

**APPLICATION – AMBULANCE  
 DRIVERS & ATTENDANTS  
 General Liability/Professional Liability  
 APPLICATION**

**GENERAL INFORMATION**

1. Named Insured \_\_\_\_\_  
(The name shown first is the first Named Insured and is responsible for premium payment, cancellation, and changes-refer to policy wording.)
2. Mailing Address \_\_\_\_\_  
Street City County State ZIP Code
3. Location of premises:  At mailing address  
 Other \_\_\_\_\_
4. Interest of Named Insured in premises:  Owner  General Lessee  Tenant  Other \_\_\_\_\_
5. Part occupied by Named Insured:  Entire  Portion (\_\_\_\_%)
6. a. Years in Business \_\_\_\_\_ b. Operate as:  Non Profit  For Profit
7. Effective Date Desired \_\_\_\_\_ Term Desired \_\_\_\_\_

8. **PRIOR INSURANCE CARRIER INFORMATION FOR THE PAST THREE YEARS**

Year	Carrier/Policy Number/Premium	Coverage

Has insurance of this type been cancelled, refused, or nonrenewed by any company during the past 3 years?  
 No  Yes - If so, give name of company, date, and reason. \_\_\_\_\_

9. 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
		\$	\$
		\$	\$
		\$	\$

10. Describe safety committee review of claims. \_\_\_\_\_

11. **COVERAGES/LIMITS DESIRED**

<input type="checkbox"/> Premises Operations	\$ _____	Each Occurrence Limit
	\$ _____	General Aggregate
<input type="checkbox"/> Products-Completed Operations	\$ _____	Aggregate
<input type="checkbox"/> Personal Injury	\$ _____	Limit
<input type="checkbox"/> Fire Damage Legal Liability	\$ _____	Limit
<input type="checkbox"/> Medical Payments	\$ _____	Limit
<input type="checkbox"/> Contractual Liability (No Separate Limit)	\$ _____	
<input type="checkbox"/> Professional Liability	\$ _____	Each Occurrence Limit
	\$ _____	Aggregate

Is 24 hour coverage for Good Samaritan Acts desired?  Yes  No

12. Applicant is:  Individual  Partnership  Corporation  Other \_\_\_\_\_
13. Years under current ownership: \_\_\_\_\_
14. Type of service:  Private  Fire Department  Ambulance District  
 City, Township, Village  Public Hospital  Funeral Home  
 County  Private Hospital  Volunteer (not assoc. with above)

**OPERATIONS**

1. Number of units maintained: Operational \_\_\_\_\_ Stand-by \_\_\_\_\_ Total \_\_\_\_\_
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
Emergency (ambulance only)		
Non-Emergency (ambulance only)		
Medical Transport (vans, private passenger vehicles)		
Air Ambulance calls		
<b>TOTAL</b>		

5. What percentage of non-emergency and medical transport calls are wheelchair transport? \_\_\_\_\_
6. What certification is required of staff handling wheelchair calls? \_\_\_\_\_
7. Describe wheelchair tie-down procedures. \_\_\_\_\_

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 8. Are drivers/attendants trained in wheelchair and other tie-down procedures? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Does service provide heavy rescue/extrication?                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you use "Jaws of Life" or similar equipment?                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you provide any over-water operations?                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Does service have special rapid telemetry with the hospital?               | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Is a call report completed on each and every call/run?                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Is a call report completed every time an ambulance is requested?           | <input type="checkbox"/> | <input type="checkbox"/> |

15. How often are your call reports reviewed for completeness, legibility and professional content?  
 \_\_\_\_\_

16. Who reviews these reports? \_\_\_\_\_  
 Name Title

17. Calls are dispatched by:  911  In-house by employees/volunteers  
 Outside source (explain) \_\_\_\_\_

18. 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

19. Are all calls coming into your service tape recorded?  Yes  No  
 If yes, indicate the system being utilized and how long tapes are kept. \_\_\_\_\_

- |  |            |           |
|--|------------|-----------|
|  | <b>Yes</b> | <b>No</b> |
|--|------------|-----------|
20. Do you screen calls to determine whether or not an ambulance will be dispatched?    
*If yes, attach a copy of written procedures.*
21. 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?
22. Is your service involved in fund raising activities?    
 If yes, describe. \_\_\_\_\_
23. Is your service operating under an exception, variance, or probation relating to a provision of license, or applicable state law or code?    
 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 \_\_\_\_\_
- |  |            |           |
|--|------------|-----------|
|  | <b>Yes</b> | <b>No</b> |
|--|------------|-----------|
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?

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

Any person who, with the intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud and subject to fines and/or imprisonment.

Signature of Applicant	Title	Date
Signature of Producing Agent	Date	
Agent Name and Address		

## Public Auto Supplemental Application Social Service and Ambulance

1. What is the primary purpose of your operation and how are these services provided? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

2. Is this operation for  profit or  nonprofit?

3. What are the total number of trips per year? \_\_\_\_\_  
 Of those, what is the number of emergency? \_\_\_\_\_ and non-emergency? \_\_\_\_\_

4. How many of the vehicles have lights and sirens? \_\_\_\_\_

5. Who dispatches your calls?  911  Outside sources  In-house by your own employees or volunteers

6. Do you distribute any medical supplies or equipment?  Yes  No If yes, please provide details:  
 \_\_\_\_\_  
 \_\_\_\_\_

7. Indicate number of individuals who drive and/or provide client care (full-time, part-time, pair or volunteer):

	EMT BASIC	EMT ADVANCED	EMT PARAMEDIC	OTHER	NONE
EMPLOYEES					
VOLUNTEERS					

If "other" marked above, please explain: \_\_\_\_\_

8. Identify the types of special driver training programs that your drivers receive:

- |   |  |
|---|--|
| <input type="checkbox"/> General driver orientation   | <input type="checkbox"/> Defensive driving             |
| <input type="checkbox"/> Primary first aid            | <input type="checkbox"/> Advanced first aid            |
| <input type="checkbox"/> CPR                          | <input type="checkbox"/> Passenger assistance training |
| <input type="checkbox"/> Human relations skills       | <input type="checkbox"/> Nonmedical emergency training |
| <input type="checkbox"/> Emergency vehicle evacuation |  |

9. What are your criteria for driver selection? \_\_\_\_\_  
 \_\_\_\_\_

10. What safety procedures are in place? \_\_\_\_\_  
 \_\_\_\_\_

11. Do you have specific wheelchair tie-down procedures and what are they? \_\_\_\_\_  
 \_\_\_\_\_

12. Is there an accident review procedure?  Yes  No If yes, briefly describe: \_\_\_\_\_  
 \_\_\_\_\_

13. What type of vehicle maintenance is there? \_\_\_\_\_  
 \_\_\_\_\_

14. Do you have professional coverage?  Yes  No Policy #: \_\_\_\_\_ Term: \_\_\_\_\_  
Name of carrier: \_\_\_\_\_

15. Has this service ever operated under another name?  Yes  No If yes, what name: \_\_\_\_\_

16. Are all vehicles owned by you?  Yes  No If no, who owns them? \_\_\_\_\_  
Are they leased, etc.?  Yes  No Give details: \_\_\_\_\_

17. Do employees use their own vehicles in your business?  Yes  No If yes, describe how often and if they transport clients: \_\_\_\_\_

18. Any other pertinent information about your business: \_\_\_\_\_

APPLICANT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_