INSURED PERSONS

1 All Volunteers performing volunteer service on behalf of the Policyholder, excluding volunteer firefighters and volunteer police officers.

B) PRINCIPAL SUM

1 $50,000

C) HAZARD

1 Volunteer Duties

D) ACCIDENTAL DEATH AND DISMEMBERMENT

Class

All

Accidental: SPECIMEN	**Benefit Amounts (Percentage of Principal Sum)**
Loss of Life	100%
Loss of Speech and **Loss of Hearing**	100%
Loss of Speech and one of **Loss of Hand, Loss of Foot or Loss of Sight of One Eye**	100%
Loss of Hearing and one of **Loss of Hand, Loss of Foot or Loss of Sight of One Eye**	100%
Loss of Hands(Both), **Loss of Feet**(Both), **Loss of Sight** or a combination of any two of **Loss of Hand, Loss of Foot or Loss of Sight of One Eye**	100%
Loss of Hand, **Loss of Foot** or **Loss of Sight of one Eye** (Any one of each)	50%
Loss of Speech or **Loss of Hearing**	50%
Loss of Thumb and Index Finger of the same Hand	25%

E) ADDITIONAL BENEFITS

CLASS	BENEFIT	BENEFIT AMOUNT
1 SPECIMEN	**Accident Medical Expense**	**$25,000** **Deductible $0** **Dental Benefit Amount $1,000** **Physical Therapy Benefit Amount $2,500** **Orthopedic Appliance Benefit Amount $1,000**
1	**Temporary Total Disability**	**Weekly Amount $100** **Maximum Benefit Period 26 week(s)** **Elimination Period 7 day(s)**

Aggregate Limit of Insurance

The Aggregate Limit of Insurance applies:
$500,000 per **Accident**

Premium

Amount Due	$2,793
Due Date	02/11/2023

Employee Retirement Income Security Act
Is this plan subject to Employee Retirement Income Security Act (ERISA) regulations? (Y/N) _____

Policy Acceptance
The undersigned declares that all information provided in this application and any attachments hereto is true and correct. The undersigned understands that all information provided in this application and any attachments hereto is material to the insurer's decision to provide this insurance, and that insurance will be provided, at the insurer's sole discretion, in reliance upon the truth of such information. It is hereby agreed and understood this insurance is provided by the **Company** in consideration of payment of the required premium. The insurance under the policy begins on the Effective Date shown in the Insuring Agreement of the policy. The acceptance of the policy terminates any prior policy of the same policy number, effective with the inception of the policy.

Fraud Warning

A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Name of Policyholder:_____

_____	_____	_____
Date	Signature	Title

Company Authorized Representative

BT 3000 APP (Rev. 09/2006)