Ambulance Application

Agent Number: F861659
Agent Name: _____
Phone No: _____ Fax No: _____

Agent Address: _____
City: _____
State: _____ Zip Code: _____

Today's Date: _____ **(Must be attached to Acord Application)**

BASIC INFORMATION:

1. Named Insured: _____ 2. DBA: _____
3. Mailing Address: _____
4. Physical Address: _____
5. Phone: _____ 6. FEIN: _____ 7. Years in business: _____
8. Website Address: _____
9. Owners Name: _____ 10. Email Address: _____
11. Safety Manager's Name, Cellphone Number & Email Address:

    _____

12. Is your business a subsidiary or division of a parent company? ☐ Yes ☐ No

    If yes, name of company: _____ Service Performed: _____

    Name of company: _____ Service Performed: _____

13. Has your business had a change of ownership in the past 3 years? ☐ Yes ☐ No

    If yes, please explain: _____

14. Has your business had any change to key personnel (Medical Director, Safety/Operations Manager, Human Resource Manager) in the past year? ☐ Yes ☐ No
    If yes, please explain: _____

15. Has your business, its owner(s), officers, directors or employees ever been party to any civil, criminal or regulatory proceedings (including Medicare/Medicaid) resulting in an administrative sanction or license suspension or revocation? ☐ Yes ☐ No If yes, please explain on a separate sheet.

16. Are ICC, PUC or other filings required? ☐ Yes ☐ No (If yes, provide copies.)

OPERATIONAL INFORMATION:

1. List the major metropolitan area(s) served:

    _____

2. Type/Number of Calls — Past 12 months — Next 12 months

Emergency	_____	_____	(Ambulance transports)
Non-Emergency	_____	_____	(Ambulance transports)
Paratransit Ambulatory	_____	_____	(Non-ambulance transports)
Paratransit Wheelchair	_____	_____	(Non-ambulance transports)

3. Does your service perform the following?
   ☐ Thrombolytic Therapy ☐ Conscious Sedation ☐ Endotracheal Intubation ☐ Capnography ☐ Capnometry
   ☐ Pulse Oximetry ☐ Manual Defibrillation ☐ 12-Lead EKG Monitoring ☐ Telemetry ☐ Mechanical Ventilation
   ☐ IV Therapy or Monitoring ☐ Automatic External Defibrillation ☐ Paralytic Administration
   ☐ Transexamic Acid Administration ☐ ECMO Transports

4. Does your service have a Medical Director? ☐ Yes ☐ No
   If yes, is your Medical Director:
   a. Licensed to practice medicine or osteopathy? ☐ Yes ☐ No
   b. Familiar with local regional EMS activity? ☐ Yes ☐ No
      If yes, ☐ experientially and/or ☐ completion of an EMS Fellowship or ☐ Other_____?
   c. Board certified or prepared in Emergency Medicine? ☐ Yes ☐ No
   d. Actively practicing Emergency Medicine? ☐ Yes ☐ No
   e. Compensated by your organization? ☐ Yes ☐ No

   Does your Medical Director:
   a. Have a formal job description? ☐ Yes ☐ No
   b. Provide direct patient care while working with your service? ☐ Yes ☐ No
   c. Give orders/instruction to your personnel while patient care is given? ☐ Yes ☐ No
      If yes, is this done ☐ remotely (radio, etc.) or ☐ directly on the scene?

5. Number of full and part time employees/volunteers that drive or provide patient care: _____

Full-Time	Part-Time	Type	Full-Time	Part-Time	Type
		Paramedics			Advanced EMT (EMT-A or EMT-I)
		Critical Care Paramedics			Emergency Medical Tech (EMT-B)
		Registered Nurses			Emergency Medical Responder (EMR, First Responder)
		Other:			

6. What are the vehicle counts for the following classifications:

Type of Auto	**As of Today**	**Renewal Date 1 year ago**	**Renewal Date 2 years ago**
Ambulances			
Paratransit/Wheelchair			
First Responder			
Service (all other autos)			

7. Do we insure all of your vehicles titled to the Named Insured(s)? _____

8. Patient Handling: Stretcher
   a) Select all Stretcher types used at your service and give the brand and number of each type:

Type of Stretcher	**Brand**	**Number**
X-Frame		
Fold Away Undercarriage		
Power Cot		
Bariatric Cot		
Other		

   b) Does your service use knee, hip, chest and over the shoulder safety restraints on your stretchers? ☐ Yes ☐ No
   c) Does your service have a mandatory lift assist policy? ☐ Yes ☐ No
   d) Select the engineering controls used at your service and given the brand and number of each type:

Engineering Control	**Brand**	**Number**
Specialty Vehicles (Bariatric Units)		
Ramps with Winches		
Lateral Transfer Aids		
Motorized Stair Chairs		
Other		

9. Patient Handling: Wheelchair ☐ Not Applicable
   a) Name the wheelchair tie-down occupant restraint system (WTORS) you use: _____
   b) Does your WTORS meet SAE J2249 (WTORS) ISO 10542 standards? ☐ Yes ☐ No
   c) If you do not use a commercially develop WTORS, please provide a copy of the section of your SOP that outlines the manner in which you use the system to tie down a wheelchair and restrain its user.
   d) Does your SOP address the transportation of a scooter and its user? ☐Yes ☐ No

10. Do you transport prisoners or others whose pick up site is determined by their legal status? ☐Yes ☐ No
    If yes, please list the contracts responsible for these transports and provide a copy of your restraint policy including obligations regarding client escape:

    _____

    _____

    _____

11. Onboard Monitoring (OBM) (☐ black box, ☐ cameras, ☐ GPS, ☐ stickers) ☐Not Applicable
    a) Brand name of system(s):
    b) Date the system was installed:
    c) Number of vehicles currently installed with the system:
    d) Employee responsible for the management of the OBM:

    Name: _____ Phone Number: _____

    Email: _____

12. Dispatch ☐ Not Applicable
    a) Is your dispatch center a Public Safety Answering Point (PSAP)? ☐ Yes ☐ No
       If no, please check the following if it applies:
       ☐ PSAP directly dispatches your units
       ☐ PSAP refers calls to your service for internal dispatch.
       ☐ You do not interact with a PSAP.
    b) Check the functions performed by your internal dispatchers:
       ☐ Dispatch emergency requests for your service. ☐ Dispatch non-emergency requests for you service.
       ☐ Schedule routine ambulance transfers. ☐ Schedule wheelchair/paratransit transfers.
       ☐ Screen calls to determine whether or not an ambulance will be sent.
    c) How many years of experience are dispatchers required to have prior to hiring? _____
    d) Are your dispatchers Emergency Medical Dispatch Certified? ☐Yes ☐ No
    e) Describe your in-house training for dispatchers, including length of training:

       _____

       _____

       _____

    f) The name of the dispatch software used: _____

13. Is your business involved in: ☐Not Applicable
    ☐Air Ambulance ☐ Water Rescue ☐ Off-Shore EMS ☐ Aerial Rescue ☐Tactical Medic Services
    ☐Confined Space Rescue
    Special Events: ☐Car/Motocross Races ☐ Horse Races ☐ Concerts ☐ High School Sports
    ☐Professional Sports ☐ Night Clubs ☐ Rave Events
    Total Annual Receipts from the above contracts: _____

14. Does your service perform Community Paramedicine/Mobile Integrated Health Services? ☐Yes ☐No
    If yes, explain: _____

15. Does your service operate a school to become certified as an EMT or Paramedic? ☐Yes ☐No
    If yes, are you looking for professional coverage? ☐ Yes ☐ No
    ☐ Internal employees only ☐ Non-employees only ☐ Both Number of students annually? _____
    How many instructors are employed? _____ How many classes annually? _____
    Who would teach the course? _____

VEHICLE MAINTENANCE

1. Is a condition report completed on each transport vehicle and its equipment on each shift? ☐ Yes ☐ No
   If no, please explain: _____

2. Does the maintenance schedule for your fleet meet or exceed the manufacturer's recommendations? ☐ Yes ☐ No
   If no please explain: _____

3. Who performs the maintenance on your fleet? _____
   Are they certified by the manufacturer? ☐ Yes ☐ No
   Are they a certified mechanic? ☐ Yes ☐ No

4. Do you keep maintenance repair records on file for each vehicle? ☐ Yes ☐ No
   If no, please explain: _____

5. Do you perform any after-market vehicle modifications? ☐ Yes ☐ No
   If no, please explain: _____

HUMAN RESOURCE

1. Please provide the following information for the person who is responsible for new employee orientation:
   Name: _____ Title: _____
   Cell Phone: _____ Email: _____

2. Check all that apply to your employee selection process:
   ☐ Written Application ☐ Job Specific Physical Examination ☐ Psychological Testing
   ☐ Criminal Background Check ☐ MVR Check ☐ Obtain evidence of Pertinent Certification Licensure
   ☐ Post-Employment Drug Screening

3. Is previous ambulance driving experience required on new hires? ☐ Yes ☐ No
   If yes, how many years? _____

4. Please provide the name of the driver training program(s) that you provide or participate in:
   ☐ CEVO ☐ EVOC ☐ Arrive Alive Do No Harm ☐ In house driver training ☐ Other: _____
   # of Classroom Hours: _____ # of Behind the Wheel Hours: _____

5. How many drivers left or were let go due to disciplinary reasons in the past 12 months? _____

6. Is your service staffed at 100% capacity? ☐ Yes ☐ No If not, what is your staffing level? _____

7. Describe your new employee orientation including topics, duration, practical skills training including driving and patient handling, and any probationary periods and time spent with a Field Training Office or Preceptor.
   _____
   _____
   _____

SAFETY/RISK MANAGEMENT

1. Is a record kept of each request for service? ☐ Yes ☐ No

2. Is a trip ticket for billing purposes completed for each transport? ☐ Yes ☐ No

3. Is a patient care report (PCR) completed for each transport in which medical care, evaluation or observation has been performed? ☐ Yes ☐ No ☐ N/A

4. What % of your trip tickets and call reports are reviewed for completeness, legibility and when applicable, clinical content? _____
   How frequently are they reviewed? ☐ Daily ☐ Weekly ☐ Other _____
   Who is responsible for the reviews?
   Name: _____ Title: _____
   Phone #: _____ Email: _____

5. At what speed may your ambulances operate with the Emergency Warning Systems (EWS) activated? _____

6. Who determines when the EWS is to be activated? _____

7. What percentage of your scene to hospital trips occur with EWS activated? _____

8. Are your vehicles always locked when unattended? ☐Yes ☐ No

9. Do you require third party riders (non patient/ non EMS personnel) to sit in the front passenger seat unless the patient's well-being requires the rider to be in the back of the ambulance? ☐ Yes ☐ No
   If they ride in the rear of the ambulance, do you require they wear seat restraints? ☐ Yes ☐ No

10. Does your service maintain accident files? ☐ Yes ☐ No If yes, how long do your keep the files? _____

11. Are safety violations (i.e. auto crashes, patent handling events) part of your progressive discipline process?
    ☐ Yes ☐ No

12. Does your service have a Medical Equipment Failure policy? ☐ Yes ☐ No
    If yes, does it address checking, charging and replacing batteries for medical equipment? ☐ Yes ☐ No

13. Do you have a violent patient restraint policy? ☐ Yes ☐ No

14. Do you have a Safety Committee? ☐ Yes ☐ No
    If yes, how often? ☐ Monthly ☐ Quarterly ☐ Semi-Annual or ☐ Annual
    Do you: ☐ Review losses ☐ Remedial training ☐ Identify, implement, and monitor training methods

15. Do you have a written driver fatigue policy in place? ☐ Yes ☐ No
    Does your policy apply to all employees (full and part-time)? ☐ Yes ☐ No
    Do you allow the ability to stop working if employee is fatigued? ☐ Yes ☐ No
    Maximum number of consecutives hours worked (includes other employment): _____
    Minimum number of hours between shifts: _____ Maximum number of hours worked per 7 day period: _____
    Schedule rest periods: _____

16. Does your supervisory staff directly monitor employee patient handling and driving and patient handling behaviors and document their findings? ☐ Yes ☐ No
    If yes, explain: _____

WORKERS' COMPENSATION ☐Not Applicable ☐Occ/Acc Policy

Name of Carrier: _____
Policy #: Eff. Dates: _____ to _____
Employers Liability Limit: $ _____
Bodily Injury by Accident: $ _____ Each Accident
Bodily Injury by Disease: $ _____ Policy Limit
Bodily Injury by Disease: $ _____ Each Employee

LIMITS OPTIONS

Automobile Liability Limits (check one):
☐ $500,000 Combined Single Limit Bodily Injury & Property Damage
☐ $1,000,000 Combined Single Limit Bodily Injury & Property Damage

Professional Liability and General Liability Limits (check one):
☐ $500,000 any one claim/$1,000,000 annual aggregate
☐ $1,000,000 any one claim/$2,000,000 annual aggregate
☐ $1,000,000 any one claim/$3,000,000 annual aggregate

Excess Liability:
Please provide limit: _____

Inland Marine (medical equipment/inventory): Blanket limit: _____
Maximum limit per item: _____
Deductible: ☐ $500 ☐ $1000

Auto Physical Damage Deductible Options (check one): ☐ $500 ☐ $1,000 ☐ $2,000 ☐ Other: _____

Is Property Coverage desired? ☐ Yes ☐ No If yes, please complete the Acord Property application.

FRAUD WARNINGS

GENERAL FRAUD STATEMENT (not applicable in Colorado, Florida, Hawaii, Massachusetts, Nebraska, Ohio, Oklahoma, Oregon and Vermont) Any person who knowingly and with intent to defraud any insurance company or another 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 subjects the person to criminal and (NY: substantial) civil penalties. In the District of Columbia, Louisiana, Maine, Tennessee and Virginia, and Washington insurance benefits may also be denied.

NOTICE TO COLORADO APPLICANTS: THIS NOTICE IS A PART OF YOUR APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

NOTICE TO HAWAII APPLICANTS: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment or both.

NOTICE TO OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: A person who knowingly and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO OREGON APPLICANTS: Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact, may be violating state law.

NOTICE TO VERMONT APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto, may be committing a crime, subjecting the person to criminal and civil penalties.

THE APPLICANT DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE APPLICANT AGREES THAT IF THE INFORMATION SUPPLIED ON THE APPLICATION BY THE APPLICANT CHANGES BETWEEN THE DATE OF THE APPLICATION AND THE EFFECTIVE DATE OF INSURANCE, APPLICANT WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS AND/OR AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

Applicant's Signature: _____ Date: _____

Producer's Signature: _____ Date: _____
(Only applicable if using a producer)

Producer's License Number: _____ Exp Date: _____

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