Application for medical transportation services

1. Complete Legal 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

Contact name:

Title

Phone Website address Fax

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

2. In what state is the applicant domiciled?

3. In what state(s) do you operate?

4. Are any services provided outside of the United States? Yes No

If "Yes," please explain, including what countries, what types of services are provided and what percentage of your revenues are derived from these services:

5. Applicant is:

a. Individual Partnership Corporation

Professional association Other:

b. Not-for-profit For-profit Both

c. Public Ambulance service—city or county owned Fire dept./rescue squad Hospital owned

6. Is the company accredited? Yes No

If yes, by whom?

7. Is the firm engaged in, owned by, associated with or controlled by any other business? Yes No

If yes, give details: (Use an additional sheet of paper if necessary)

8. Date established

9. Does the applicant own (wholly or in part), operate or administer any other business or other institution where medical services are customarily rendered? Yes No

10. Limits of liability desired for professional liability:

$1,000,000/$1,000,000 $1,000,000/$2,000,000 $1,000,000/$3,000,000

Deductible desired:

$2,500 $5,000 $10,000 $25,000 $50,000 Other:

Maximum and minimum deductibles will be subject to underwriting approval.

11. Effective date desired:

Please include Resumes and/or CV's for all key personnel, Principals, Executives, and/or Administrators with your submission.

12. Does the applicant anticipate any expansions within the next year? Yes No

If yes, please describe:

13. Professional activities and specialty

Check All Services Provided	Percentage of Total Call Volume
BLS (Basic Life Support)	%
ALS (Advanced Life Support)	%
First Responder	%
Ambulet (wheelchair) Service	%
Wheelchair Transports	%
Ambulatory—sedan	%
Air Ambulance operations*	%
Special Event EMS	%
Water rescue/offshore operations*	%
Other(describe):	

*If you indicated a percentage for these, please advise if your company owns or leases any airplanes, helicopters, boats or other air/water transportation vehicles? Yes No

If "Yes," describe number and type:

14. Radius of operation:
    - 0—25 miles %
    - 25—50 miles %
    - over 50 miles %
    - over 100 miles %

15. Total number of:
    - Ambulances
    - Wheelchair vans w/lifts
    - Van w/out lifts
    - Private passenger
    - Other

16. Total number of calls per year:
    - 911 %
    - Emergency %
    - Non-Emergency %
    - Non-Medical %
    - (Please describe types of destinations):

17. Does the company contract services, personnel, and/or vehicles to other transportation companies/providers on an independent contractor basis? Yes No
    If “Yes,” please describe:

18.
    a. Gross annual revenues
    b. Percentage of gross revenues from your largest client?

19. Population of Area Served
    Types of entities served by percentage of total calls:
    - Nursing homes %
    - Physicians offices %
    - Clinics (MH/MR) %
    - Countries %
    - Psychiatric hospitals %
    - Medical hospitals %
    - Rehabilitation %
    - Other
    - Please describe:

*If Psychiatric patients are transported, does the company have a written patient handling policy? Yes No

20. Have you ever been cited or investigated for a violation of a local, state or federal regulation? Yes No
    If "yes", please explain:

21. Number of Employees, Contractors, and Volunteers by type:

Type	Employee		Independent Contractor		Volunteer	
	Full Time	Part Time	Full Time	Part Time	Full Time	Part Time
EMT's						
Paramedics						
Nurses						
Emergency Medical Responder						
Basic Life Support						
Basic First Aid						
Clerical						
WC Van Drivers						
Dispatchers						
Other (describe): _____						
Total						

22. Are all the above individuals licensed in accordance with applicable state and federal regulations? Yes No
    If "No," attach an explanation.

23. Are any EMT's or Paramedics trained in specialized services? Yes No
    If "Yes," please describe:

24. Who dispatches your calls? 911 In-house by your own employees/volunteers Outside sources
    a. If outside, please describe
    b. If In-house, is previous dispatching experience required?

Hiring practices

Do you:

1. Check Driving records upon hire? Yes No
2. Require signed applications on all prospective employees? Yes No
   Please include a copy of your employment application with this submission.
3. Verify all professional qualifications, licenses and certifications? Yes No
4. Conduct a personal interview with prospective employees and non-employees (Contractors & Volunteers)? Yes No
5. Require professional and personal references on each employee? Yes No
6. Conduct a Criminal Background Check on each employee? Yes No

7. Provide training and orientation for new employees?	Yes	No
8. Verify any pending license/certification suspensions or revocations or any pending disciplinary actions by other facilities?	Yes	No
9. Ask if there have been any professional liability or work-related claims made against the applicant in the past?	Yes	No
10. Have written job descriptions?	Yes	No
11. Require drug/alcohol screening?	Yes	No
	Yes	No

Internal procedures

Do you:

1. Review reported incidents with the personnel involved?	Yes	No
2. Impose consequences on personnel for at fault incidents?	Yes	No
3. Require signed release forms from patients refusing treatment?	Yes	No
4. Monitor certificates and continuing education?	Yes	No
5. Routinely monitor reporting/charting?	Yes	No
6. Use a standard incident reporting form?	Yes	No
7. Keep medical records along with the standard incident reporting form?	Yes	No

Risk management/loss control

Do you:

1. Have a formal Safety/Loss Control Program?	Yes	No
2. Conduct routine checks on medication inventories?	Yes	No
3. Check motor vehicle records annually?	Yes	No
4. Have qualified personnel inspect and maintain the equipment/supplies on a regular basis?	Yes	No
5. Practice universal precautions?	Yes	No
6. Perform random drug/alcohol screening?	Yes	No
7. Require continuing education for your employees?	Yes	No
8. Have written procedures for safe patient handling?	Yes	No
9. Have all emergency vehicles equipped with the first aid supplies per state mandate?	Yes	No
10. Have a written procedure for proper disposal of contaminated medical waste?	Yes	No

General liability

28. Is coverage for general liability desired? Yes No

If you answered "Yes," please answer questions a. through h.

If you answered "No," please skip to question 42.

a. Complete the following for any owned or leased premises (use a separate sheet of paper if needed):

Location Address	Occupancy	Square Footage
	Owned Leased	
	Owned Leased	
	Owned Leased	

b. Are you required to name your landlord or any other business as an additional insured?

Yes No

(If "Yes," please list name and address of each and state type of interest. Use separate sheet if needed.)

Name	Address	Interest

c. Do you supply or sell any medical supplies or equipment to patients or clients Yes No

d. Have any operations been sold, acquired or discontinued in the past five (5) years? Yes No

e. Is machinery, equipment or vehicles loaned or rented to others? Yes No

29. Fleet information

a. Does your company have a formal maintenance program for your vehicles? Yes No

b. Do drivers inspect vehicles prior to their shift? Yes No

c. Describe the maintenance of your vehicles: Yes No

d. Total number of vehicles in fleet per policy year for past five (5) years:

Current Year	**Last Year**	**Third Year**	**Fourth Year**	**Fifth Year**

e. Does your company have an in-house Driver Training Program? Yes No

f. Does your state require driver training for EMT or Paramedic Certification? Yes No
If "Yes," how often?

g. Are drivers trained on wheelchair patient restraint? Yes No
If "Yes," please describe:

h. Do you allow passengers in vehicles that are not patients or employees? Yes No
If "Yes," who do you allow and under what circumstances?

Insurance and claim information

30. Do you currently carry Professional Liability Insurance? Yes No

List the Professional Liability Insurance carried by the firm for each of the past five (5) years including the current year and include periods of no coverage.

Policy Period		Insurance Company	Limit Of Liability	Deductible	Claims Made or Occurrence	Premium
From MM/DD/YY	To MM/DD/YY					
/ /	/ /					
/ /	/ /					
/ /	/ /					

If coverage is Claims Made, what is the Retroactive Date/Prior Acts Date on your current policy?

31. Do you currently carry General Liability Insurance? Yes No

If "Yes," please list the Commercial General Liability Insurance currently carried by the firm:

Policy Period		Insurance Company	Limit Of Liability	Deductible	Claims Made or Occurrence	Premium
From MM/DD/YY	To MM/DD/YY					
/ /	/ /					
/ /	/ /					
/ /	/ /					

If coverage is Claims Made, what is the Retroactive Date/Prior Acts Date on your current policy?

32. Do you maintain Commercial Automobile Insurance Coverage? Yes No

If "No," explain:

If "Yes," please list the Commercial Automobile Insurance carrier information:

Policy Period		Insurance Company	Limit Of Liability	Deductible	Claims Made or Occurrence	Premium
From MM/DD/YY	To MM/DD/YY					
/ /	/ /					

33. Claims history

a. Have there been any Professional Liability claims or incidents, or General Liability claims or incidents made against you, any employee or former employee, the Applicant or anyone proposed for this insurance, in the last five (5) years? Yes No

If "Yes," how many?

If "Yes," please complete a Claim/Circumstances Supplement for each.

b. Are you or anyone proposed for this insurance aware of any facts or circumstances which might give rise to a Professional Liability claim or complaint or a General Liability claim or complaint? Yes No

If "Yes," how many?

If "Yes," please complete a Claim/Circumstances Supplement for each.

c. Are you or anyone proposed for this insurance aware of any charges, inquiries, investigations, grievances, or other administrative hearings in the last five (5) years or currently? Yes No

If "Yes," how many?

If "Yes" to any, please complete a Claim/Circumstances/Administrative Hearings Supplement for each.

d. Was prior Professional Liability coverage or General Liability coverage ever cancelled or nonrenewed? (other than being nonrenewed due to the carrier no longer writing coverages) (not applicable to Missouri applicants) Yes No

If "Yes," please explain the reason for nonrenewal or cancellation:

Note: the applicant understands and agrees that if any facts, incidents or circumstances exist which may reasonably give rise to a claim under this proposed policy, then any claims arising from such facts, incidents or circumstances are excluded from coverage.

The following information must be included with your submission:

1. Most current financial statement
2. Currently valued loss runs for the past five years
3. Fully completed claim supplements for all claims in the past five (5) years
4. Resumes/cv's for key personnel, principals, executives, medical directors and/or admin-istrators
5. Evidence of retroactive date
6. Copy of a sample client contract

Signature section and other information

Note: please recheck all answers and sign below. Coverage cannot be bound without signature or if this application is incomplete.

The undersigned represents to the best of his or her belief and knowledge, after reason-able inquiry and due diligence, the statements set forth in this application and any supple-ments thereto are true and correct.

The undersigned declares that any claim, incident or circumstance taking place prior to the effective date of the insurance applied for will immediately be reported in writing to the insurer. As a result, the insurer may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance.

The signing of this application does not bind the undersigned to purchase the insurance, nor does the review of this application bind the insurance company to issue a policy.

The applicant understands and agrees this application and any supplements thereto shall be incorporated into any policy that may be issued and the underwriters are relying on the truth of the statements set forth herein in making a determination to issue any policy. The applicant also understands and agrees this application for coverage does not mean any requested coverages, limits or deductibles shall be granted; in fact, underwriters must agree to any requests whether in the application or otherwise.

The undersigned individual represents he or she is duly authorized and empowered to make this application, including the representation, on behalf of the applicant or any individual who may seek coverage under any binder or insurance policy issued in reliance hereon.

Fraud warning: 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.

Applicable in the state of new york: 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 mislead-ing, information containing any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thou-sand dollars and the stated value of the claim for each such violation.

Name of applicant:			
Signature and Title of Principal (must be owner, partner or officer):		**Date:**	
Dated:			