

AMBULANCE EMERGENCY/NON-EMERGENCY PROFESSIONAL LIABILITY APPLICATION and GENERAL LIABILITY APPLICATION (CLAIMS MADE AND REPORTED COVERAGE)

SECTION I – GENERAL INFORMATION

1) Name of Applicant:

2) Address:

3) Website:

4) Phone Number:

5) Applicant is:

Private for-profit ambulance service (not Hospital based)

Public Ambulance service (city or county owned)

Non-profit ambulance service

Hospital owned ambulance service

Fire Department/Rescue Squad

Other (Specify):

6) Date service was established (mm/dd/yy):

7) FEIN:

8) Has your service had any change in ownership over the last three (3) years?

Yes No

If Yes, explain:

SECTION II – OPERATIONS

9) Total Calls and Transports:

| | This Year | Last Year | Next Year |
|--|-----------|-----------|-----------|
| Air Ambulance: Emergency Transports | | | |
| Air Ambulance: Non-Emergency Transports | | | |
| Ground Ambulance: Emergency Transports | | | |
| Ground Ambulance: Non-Emergency Transports | | | |

Vehicle Units:

10) Gross Annual Receipts/Revenue:

This Year \$

Last Year \$

Next Year \$

11) Check any of the following which your service performs: (If none, check here)

Mast Trousers EQA IV therapy/monitoring

Drug Therapy Intubation Defibrillation

12) Do you employ or contract the services of a Medical Director? Yes No

If Yes, provide resume as attachment to this application.

SECTION III – STAFF

13) Number of Staff:

| | Employed | Contracted | Volunteer |
|-------------------------|----------|------------|-----------|
| Administrator | | | |
| EMT (basic) | | | |
| EMT (advanced) | | | |
| EMT Paramedic | | | |
| Dispatchers | | | |
| Administration/Clerical | | | |
| Other: | | | |
| Total: | | | |

14) Do you require:

Pre-employment physical exams Periodic physical exams

15) Are all technicians state/nationally certified prior to patient care? Yes No

16) Are records maintained as to the certification status of all technicians? Yes No

17) Are records monitored to ensure technicians are in compliance with certification requirements? Yes No

If Yes, are these records checked:

Annually Bi-annually Monthly

Who is responsible for monitoring?

18) Do you employ or contract nurses or physicians for critical care transportation or other medical services? Yes No

If Yes, explain transports/services and include individual professional application for nurse/physician by separate attachment:

If the nurses or physicians are independent contractors what limits of professional liability do you require that they maintain? \$

Do you record certificates for your records? Yes No

Do you verify that all nurses and physicians are currently state licensed? Yes No

19) Who dispatches your calls?

911 In-house by your own employees Outside Service

a. If Outside service, attach a copy of your contract with the provider.

b. If In-house:

What are the minimal education requirements for hire?

High School Some College College Graduate

Do you provide in-house training? Yes No

Minimum hours for training:

Are dispatchers trained in Pre-arrival instruction or CPR/First Aid? Yes No

c. Is a standard call report completed for every call? Yes No

d. Who reviews the standard call reports for completeness, legibility and content?

e. When are these reviews completed?

Daily Weekly Monthly

f. How many shifts do you run?

Hours per shift?

g. When an ambulance is dispatched, how many EMT/Paramedics accompany the driver?

h. Are all emergency vehicles equipped with the first aid supplies and medical equipment mandated by state regulations? Yes No

i. Are you involved in any of the following:

Special Event/Sports EMS

Offshore EMS or Water Rescue

Air Ambulance

Activities other than EMS

20) What is the radius of your operations:

0-50 miles 50-100 miles Over 100 miles

21) What is the estimated population of the area you service?

22) How often is a condition and supply report completed on each ambulance?

By run By Shift Daily

23) Is there a written standard operation manual provided by employees? Yes No

Does this manual include specifics on medical waste disposal/containment? Yes No

24) Are MVR's checked for all drivers? Yes No

Are they checked: Bi-annually Annually

SECTION IV – COVERAGE HISTORY

PROVIDE 5 YEARS OF CURRENTLY VALUED LOSS RUNS.

25) Have you maintained continuous coverage for Professional Liability? Yes No

26) Provide Professional Liability policy information for the last five (5) years (if no current Professional Liability insurance is in place, check here NONE):

| Carrier | Limit | Deductible | Premium | Expiration (MM/DD/YYYY) |
|---------|-------|------------|---------|----------------------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

27) Provide General Liability policy information for the last one (1) year (if no current Professional Liability insurance is in place, check here NONE):

| Carrier | Limit | Deductible | Premium | Expiration (MM/DD/YYYY) |
|---------|-------|------------|---------|----------------------------|
| | | | | |

28) Provide Automobile Liability policy information for the last one (1) year (if no current Professional Liability insurance is in place, check here NONE):

| Carrier | Limit | Deductible | Premium | Expiration (MM/DD/YYYY) |
|---------|-------|------------|---------|----------------------------|
| | | | | |

29) Has any insurer cancelled/refused to renew any insurance coverage during the last five (5) years? Yes No

If Yes, provide details on a separate attachment.

30) Has any professional liability claim or suit been made against you, any predecessor in business or against any past or present partner/officer(s)? Yes No

If Yes, complete the [Supplemental Claim Information Form](#) for each and every claim.

31) Are you aware of any circumstances or incidents which may result in any claim against you? Yes No
If Yes, provide details on a separate attachment.

32) Are you interested in a quote for General Liability? Yes No

If Yes, complete the General Liability Supplemental Application below.

GENERAL LIABILITY SUPPLEMENTAL APPLICATION

SECTION I – YOUR LOCATIONS

IF YOU HAVE MORE THAN FIVE (5) LOCATIONS, PROVIDE A SPREADSHEET WITH THE INFORMATION BELOW FOR EACH LOCATION.

1)

| Loc # | Facility Name | Address | Description / Use | Square Footage |
|-------|---------------|---------|-------------------|----------------|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |

| | Location 1 | Location 2 | Location 3 | Location 4 | Location 5 |
|-----------------------------------|--------------|--------------|--------------|--------------|--------------|
| Own or Lease | Own Lease | Own Lease | Own Lease | Own Lease | Own Lease |
| % occupied by applicant | % | % | % | % | % |
| Are there other occupants? | Yes No | Yes No | Yes No | Yes No | Yes No |
| # of beds / units (if applicable) | | | | | |

SECTION II – MAINTENANCE

2) Does the Applicant have a full-time maintenance staff? Yes No

Confirm the type of maintenance, service and repair performed by the Applicant (Direct) or subcontracted (Subbed) by completing the table below.

NOTE: Direct is a percentage of total direct payroll and Subbed is a percentage of total subcontractor cost.

| Type | Direct | Subbed |
|-------------------------------|--------|--------|
| Snow & Ice Removal | % | % |
| Janitorial/Cleaning Services | % | % |
| General Maintenance & Repairs | % | % |
| Landscaping | % | % |
| Other: | % | % |

3) Does the Applicant have written procedures for routine inspections of the premises to identify and address potential liability hazards? Yes No

If Yes, are records of the completed inspections and repairs retained for at least five years? Yes No

4) Are there any construction projects planned for the upcoming policy term? Yes No

If Yes, provide full details of project, location, total costs, payroll and sub costs:

a. Will the construction be subbed out? Yes No

b. Are signs clearly posted to warn the third party of construction and/or during routine Maintenance? Yes No

SECTION III – FIRE-LIFE SAFETY INFORMATION

5) Are all of your locations equipped with:

- | | | |
|---|-----|----|
| a. Complete sprinkler system? | Yes | No |
| b. At least two clearly marked exits on each floor? | Yes | No |
| c. Smoke detectors? | Yes | No |
| d. Emergency electrical system? | Yes | No |
| e. Heat sensors? | Yes | No |
| f. Fire escape(s)? | Yes | No |
| g. Posted emergency evacuation procedures? | Yes | No |
| h. Properly maintained fire extinguishers? | Yes | No |

Attach a separate sheet detailing any No answers.

SECTION IV – OTHER PREMISES EXPOSURES

6) Are any of the following provided:

- | | | |
|--|-----|----|
| a. Sale of any food or drinks? | Yes | No |
| b. Recreational facilities? | Yes | No |
| c. Gym or exercise equipment available to members or the public? | Yes | No |
| d. Swimming pool on any premises? | Yes | No |
| e. Daycare or childcare services? | Yes | No |
| f. Sponsor any sporting or social events? | Yes | No |
| g. Hold any fundraising events? | Yes | No |
| h. Provide alcohol with any of your events or services? | Yes | No |
| i. Participation in trade shows, exhibits or conventions? | Yes | No |
| j. Any plans for new construction or renovations during the next twelve (12) months? | Yes | No |

Attach a separate sheet detailing any Yes answers.

SECTION V – PRODUCTS AND EQUIPMENT SOLD OR LEASED

7) Do you loan, lease or rent equipment to others?

Yes No

- a. Annual gross revenue for equipment rental \$
- b. With or without operator (technician)? With Without
Provide details:

- c. Who is responsible for equipment maintenance?

- 8) Do you sell durable medical equipment? Yes No
If Yes, complete the following table for Medical Equipment Suppliers Revenue:

| | Annual Sales | Annual Lease/Rental |
|---|--------------|---------------------|
| Category I: Expendable Items (i.e. adhesive tape, bandages, hypodermic needles) | \$ | \$ |
| Category II: Non-Expendable Items (i.e. hospital beds, bathroom safety bars, canes, walkers, wheelchairs, crutches, IV stands, etc.) | \$ | \$ |
| Category III: Diagnostic or Treatment Devices (i.e. oxygen, IV pumps, blood pressure gauges, transmitting devices) | \$ | \$ |
| Category IV: Life Sustaining or Critical Life Monitoring Equipment or Devices (i.e. dialysis machines, heart/lung machines, ventilators, etc.) | \$ | \$ |

SECTION VI – ADVERTISING

- 9) Do you obtain proper consents and utilize contractual agreements prior to using the image/oral/written publication of any person/celebrity? N/A Yes No
- 10) Are you making any structure/function claims for your products on labels, websites or other marketing materials? Yes No
- Do you maintain documentation that substantiates each claim you make? Yes No
 If Yes, explain the documentation and length of time records are retained:

SECTION VII – ADDITIONAL INSURED

- 11) List all parties that should be considered for Additional Insured status under the General Liability. Include a copy of the contract for each entity and a certificate of insurance evidencing GL coverage in place.

| Name and Address | Relationship to Applicant |
|------------------|---------------------------|
| | |
| | |
| | |

SECTION VIII – PRODUCTS & COMPLETED OPERATIONS

Attach a separate sheet detailing any Yes answers, along with a list of products sold.

If product labels cannot be found on your website, include copies with this application.

- 12) Do you sell any products? Yes No
 If No, skip to question 29.

If Yes, answer the following questions and include product brochures.

Describe the types of products you sell:

- 13) Total gross revenue **from product sales:**

- a. Last twelve (12) months: \$
- b. Next twelve (12) months: \$

- 14) Any herbal supplements, homeopathic remedies, and/or nutraceuticals? Yes No
- 15) Do any of your products include:
- a. Caffeine exceeding 300 mg per servicing (all sources)? Yes No
 - b. Cannabidiol (CBD) hemp products? Yes No
 - c. Class I & Class II Medical Products / Devices? Yes No
- 16) Do you mix or compound any ingredients? Yes No
- 17) Is a prescription required for any of the products you sell? Yes No
- 18) Are products of others sold or re-packaged under your label? Yes No
- 19) Do all of your labels include a disclaimer that the FDA has not evaluated the claims on your labels and that your products are not intended to diagnose, treat, cure or prevent any diseases? Yes No
- 20) Do you obtain Certificates of Insurance from all suppliers evidencing Product Liability Insurance? Yes No
- 21) Are foreign products sold, distributed, or used as components? Yes No
- 22) Have any of your products been recalled, discontinued or changed? Yes No
- 23) Do you offer training or instruction to the user of your products? Yes No
- 24) Do you offer guarantees, warranties or Hold Harmless agreements with your products? Yes No
- 25) Do you install, service or demonstrate products? Yes No
- 26) Is research and development conducted on new products? Yes No
- 27) Are any new products planned in the next year? Yes No
If Yes, provide explanation:

- 28) Are you a manufacturer, wholesaler or importer of products to others? Yes No

If Yes, answer the following questions and attach a separate sheet detailing any No answers, along with copies of product labels (if not available on website).

- a. Are all warning labels and instructions for use reviewed by outside legal counsel? Yes No
- b. Has legal counsel reviewed your labeling and confirmed it is in compliance with regulations established by the FDA and FTC? Yes No
- c. Have you conducted or are you planning to conduct human clinical trials to substantiate your product claims? Yes No

SECTION IX – PRIOR GENERAL LIABILITY COVERAGE HISTORY

- 29) List prior General Liability insurance carried for each of the past five (5) years. If NONE, check this box

| Insurance Company | Limits of Liability | Deductible | Premium | Expiration Mo/Day/Yr | Was this a Claims Made Policy Form? | Retro Date |
|-------------------|---------------------|------------|---------|----------------------|-------------------------------------|------------|
| | | | | | Yes No | |
| | | | | | Yes No | |
| | | | | | Yes No | |
| | | | | | Yes No | |
| | | | | | Yes No | |

SECTION X – CLAIMS

PROVIDE 5 YEARS OF CURRENTLY VALUED LOSS RUNS.

- | | | |
|---|----------------|--------|
| 30) Has any General Liability claim or suit been brought against you and/or any of your employees? If Yes, complete a Supplemental Claim Information Form for each and every claim or suit. | Yes | No |
| 31) Are any persons or entities proposed for this insurance aware of any fact, circumstance, or situation which may result in a GL claim, and has not been reported to your current GL insurance carrier? If Yes, provide details: | None to Report | Yes No |
| 32) Are you aware of any incident, condition, circumstance, defect or suspected defect in any product, which may result in a claim or claims against you that are not listed above? If Yes, provide details: | None to Report | Yes No |

Fraud Notices

Applicable in AL, AR, DC, LA, MD, NM, RI and WV: Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. *Applies in MD only.

Applicable in CO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Applicable in FL and OK: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony (of the third degree)*. * Applies in FL only.

Applicable in KS: Any person who knowingly and with intent to defraud, presents, causes to be presented, or prepares with knowledge or belief that it will be presented, to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

Applicable in KY, NY, OH and PA: 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 (not to exceed five thousand dollars and the stated value of the claim for each such violation)*. *Applies in NY only.

Applicable in ME, TN, VA, and WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties (may)* include imprisonment, fines and denial of insurance benefits. *Applies in ME only.

Applicable in NJ: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Applicable in OR: Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

Applicable in PR: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Applicable in all other States: 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 material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

Other State Notices

Applicable in RI: THIS INSURANCE CONTRACT HAS BEEN PLACED WITH AN INSURER NOT LICENSED TO DO BUSINESS IN THE STATE OF RHODE ISLAND BUT APPROVED AS A SURPLUS LINES INSURER. THE INSURER IS NOT A MEMBER OF THE RHODE ISLAND INSURERS INSOLVENCY FUND. SHOULD THE INSURER BECOME INSOLVENT, THE PROTECTION AND BENEFITS OF THE RHODE ISLAND INSURERS INSOLVENCY FUND ARE NOT AVAILABLE.

I/We understand that this is an application for insurance only and that the completion and submission of this Application does not bind the Company to sell nor the applicant to purchase this insurance. I/We hereby declare that the above statements and particulars are true and I/we agree that this Application shall be the basis for any contract of insurance issued by the Company in response to it.

Electronic Signature of Applicant or Authorized Representative:

Title:

Date:

If you prefer not to return the questionnaire with an electronic signature, please print and sign.