

**ALLIED MEDICAL AMBULANCE/NON-EMERGENCY TRANSPORT
SUPPLEMENTAL APPLICATION**
SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION

GENERAL INFORMATION:

1. Number of volunteer members: _____ Number of Paid members: _____
 Population of area served: _____ Radius of operation (mi.): _____
2. Is your service involved in:
- | | |
|---|--|
| Air Ambulance Operations | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Water Rescue Operations | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Off-shore EMS | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Activities or Operations other than EMS | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Special Event EMS | <input type="checkbox"/> No <input type="checkbox"/> Yes |

If "Yes," to any of the above, provide details: _____

Number of:		<i>Number of hours of annual training for each:</i>
EMTS – A		
EMTS – P		
Nurses		
Other		

Number of:		Number of:	
EMTS		Non-emergency Calls	
Paramedics		Ambulances	
Emergency Calls		Vans	
		Air Ambulance	

3. Do you administer any anesthesia? No Yes
4. Any physician, nurse practitioner or CRNA exposure? No Yes
 Please provide number _____ and explain duties: _____
5. Do you contract your services to others on an independent contractor basis? No Yes
6. If "Yes," please advise to whom you contract your work: _____

7. Name of your Auto Liability Insurance Carrier for the upcoming policy year? _____

- a. Does your Auto Liability policy specifically exclude claims arising from loading and unloading of patients? No Yes
- b. Does your Auto Liability policy remain silent on the applicability of coverage for claims arising from loading and unloading of patients? No Yes
- c. If "No," please explain: _____

* 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, may be committing a fraudulent insurance act, and may be subject to a civil penalty or fine.
* not applicable in all states

DECLARATION AND SIGNATURE:

The undersigned declares that to the best of his/her knowledge the statements in this application and its attachments are true. The company is hereby authorized to make any investigation and inquiry deemed necessary in regard to this application.

Applicant's Signature

Sub-Producer

Title/Date

Producer

SIGNING THIS FORM DOES NOT BIND THE APPLICANT OR THE COMPANY OR THE UNDERWRITING MANAGER TO COMPANY THE INSURANCE. Application MUST be currently signed, completed and dated to be considered for quotation.

ALLIED MEDICAL GENERAL APPLICATION

I. APPLICANT INFORMATION

1. Desired Effective Date: _____
2. Applicant Name: _____
3. Mailing Address: _____
4. City, State, Zip: _____
5. County: _____ 6. Telephone Number: _____
7. Inspection Contact: _____ 8. Website Address: _____
9. Date Established: _____ 10. Years in Business Under Current Management: _____
11. Type of Enterprise: Corporation Individual Partnership Joint Venture
 Municipality In-Patient -Psychiatric
 Other (describe): _____
12. Enterprise is: For Profit Not For Profit
13. Estimated receipts/operating budget for the next twelve (12) months: _____
14. Estimated payroll for the next twelve (12) months: _____
15. Type of Operation: Mental Health Inpatient Group Home (Non-Elderly)
 Prison/Jail Boot Camp Lock-down Facility Shelters/Halfway House
 Alcohol/Drug Detox. Alcohol/Drug Inpatient Apartments Foster Care (children)
 Independent Living (Elderly) Assisted Living Facility
 Other (describe): _____
16. Full description of services rendered: _____

II. CURRENT INSURANCE

This section must be completed for prior acts consideration. Attach a copy of expiring policy declarations page.

1. a. Has Applicant had previous insurance for this enterprise? Yes No
- b. If Yes, complete the following for prior three (3) years of general/professional liability coverage:

Name of Carrier	Effective Date	Expiration Date	Limit	Deductible	Premium	Claims Made (CM) or Occurrence?	CM Retroactive Date

III. CLAIMS ACTIVITY AND INCIDENT REPORTING PROCEDURES

1. Claims and Incident Activity

Important Notice: All known claims and/or incidents that could reasonably result in a claim are specifically excluded from coverage. Report all such claims or incidents to your current insurer. Your failure to disclose any claim, or incident that could reasonably result in a claim, may result in the proposed insurance being void and/or subject to rescission.

- a. Claims Activity - Please list all claims that have been presented to you or to your past or your current insurer during the past five years. Please continue on a separate sheet of paper if necessary.

Date of Loss	Current Reserve or Paid Amount	Description of Loss	Insurer

- b. Incident Activity - Please outline the details below regarding any of the following incidents that have taken place at any of your facilities for which coverage is being requested, but where such incidents have not been reported to any insurer:

- Death of a client, patient or resident from other than natural causes;
- Injury to a client, patient or resident that required hospitalization;
- Incident involving abuse, molestation, sexual assault, rape or improper contact;
- Incident that generated a formal complaint or notice from any federal or state regulatory body;
- Injury resulting from an elopement or unauthorized absence of a client, patient or resident;
- Improper medication or improper dosage resulting in hospitalization; or
- Decubitus ulcer(s) first acquired under your care that have reached Stage IV.

- 1) Are there any other known incidents that could reasonably be expected to result in a claim against the Applicant? Yes No
- 2) Have all known incidents that could reasonably be expected to result in a claim been reported to your current or prior insurer? Yes No

2. Risk Management Protocols

- a. Are there procedures in place requiring the documentation of all incidents in a written report? Yes No
- b. Who is responsible for receiving and recording information relating to incidents and reporting them to your insurer?

Name: _____ Title: _____

3. Other

a. Has any license or accreditation ever been suspended, denied or revoked? Yes No

b. Please list all professional association(s) in which the Applicant is a member in good standing:

c. Has the Applicant ever had its professional liability insurance policy cancelled or non-renewed? Yes No

d. If Yes, please explain: _____

IV. OPERATIONS

1. Indicate current staffing levels:

Staff	Employed		Contracted	
	Full Time	Part Time	Full Time	Part Time
Administrators				
MD/Physicians				
Nurses				
Homemakers/Nurse Aids				
Psychologists				
Counselors				
Therapists				
Students or volunteers				
Other (describe): _____				

2. Check the hiring procedures that apply or are performed by this operation:

- Criminal Background Checks Verification of certification or professional licensing
 Drug, alcohol and sexual abuse screening or testing Reference Checks
 Questioning of employees in their previous involvement as defendants in professional malpractice litigation

3. **Schedule of Physicians** – on Staff or Contracted:

Name & Specialty	Board Certified	Board Eligible	Hours/Week Worked	Volunteer, Contracted or Employed	Has Malpractice Insurance
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

4. List the duties of the physician(s) in 3. above: _____

5. Do you want any listed physician to be covered under the facility's policy? Yes No

6. a. Are any drugs or medications administered or prescribed? Yes No

b. If Yes, please explain: _____

V. LOCATION INFORMATION

1. **Schedule of Locations:** If more than five locations, please attach a separate sheet of locations.

	Address	Types of Services Provided
# 1		
# 2		
# 3		
# 4		
# 5		

2. a. Are there any camp, adventure/wilderness, ropes courses or any type of recreational programs? Yes No
- b. If Yes, please submit brochure or describe activities: _____
3. a. Are there any firearms on the premises? Yes No
- b. If Yes, please describe: _____
- c. Are the firearms locked in a secure place away from the residents? Yes No
- d. If No, please describe: _____
4. a. Are there any animal exposures on the premises? Yes No b. If Yes, are the animal exposures: Owned? Non-owned?
- c. If Yes, please describe, including number of animals and type/breed: _____
5. a. Are there any lakes, ponds, rivers, pools or other bodies of water on the premises? Yes No
- b. If Yes, please describe: _____
- c. Are there any swimming or boating activities? Yes No
- d. If there is a pool or body of water, then is it fenced with a self-locking gate? Yes No
- e. If there is a pool or body of water, then is there a diving board and/or slide? Yes No

VI. COVERAGE REQUESTED

1. Complete and attach the appropriate supplemental application with your submission.
2. Check the coverages and limits that the Applicant would like quoted:
- a. Coverages: GL Professional Excess (Attach Acord App)
- b. Limits: \$100,000/\$100,000 \$300,000/\$300,000 \$500,000/\$500,000
 \$1,000,000/\$1,000,000 \$1,000,000/\$2,000,000 \$1,000,000/\$3,000,000
3. a. Do you want physical abuse/sexual molestation coverage to protect you for alleged acts of your employees? Yes No
- b. If Yes, at what limits? \$25,000/\$50,000 \$50,000/\$100,000 \$100,000/\$300,000
 \$250,000/\$250,000 \$500,000/\$500,000 Other: _____

Please attach a copy of the following with your submission:

Five (5) years of currently dated loss runs (if in business less than five (5) years, please attach a resume of the owner/director)

Brochure(s) available or other information pertaining to the programs offered

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* Not applicable in all states

WARRANTY STATEMENT AND SIGNATURE:

The undersigned authorized officer of the Applicant declares that the statements set forth herein are the result of said officer's inquiry and, as such, are true, accurate and complete. The undersigned authorized officer agrees that if the information supplied on the application changes between the date the application is signed and the effective date of the insurance that is the subject of this application, such officer will immediately notify us of such changes and we may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance. Signing this application does not bind the Applicant to purchase, or us to issue, any insurance policy.

Authorized Signature on behalf of Applicant

Sub-Producer

Title/Date

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