

**LAW ENFORCEMENT FAMILY FIREARM PROTECTION POLICY APPLICATION**

PLEASE COMPLETE THE FOLLOWING APPLICATION

- Active Duty** \$229.00 per year
- Retired**
- 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 until 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 correspondence 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 subsequently 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 check to : Shield U Insurance 6785 Weaver Rd. Unit 1D, Rockford, IL 61114**  
or Fax Application with credit card info on next page 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) \_\_\_\_\_

**\*\* CREDIT / DEBIT CARD TRANSACTIONS WILL BE CHARGED A 3.5% TRANSACTION FEE \*\***  
**THIS CAN BE AVOIDED IF YOU PAY BY CHECK**

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) 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 its 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