401 Fayette Avenue
Springfield, IL 62704

LAW ENFORCEMENT FAMILY FIREARM PROTECTION POLICY APPLICATION

PLEASE COMPLETE THE FOLLOWING APPLICATION

○ **Active Duty**
○ **Retired**

$229.00 per year

Affiliation

○ FOP ○ PBPA ○ MAP
○ ICOPS ○ AFSCME ○ TEAMSTERS
○ NONE ○ OTHER ____________________

First Name ______________________________ Last Name ______________________________

Home Address ____

City ____________________________ State _________ Zip Code _____________

County __________ Email Address ____________________________ Phone ___________________

Have you been criminally charged or convicted of any crime in the last 10 years? ***

○ Yes ○ No

Other than for law enforcement, do you carry your firearm in any other trade, profession, occupation, or job?

○ Yes ○ No

Please explain any Yes answers above:

____

Have you been issued an Illinois Retired Officer concealed carry permit?

○ Yes ○ No

If yes, please provide the concealed carry license permit number:__________________ Sticker only check here [ ]

*** Answer may cause applicant to be ineligible for coverage

All premiums and fees are fully earned at policy inception. No coverage is bound untill application is approved and premiums are paid.

To the extent permitted by law, I agree to accept electronic delivery of policy documents, renewals, privacy notices, and other correspondance from SPRISKA. Additionally, I hereby warrant that all of the foregoing statements contained in this application are complete and true, and that these statements are offered by me as an inducement to the company to issue a policy for which I am applying. I understand the company is relying on these statements to determine my acceptability for the coverage under the policy for which I am making application. I further understand that if the statements contained in the application are subseqently found to be not true, coverage under any policy issued as a result of this application could be compromised, or considered null and void.

____ ____________________
Signature of Applicant Date

Producer Name : Shield U Insurance Group Producer # GUN1014

NOTE------IF PAYING BY CHECK, MAKE IT PAYABLE TO : **SPRISKA** (Speciality Risk of America)

Mail Application and payment to : Shield U Insurance 6785 Weaver Rd. Unit 1D, Rockford, IL 61114

or Fax Application with credit card info to : 630-820-8635

Payment Authorization Agreement

☐ Annual - $229.00 ☐ Active Duty ☐ Retired

Credit Card Information: ☐ Visa ☐ Mastercard

Name (as it appears on card) ____________________

Billing Street Address ____________________

City __________ **State** __________ **Zip Code** __________

Card Number ____________________

Expires (MM/YYYY) __________ **CID # (3 Digit Code on Back)** __________

I (we) hereby authorize Specialty Risk of America to initiate the annual deduction from my (our) account, identified above, for payment of premium on the insurance policy issued to me (us) by Specialty Risk of America. I (we) authorize the financial institution named above to accept and post entries to my (our) account.

I (we) understand that if payment is declined by the credit / debit card designated above this agreement will be considered cancelled and the dishonored payment will be required to be made by check or other negotiable instrument to ensure the continuance of my (our) coverage. All payments must be paid as invoiced.

This authorization will remain in effect until I (we) provide written notice to Specialty Risk of America of it's termination in such time and in such manner as to afford Specialty Risk of America a reasonable opportunity to act on it.

____

Signature of Insured / Policyholder **Date**

Please allow five (5) business days for processing of this authorization.

Send Completed Form To:
Fax: (630) 820-8635
E-Mail: Info@ShieldUins.com
Mailing Address:
Shield U Insurance Group
6785 Weaver Rd., Unit 1D, Suite 110
Rockford, IL 61114