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Application

MEDICAL FACILITIES AND PROVIDERS AMBULANCE SERVICES SUPPLEMENTAL APPLICATION

This Supplemental Application is part of the Medical Facilities and Providers Liability Application.

A. ACCOUNT INFORMATION

1. Applicant Name (as identified in the Medical Facilities and Providers Liability Application):

B. FINANCIAL AND EXPOSURE DETAIL

2. Provide the number of trips in the following categories:

	Projected	Current
Ground Advance Life Support (ALS)		
Ground Basic Life Support (BLS)		
Air Advance Life Support (ALS)		
Air Basic Life Support (ABS)		
Non Medical Transport (Wheelchair, Vans, etc)		
Other (Describe): _____		

3. Provide the number of vehicles:

	Owned	Leased
Ambulances		
Wheelchair Vans		
Aircraft Fixed Wing		
Aircraft Helicopter		
Other Vehicles (Describe): _____		

4. Radius of operation (miles): _____

C. OPERATIONS AND ADMINISTRATION

5. How are calls dispatched? ☐ 911 ☐ In House ☐ Other

Describe (Other): _____

6. Is the Applicant accredited by the Commission on Accreditation of Medical Transport? ☐ Yes ☐ No

7. Do the Applicant's operations include the following services?

a. Dispatch/communication for others? ☐ Yes ☐ No

b. Special Event EMS or staffing? ☐ Yes ☐ No

c. Training school, CPR, First Aid or other certification course? ☐ Yes ☐ No

If "Yes" to any of the above, please explain details:

8. Please indicate if the following policies and procedures are established and adhered to by all staff, including contractors.

a. Scheduled inspections and preventative maintenance on all vehicles and equipment ☐ Yes ☐ No

b. MVRs checked annually on all drivers ☐ Yes ☐ No

c. Random drug and alcohol testing ☐ Yes ☐ No

d. Mandatory reporting to management of any business related traffic violations or accidents ☐ Yes ☐ No

e. Defensive driver certification ☐ Yes ☐ No

f. Passenger loading and assistance training ☐ Yes ☐ No

g. First Aid/CPR ☐ Yes ☐ No

h. Patients and equipment must be secured/strapped when vehicle is in motion ☐ Yes ☐ No

i. If the Applicant intubates or transfers patients with endotracheal tubes, does the Applicant document the position of the ET tube during and upon completion of the transfer? ☐ Yes ☐ No

If "No" to any of the above, please explain details:

9. Please provide details of the applicant's Auto and/or Aircraft Liability Insurance for the upcoming policy year:

Carrier: _____ Limits of Liability: _____

10. Is the Applicant's Auto Liability policy silent on coverage for claims arising from loading or unloading patients? ☐ Yes ☐ No

If "No," please explain details:

E. SIGNATURE AND AUTHORIZATION

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, declares that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Supplemental Application and any attachments of information submitted with this Supplemental Application are true and complete. The undersigned understands that information submitted herein becomes part of the Applicant's Medical Facilities and Providers Liability Application and is subject to the representations and conditions set forth therein.

NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Applicant Name	
By (Authorized Signature)	
Name/Title	
Date	

NOTE: THIS APPLICATION MUST BE SIGNED BY THE CHIEF EXECUTIVE OFFICER, PRESIDENT, CHAIRMAN OR OTHER OFFICER OF THE APPLICANT ACTING AS THE AUTHORIZED AGENT OF ALL INDIVIDUALS AND ENTITIES PROPOSED FOR THIS INSURANCE.