



**APPLICATION – EMERGENCY MEDICAL TECHNICIANS
General Liability/Professional Liability**

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
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3. Accounting Records (Contact/Phone Number) _____
4. Location of Premises: At mailing address
 Other _____
5. Interest of Named Insured in premises: Owner General Lessee Tenant Other _____
6. Type of Service: Private Fire Department Ambulance District
 City, Township, Village Public Hospital Funeral Home
 County Private Hospital Volunteer (not assoc. with above)
7. Years under current ownership _____ Operate as: Non Profit For Profit
8. Applicant is: Individual Partnership Corporation Governmental Unit
 Trust Other _____
9. Effective Date Desired _____ Term Desired _____

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

Year	Carrier/Policy Number/Premium	Coverage

Missouri applicants: DO NOT answer this question.

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. _____

11. 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
		\$	\$
		\$	\$
		\$	\$

12. Describe any risk management or safety committee activities. _____

13.

COVERAGE/LIMITS DESIRED		
<input type="checkbox"/> Premises - Operations	\$ _____	General Aggregate
<input type="checkbox"/> Products-Completed Operations	\$ _____	Products-Completed Operations Aggregate Limit
	\$ _____	Each Occurrence Limit
<input type="checkbox"/> Personal & Advertising Injury	\$ _____	Personal & Advertising Injury Limit
<input type="checkbox"/> Damage to Premises Rented to You	\$ _____	Damage to Premises Rented to You Limit
<input type="checkbox"/> Medical Payments	\$ _____	Medical Payments Limit
<input type="checkbox"/> Contractual Liability (No Separate Limit)		
<input type="checkbox"/> Professional Liability	\$ _____	Each Occurrence Limit
	\$ _____	Aggregate
Is Loading and Unloading Coverage desired? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is Loading and Unloading included on this insured's auto policy? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is 24 hour coverage for Good Samaritan Acts desired? <input type="checkbox"/> Yes <input type="checkbox"/> No		

OPERATIONS

- Number of units maintained: Ambulances _____ Wheelchair Vans _____ Other _____
- Are any vehicles hospital owned? Yes No
- 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		
TOTAL		

- What percentage of medical transport calls are wheelchair transport? _____
 - What medical certification is required of staff handling wheelchair calls? N/A - No wheelchair calls
 Paramedic EMT No certification required
- | | Yes | No |
|---|--------------------------|--------------------------|
| 7. Is training on wheelchair tie-down procedures given to all staff handling wheelchair transport? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Does service provide heavy rescue/extrication? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you provide any over-water operations? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Does service have special rapid telemetry with the hospital? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Is a call report completed on each and every call/run? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you adhere to medical protocol as established by the OSHA Bloodborne Pathogens Standard? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Has any Insured ever experienced a claim as a result of allegations that they contribute to the spread of contagious disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Are your call reports reviewed for completeness, legibility and professional content? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Calls are dispatched by: | | |
| <input type="checkbox"/> 911 <input type="checkbox"/> In-house by employees/volunteers | | |
| <input type="checkbox"/> Outside source (explain) _____ | | |

16. If dispatching duties are performed in-house:
- Years of dispatching experience required for employment. _____
 - Describe in-house training for dispatchers, including length of training time involved. _____
 - Do you perform dispatch duties for any other entity (police, fire)? Yes No
17. Are all calls coming into your service tape recorded? Yes No
 If yes, indicate the system being utilized and how long tapes are kept. _____

- | | Yes | No |
|---|--------------------------|--------------------------|
| 18. Do you screen calls to determine whether or not an ambulance will be dispatched?
<i>If yes, attach a copy of written procedures.</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Has the service entered into any written contractual agreements to perform ambulance service for a governmental entity, hospital, or nursing home? | <input type="checkbox"/> | <input type="checkbox"/> |
| a. If yes, is legal advice sought to write and approve? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Does agreement require you to hold a third party harmless? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. 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. _____ | <input type="checkbox"/> | <input type="checkbox"/> |

STAFF

- Number of crew members: Per Call, Per Vehicle _____ Total _____
 - Crew members are: Paid Volunteer
 - List the number of individuals certified in each area: _____ First Responders
 _____ Paramedics _____ Advanced First Aid (Red Cross)
 _____ EMTs (Class _____) _____ Nurses _____ Other - specify _____
 - Are all drivers/attendants required to obtain continuing education/training? Yes No
 If yes, describe. _____
 - Number of hours your employees/volunteers: Work per shift _____ Are off duty between shifts _____
- | | Yes | No |
|--|--------------------------|--------------------------|
| 6. Do you contract with a medical advisor? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Does the medical advisor carry medical malpractice insurance? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Are references checked on new hires? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Are MVRs checked on new hires? | <input type="checkbox"/> | <input type="checkbox"/> |

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