APPLICATION FOR EMERGENCY MEDICAL TECHNICIANS

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: _____ Web site Address: _____ Fax: _____

   FEIN: _____ Owner On Site? ..... ❑ Yes ❑ No

   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

   If "Yes," give details: _____

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: _____

12. Please list the individual shareholders or partners of the facility: _____

_____

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

13. Name of Medical Director, if any: _____

Please include Resumes and/or CV's for all Medical Directors with your submission.

Is coverage provided for the Medical Director under any other insurance policy? .....❑ Yes ❑ No

If "Yes," please provide proof of Medical Malpractice/Professional Liability Insurance.

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

If "Yes," please describe: _____

_____

15. 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: _____

16. Radius of Operation:

☐ 0—25 miles ..... _____%

☐ 25—50 miles ..... _____%

☐ over 50 miles ..... _____%

☐ over 100 miles ..... _____%

17. Total number of ambulances: _____ wheelchair vans w/lifts: _____

vans w/out lifts: _____ Private Passenger: _____ Other: _____

18. Total number of calls per year: _____

What percentage of total calls are:

- ❑ 911 ..... _____%
- ❑ Emergency ..... _____%
- ❑ Non-Emergency ..... _____ %
- ❑ Non-Medical ..... _____ %

(Please describe types of destinations): _____

_____

19. 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: _____

20. a. Gross annual revenues: _____

b. Percentage of gross revenues from your largest client? ..... _____%

Please include with your submission, a copy of your contract with this (your largest) client.

21. Do you have a positive net worth? .....❑ Yes ❑ No

22. Do you have sufficient working capital? .....❑ Yes ❑ No

23. State percentage of revenues derived from:

Source	Percentage Last Policy Year	Estimated Percentage for Current Year
A. Charitable Contributions	%	%
B. Government Funding	%	%
C. Fee For Service	%	%
D. Other: _____	%	%

Please include a copy of your most current financial statement with your submission.

24. Population of Area Served: _____

Types of Entities served by Percentage of Total Calls:

- ❑ Nursing Homes ..... _____%
- ❑ Physicians Offices ..... _____%
- ❑ Clinics (MH/MR) ..... _____%
- ❑ Counties ..... _____%
- ❑ Psychiatric Hospitals* ..... _____%
- ❑ Medical Hospitals ..... _____%
- ❑ Rehabilitation ..... _____%
- ❑ Other ..... _____%

Please describe: _____

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

If "Yes,"' please attach a copy.

25. List any local, state or federal entities that inspect your operations: _____

How often are inspections held? _____

Please include a copy of your company's latest inspection report.

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

27. 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						
Clerical						
WC Van Drivers						
Dispatchers						
Other (describe): _____						
Total						

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

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

30. Is anesthesia used?.....❑ Yes ❑ No
If "Yes," please answer a. through d. below:
    a. Type of anesthesia used: _____
    b. Who administers? _____
    c. What monitoring equipment is used for administration? _____
    d. Is there crash cart equipment on board the transport unit? .....❑ Yes ❑ No

31. Indicate the number of hours your employees/contractors/volunteers:
    a. work per shift: _____
    b. are off duty between shifts: _____

32. Do your employees work more than one shift per day? .....❑ Yes ❑ No

33. 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? .....❑ Yes ❑ No

34. Does your company provide dispatch service to others? .....❑ Yes ❑ No

35. Are incoming calls taped? .....❑ Yes ❑ No

36. Is a call report completed on every call, and every time an ambulance is requested? .....❑ Yes ❑ No

37. How often are your call reports reviewed for completeness, legibility and professional content? _____

38. **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. Perform pre-employment physicals? ..... ❑ Yes ❑ No
9. Verify any pending license/certification suspensions or revocations or any pending disciplinary actions by other facilities? ..... ❑ Yes ❑ No
10. Ask if there have been any professional liability or work-related claims made against the applicant in the past? ..... ❑ Yes ❑ No
11. Have written job descriptions? ..... ❑ Yes ❑ No
12. Require drug/alcohol screening? ..... ❑ Yes ❑ No

39. **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

   If "Yes," please include a copy with this submission.
7. Keep medical records along with the standard incident reporting form? ..... ❑ Yes ❑ No

40. **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

41. 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. Do you sponsor any sporting/social events? ..... ❑ Yes ❑ No

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

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

g. Where are vehicles stored when not in use? _____

h. Do you perform any other activities or services for which you have other coverage or do not require coverage under this policy? ..... ❑ Yes ❑ No

If "Yes," please describe: _____

42. 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: _____

d. Is service performed by your own mechanic? ..... ❑ Yes ❑ No

If "No," please provide the name of the entity which provides service: _____

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

Current Year	Last Year	Third Year	Fourth Year	Fifth Year

f. Does your company utilize any fifteen (15) passenger vans? ..... ❑ Yes ❑ No

If "Yes," is instruction in rollover hazards and avoidance techniques given to drivers? ..... ❑ Yes ❑ No

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

If "Yes," what is the course name? _____

If "Yes," provide:

1) Copies of any training manual
2) Qualifications of your instructor

If "No," do you use other Driver Training Programs (i.e. EVOC, JEMS)? ..... ❑ Yes ❑ No

If "Yes," list name(s) of courses used: _____

_____

_____

_____

_____

_____

_____

h. How often are employees required to take the course? _____

i. Does your state require driver training for EMT or Paramedic Certification? .....❑ Yes ❑ No

If "Yes," how often? _____

j. Are drivers trained on wheelchair patient restraint? .....❑ Yes ❑ No

If "Yes," please describe: _____

k. 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

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

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

If coverage was Claims Made, was tail coverage purchased under the previous policy? .....❑ Yes ❑ No

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

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

If coverage was Claims Made, was tail coverage purchased under the previous policy? .....❑ Yes ❑ No

45. Has any procedure, service or person been self-insured or excluded from any previous policy? .....❑ Yes ❑ No

If "Yes," please describe: _____

Please provide currently valued loss runs for the past five (5) years from the above insurance carriers.

46. **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 <u>each</u>.

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 <u>each</u>.

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 <u>each</u>.

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.

<u>The following information must be included with your submission:</u>

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 ALL KEY PERSONNEL, PRINCIPALS, EXECUTIVES, MEDICAL DIRECTORS AND/OR ADMINISTRATORS**
5. **PROOF OF MEDICAL MALPRACTICE/PROFESSIONAL INSURANCE FOR ANY EMPLOYEES OR CONTRACTORS WHO MAINTAIN THEIR OWN COVERAGE**
6. **COPY OF A SAMPLE CLIENT CONTRACT**

<u>Please include any of the following information with your submission which may apply:</u>

1. **COPY OF YOUR EMPLOYMENT APPLICATION**
2. **COPY OF ANY ADVERTISING BROCHURES OR ADVERTISEMENTS**
3. **YOUR COMPANY'S LATEST INSPECTION REPORT**
4. **COPY OF YOUR WRITTEN PATIENT HANDLING POLICY**
5. **COPY OF YOUR STANDARD INCIDENT REPORTING FORM**
6. **COPY(IES) OF ANY IN-HOUSE DRIVER TRAINING PROGRAM MANUALS AND INSTRUCTOR'S QUALIFICATIONS**

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 REASONABLE INQUIRY AND DUE DILIGENCE, THE STATEMENTS SET FORTH IN THIS APPLICATION AND ANY SUPPLEMENTS 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 MISLEADING, 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 THOUSAND 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

_____

Print Name and Title of Principal Signing Above