NEW ENGLAND EXCESS EXCHANGE

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EMERGENCY MEDICAL TECHNICIANS APPLICATION General Liability/Professional Liability

1. Proposed First Named Insured & Other Named Insured(s):

2. Mailing Address — Street — City — County — State — ZIP Code

3. Location Address — Street — City — County — State — ZIP Code

4. Accounting Records (Contact/Phone Number):

5. Interest of Named Insured in premises: ☐ Owner ☐ General Lessee ☐ Tenant ☐ Other:

6. Policy Period Desired: From: | To: | Term Desired:

BUSINESS INFORMATION

1. Type of Service: ☐ Private ☐ Fire Department ☐ Ambulance District ☐ City, Township, Village ☐ Public Hospital ☐ Funeral Home ☐ County ☐ Private Hospital ☐ Volunteer (not assoc. with above)

2. Years under current ownership: | Operate as: ☐ Non Profit ☐ For Profit

If under 3 years ownership, explain previous management/ownership experience in this industry:

3. Applicant is: ☐ Individual ☐ Partnership ☐ Corporation ☐ Governmental Unit ☐ Trust ☐ Other:

4. Describe any risk management or safety committee activities:

COVERAGE/LIMITS DESIRED

☐ Premises - Operations	$	General Aggregate
☐ Products-Completed Operations	$	Products-Completed Operations Aggregate Limit
	$	Each Occurrence Limit
☐ Personal & Advertising Injury	$	Personal & Advertising Injury Limit
☐ Damage to Premises Rented to You	$	Damage to Premises Rented to You Limit
☐ Medical Payments	$	Medical Payments Limit
☐ Contractual Liability (No Separate Limit)		
☐ Professional Liability	$	Each Occurrence Limit
	$	Aggregate

1. Is Loading and Unloading Coverage desired? ☐ Yes ☐ No
2. Is Loading and Unloading included on this insured's auto policy? ☐ Yes ☐ No
3. Is 24 hour coverage for Good Samaritan Acts desired? ☐ Yes ☐ No

PRIOR INSURANCE CARRIER INFORMATION FOR THE PAST THREE YEARS

Policy Dates	Carrier/Policy Number/Premium	Coverage

Missouri applicants: DO NOT answer this question.

Has insurance of this type been cancelled, refused, or nonrenewed by any company during the past 3 years?

☐ No ☐ Yes - If Yes, give name of company, date, and reason:

SPECIFIC LOSS INFORMATION: Include all allegations, suits, or incidents *(past 5 years)* which could result in a claim, regardless of whether or not covered by insurance.

Date	Description	Paid	Reserve
		$	$
		$	$
		$	$

OPERATIONS

1. Number of units maintained: Ambulances: Wheelchair Vans: Other:
2. Are any vehicles hospital owned? ☐ Yes ☐ No
3. Radius of operations (miles):
4. **NUMBER OF CALLS - ANNUALLY**

Type of Call	Number (annually)	Percentage of Total
Ambulance - Emergency		
Ambulance - Non-Emergency		
Non-Ambulance – Non-Emergency Medical Transportation		
Air Ambulance		
TOTAL		

5. Percentage of medical transport calls that are wheelchair transport: %
6. Indicate medical certification required of staff handling wheelchair calls: ☐ N/A - No wheelchair calls
   ☐ Paramedic ☐ EMT ☐ No certification required

		Yes	No
7.	Is training on wheelchair tie-down procedures given to all staff handling wheelchair transport?	☐	☐
8.	Do you provide search and rescue/extrication services?	☐	☐
9.	Do you provide any over-water operations?	☐	☐
10.	Does service have special rapid telemetry with the hospital?	☐	☐
11.	Is a call report completed on each and every call/run?	☐	☐
12.	Do you adhere to medical protocol as established by the OSHA Blood-borne Pathogens Standard?	☐	☐
13.	Has any Insured ever experienced a claim as a result of allegations that they contributed to the spread of contagious disease?	☐	☐
14.	Are your call reports reviewed for completeness, legibility and professional content?	☐	☐

15. Calls are dispatched by: ☐ 911 ☐ In-house by employees/volunteers
    ☐ Outside source (explain):
16. If dispatching duties are performed in-house:
    a. Years of dispatching experience required for employment:
    b. Describe in-house training for dispatchers, including length of training time involved:
    c. Do you perform dispatch duties for any other entity (police, fire)? ☐ Yes ☐ No
17. Are all calls coming into your service tape recorded? ☐ Yes ☐ No If yes, indicate:
    a. System being utilized:
    b. How long are tapes kept:

		Yes	No
18.	Do you screen calls to determine whether or not an ambulance will be dispatched? *If yes, attach a copy of written procedures.*	☐	☐
19.	Has the service entered into any written contractual agreements to perform ambulance service for a governmental entity, hospital, or nursing home?	☐	☐
	a. If yes, is legal advice sought to write and approve?	☐	☐
	b. Does agreement require you to hold a third party harmless?	☐	☐

20. Is your service operating under an exception, variance, or probation relating to a provision of license, or applicable state law or code? ☐ Yes ☐ No

If yes, explain:

STAFF

1.	Number of crew members: Per Call, Per Vehicle:	Total:
2.	Crew members are: ☐ Paid ☐ Volunteer	
3.	List the number of individuals certified in each area:	

First Responders	Paramedics
Advanced First Aid (Red Cross)	EMTs – Class:
Nurses	Other (specify):

4. Are all drivers/attendants required to obtain continuing education/training? ☐ Yes ☐ No

If yes, describe:

5. Number of hours your employees/volunteers: Work per shift: | Are off duty between shifts:

		Yes	No	
6.	Do you contract with a medical advisor?	☐	☐	
7.	Does the medical advisor carry medical malpractice insurance?	☐	☐	*Limits*: _____
8.	Are references checked on new hires?	☐	☐	
9.	Are MVRs checked on new hires?	☐	☐	
10.	Do you have any trainees on your staff?	☐	☐	

For information about how Northland compensates its agents, brokers and program managers, please visit this website:

http://www.northlandins.com/Producer_Compensation_Disclosure.asp

If you prefer, you can call the following toll-free number: 1-866-904-8348. Or you can write to us at Northland Insurance Companies, c/o Law Department, 385 Washington St., St. Paul, MN 55102.

This application, including any material submitted in conjunction with the application or any renewal, does not amend the provisions or coverages of any insurance policy or bond issued by Northland. It is not a representation that coverage does or does not exist for any particular claim or loss under any such policy or bond. Coverage depends on the facts and circumstances involved in the claim or loss, all applicable policy or bond provisions, and any applicable law. Availability of coverage referenced in this document can depend on underwriting qualifications and state regulations.

FRAUD STATEMENTS

ARKANSAS, DISTRICT OF COLUMBIA, MARYLAND, NEW MEXICO, AND RHODE ISLAND: Any person who knowingly (or willfully in MD) presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully in MD) presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

COLORADO: 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.

FLORIDA: 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.

KENTUCKY, NEW JERSEY, NEW YORK, OHIO, AND PENNSYLVANIA: 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 subjects such person to criminal and civil penalties. (In New York, the civil penalty is not to exceed five thousand dollars ($5,000) and the stated value of the claim for each such violation.)

LOUISIANA, MAINE, TENNESSEE, VIRGINIA, AND WASHINGTON: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, and denial of insurance benefits.

IMPORTANT NOTICE

DECLARATION

I DECLARE THAT THE STATEMENTS MADE IN THIS APPLICATION ARE COMPLETE AND TRUE.

As part of our underwriting procedures, a routine inquiry may be made to obtain applicable information concerning character, general reputation, and credit history. Upon your written request, additional information as to the nature and scope of the report, if one is made, will be provided.

SIGNATURES

Applicant Signature	Title	Date
Producer Signature		Date
Producer Name and Address		