GLOBAL INSURANCE BROKERAGE

Ambulance Services, Medical Transport

Mainform Application

Applicant Information

1. Applicant name:

2. Principal business address (attach separate sheet if more than one location):

3. Telephone number:

4. Date established:

5. Applicant's practice is a:

☐ Solo practitioner (unincorporated)	☐ Solo practitioner (incorporated)
☐ Corporation (for-profit)	☐ Corporation (non-profit)
☐ Partnership	☐ Professional Association
☐ Other (describe):	

6. Please state sources and amounts of total revenue:

	last 12 months	next 12 months
Charitable contributions		
Government funding		
Fee for services		
Other – specify:		
Total gross revenue:		

7. a. If applicant has a training school, complete the following:

Profession for which students are being trained	Max no. of students per session	Number of sessions per year	Number of faculty per session	Qualification of faculty (e.g. MD RN)

b. What is the total number of faculty members?

8. Type of operations (check all that apply):

☐ Air ambulance	☐ Ground ambulance	☐ Wheelchair transport
☐ Special event emergency medical service		

If other, please specify:

9. Radius of operation (miles):

10. Does your operation hold accreditations from any industry organizations? Yes ☐ No ☐

If Yes, please identify which organizations:

11. Does a board certified/eligible physician oversee the operations? If No, please explain in the comments section. Yes ☐ No ☐

12. a. Number of non-emergency transports for the last 12 months:
    b. Number of non-emergency transports for the next 12 months:
    c. Number of emergency transports for the last 12 months:
    d. Number of emergency transports for the next 12 months:

13. a. Total number of air ambulances:
    b. Total number of ground ambulances:
    c. Total number of vans:

14. Are vehicles equipped with (check all that apply):

☐ Cardiac Monitors	☐ Pacemakers	☐ Defibrilators
☐ Ventilators	☐ Intubation kits	☐ Oxygen
☐ Pules Oximeters	☐ Emergency Cardiac Drugs	

Staffing Information

15.

Type of healthcare provider	Number of employees	Number of independent contractors	Annual billable hours in last 12 months	Annual billable hours projected for next 12 months
Physicians				
EMT				
Paramedic				
Nurse				
Other (specify):				
Totals:				

16. a. Are all the above individuals licensed in accordance with applicable state and federal regulations? Yes ☐ No ☐
    If No, please explain in the comments section.

    b. i. Do you require contracted staff to carry their own professional liability insurance? Yes ☐ No ☐

    ii. Do you maintain Certificates of Insurance to confirm such coverage? Yes ☐ No ☐
    If Yes, what are the limits of professional liability each contracted employee is required to carry?

Ambulance Services, Medical Transport
Mainform Application

c. Has the applicant or have any of the above employees:
   i. ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association? Yes ☐ No ☐
   ii. ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? Yes ☐ No ☐
   iii. ever been treated for alcoholism or drug addiction? Yes ☐ No ☐
   iv. ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? Yes ☐ No ☐

   If Yes to any of the above, please explain in the comments section.

Employee Hiring Practices

17. a. Are employee/contractor references checked prior to hiring? Yes ☐ No ☐
    b. How are references checked? ☐ Written ☐ Verbal ☐ Both
    c. Does the applicant utilize criminal background checks for all employees/contractors? Yes ☐ No ☐
    d. Does the applicant conduct random drug and alcohol testing on all employees/contractors? Yes ☐ No ☐
    e. Are motor vehicle records checked for all employee/contractors? Yes ☐ No ☐

    If No to any of the above, please explain in the comments section.

18. Please indicate if the following risk indicators are monitored and/or evaluated. If No, explain in the comments section.
    a. Drug administration (e.g. wrong drug, wrong dosage, use of expired drug, etc.): Yes ☐ No ☐
    b. Failure of a piece of equipment: Yes ☐ No ☐
    c. Communications system failure: Yes ☐ No ☐
    d. Delay in treatment because the member of staff has not been trained or authorized (unless under the direct supervision of a physician): Yes ☐ No ☐
    e. Delay in treatment by paramedic/technician/nurse that contributed to the deterioration of the patient's medical condition: Yes ☐ No ☐
    f. Complaints: Yes ☐ No ☐

19. Is there a formal documented program for scheduled inspections and preventative maintenance on all vehicle and equipment? If No, explain in the comments section. Yes ☐ No ☐

20. What special training do employees receive and what steps are taken in order to prevent claims involving patient drops and falls?

Insurance and Claims History

21. Does any person to be insured have knowledge or information of any act, error or omission which might reasonably be expected to give rise to a claim against him/her? Yes ☐ No ☐

    If Yes, please attach complete details including a description of the incident(s).

22. After inquiry have any claims been made against any proposed Insured(s) during the past five (5) years? Yes ☐ No ☐

    If Yes, please complete a supplemental claims information form for each claim and attach currently valued company loss runs.

Ambulance Services, Medical Transport
Mainform Application

23. How many claims have been made in the last five (5) years?

24. a. Name of applicant's Auto Liability Insurer:

b Limits of Liability:

25. a. Name of applicant's Aircraft Liability Insurance carrier:

b Limits of Liability:

26. a. List prior professional liability insurers for the past five years (if none, please tick box) ☐

Insurer	Dates covered from-to (mm/dd/yy)	Limits of liability per claim / aggregate	Deductible	Premium	Coverage type: occurrence or claims-made
		/			
		/			
		/			
		/			
		/			

b. If the current/expiring policy is on a claims-made form, what is the retroactive date?

27. a. Is the applicant currently insured under a commercial general liability policy including products and completed operations coverage? Yes ☐ No ☐

Insurer	Dates covered from-to (mm/dd/yy)	Limits of liability per claim / aggregate	Deductible	Premium	Coverage type: occurrence or claims-made
		/			
		/			
		/			
		/			
		/			

b. If the current/expiring policy is on a claims-made form, what is the retroactive date?

28. Has any similar insurance ever been declined or cancelled? Yes ☐ No ☐

If Yes, please explain in the comments section.

Ambulance Services, Medical Transport

Mainform Application

Comments Section

It is understood and agreed that with respect to questions 25 and 26, that if such knowledge or information exists any claim or action arising there from is excluded from this proposed coverage.

Notice to New York applicants: any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any material thereto, commits a fraudulent insurance act, which is a crime.

The applicant hereby acknowledges that he/she/it is aware that the limit of liability shall be reduced, and may be completely exhausted, by the costs of legal defense and, in such event, the Insurer shall not be liable for the costs of legal defense or for the amount of any judgment or settlement to the extent that such exceeds the limit of liability.

The applicant further acknowledges that he/she/it is aware that legal defense costs that are incurred shall be applied against the deductible amount.

I DECLARE that, after inquiry, the above statements and particulars are true and I have not suppressed or misstated any material fact and that I agree that this application shall be the basis of the contract with the Underwriters.

Name of applicant:	
Signature of person authorized to execute on behalf of the applicant:	
Name/title of person authorized to execute on behalf of the applicant:	
Date:	

This application form duly completed, together with any supplementary information, must be signed in ink or by electronic signature by the person indicated.
Signing of this form does not bind the applicant or the Underwriters to complete this insurance.

A copy of this application should be retained for your records.