

APPLICATION

**FOR NON-EMERGENCY AMBULANCE AND TRANSPORTATION SERVICES
PROFESSIONAL AND GENERAL LIABILITY INSURANCE**

(CLAIMS MADE AND REPORTED BASIS)

Please email this application back to the underwriter you are working with.
For contact information please visit www.usrisk.com/healthcare.html

Effective date desired: _____

APPLICANT INFORMATION:

1. Complete name of applicant (if other than parent firm, supply full details of ownership entity)
(use an additional sheet of paper if necessary): _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Contact name: _____ Title: _____ Email address: _____

Phone: _____ Web site Address: _____ Fax: _____

List all other locations (use an additional sheet of paper if necessary): _____

2. Applicant is:

a. Individual Partnership Corporation Professional Association Other: _____

b. Not-for-profit For-profit Both

3. Date established: _____ / _____

4. **APPLICANT SERVICES:**

What service is provided to your client? _____

How are you contacted to provide your service?

Funeral Home Fire Department Hospital Individual client Physician office Surgery Center

What is your usual final destination? _____

IF YOU OPERATE A NON EMERGENCY AMBULANCE SERVICE:

a. Are the signed physician orders transported on board the ambulance with the patient? Yes No

b. Name of all medical facilities the Applicant is affiliated with: _____

c. What types of ambulance transport services are provided? _____

d. Are Medical Technicians trained and certified? _____
 Please indicate the number and type of your employees and/or volunteers. IF NONE, STATE NONE.

_____ Emergency Medical Technicians _____ No Medical Personnel in attendance – driver only
 _____ Nurses, Licensed Practical _____ Other (Specify) _____
 _____ Nurses, Registered
 _____ Paramedics

Are all of the above medical personnel licensed in accordance with applicable state and federal regulations? _____ Yes No
 If no, please attach an explanation.

Please list the number and type of independent contractors who provide professional services on your behalf. IF NONE, STATE NONE.

_____ Emergency Medical Technicians _____ No Medical Personnel in attendance – driver only
 _____ Nurses, Licensed Practical _____ Other (Specify) _____
 _____ Nurses, Registered
 _____ Paramedics

b. Do you supervise any individuals who are not your own employees? Yes No
 If yes, please provide a detailed explanation of responsibilities and relationships to the entity which employs these individuals.

5. APPLICANT PROCEDURES:

a. Do you render professional services directly to patients? Yes No
 If yes, please describe these services in detail and indicate whether you are supervised and by whom.

<u>Detailed Description of Professional Services</u>	<u>Percent of Time</u>	<u>Supervised Yes/NO</u>	<u>Title of Supervisor</u>
_____	_____ %	_____	_____
_____	_____ %	_____	_____
_____	_____ %	_____	_____

b. Do you render professional services that do not involve contact with a patient? Yes No
 If yes, please describe these services in detail _____

6. APPLICANT AFFILIATIONS:

a. Are you employed by or under contract to any governmental entity? Yes No
 If yes, please attach an explanation, including details of your responsibilities.

b. Are you associated with any agency or organization that engages in advertising for, or solicitation of, patients? Yes No
 If yes, please attach a detailed explanation and a copy of ALL relevant advertisements.

7. SERVICE BOUNDARY:

a. What is the radius of operations of the non-emergency ambulance or transportation service? _____
 b. Does the radius of operations include air ambulance service? Yes No
 (i) How much of operations is provided for non-emergency air ambulance? _____
 (ii) Does the staff include Attending Flight Physicians? Yes No
 If so, do they carry Attending Flight Physician’s insurance? _____ What limits? _____

8. ANNUAL NUMBERS:

a. What are your gross annual revenues? _____
 b. Please state the annual number of patient encounters (the number of patients transported by the ambulance service):
 Last 12 months: _____ Estimated next 12 months: _____
 b. Please state the annual number of calls for emergencies:
 Last 12 months: _____ Estimated next 12 months: _____

c. Please state the annual number of calls for transporting patients to and from a hospital or other institution that are not accident cases:
 Last 12 months: _____ Estimated next 12 months: _____

9. DESCRIPTION OF VEHICLE(S)

- a. Are the vehicles you use specifically built to transport clients? Yes No
 If no, what conversions were made? _____
- b. Are the vehicles best described as Vans Busses Passenger Cars Other (specify) _____
- c. Advise safety features or equipment in all vehicles Lifts Wheelchair accessible Standard tie-downs
 Ratchet tie-downs Stepwell lights Emergency exits Other (specify) _____
- d. Advise number of vehicles including maximum passenger capacity currently in use: _____
- e. Is vehicle equipped with any life saving apparatus? Yes No
 If yes, explain fully _____

10. RISK MANAGEMENT

- a. Who assists client into vehicle? _____
- b. Are all drivers license checked for currency? _____
- c. Are MVRs checked for all drivers? Yes No
- d. Do you keep detailed records of all pick up and deliveries of clients? Yes No
- e. Are drivers trained in proper use of safety devices in vehicles? Yes No
- f. Does your Automobile Liability policy specifically exclude claims arising from loading and unloading of clients? Yes No
- g. Do you allow volunteers to operate any vehicle? Yes No
 If yes, describe fully _____

11. APPLICANT HISTORY (ATTACH DETAILED EXPLANATION FOR ANY "YES" ANSWERS)

Have you or any of your employees:

- a. Ever been the subject of disciplinary or investigatory proceedings or reprimand by an administrative or governmental agency, hospital or professional association? Yes No
- b. Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? Yes No
- c. Ever been treated for alcoholism or drug addiction? Yes No
- d. Ever had any state professional license refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? Yes No
- e. Ever had any insurance company or Lloyd's cancel, decline, refuse to renew or accept only on special terms their malpractice insurance? Yes No

12. INSURANCE AND CLAIM INFORMATION

Do you currently carry the following:

- a. Professional Liability Insurance? Yes No

List the Professional Liability Insurance carried by the firm for each of the past **five** years including periods of no coverage.

Policy Period		Insurance Company	Limit of Liability	Deductible	Policy Form: Claims Made or Occurrence?	Premium
From: MM/DD/YY	To: MM/DD/YY					
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