PROFESSIONAL LIABILITY APPLICATION FOR AMBULANCE SERVICES

INSTRUCTIONS: ANSWER ALL QUESTIONS; APPLICANT'S NAME MUST INCLUDE THE NAMES OF ALL BUSINESSES AND LOCATIONS FOR WHICH COVERAGE IS DESIRED.
If the answer is NONE, state NONE;
If the answer is NOT APPLICABLE, state NOT APPLICABLE (N/A).
If the space provided is insufficient to fully answer the question, PLEASE ATTACH A SEPARATE SHEET.
NOTE: APPLICATION MUST BE DATED AND SIGNED BY OWNER, PARTNER, OFFICER OR ADMINISTRATOR. PLEASE TYPE OR PRINT IN INK.

PART I. GENERAL INFORMATION

1.1 Applicant Name (including dba's): _____

1.2 Mailing Address: _____

1.3 Location Address(es): _____

1.4 County (parish) of each location: _____

1.5 Telephone Number: Office ____/_____ Fax ____/_____

1.6 Person to contact for survey: Name _____
Title _____

1.7 Year entity established: _____

1.8 Entity is ___ Individual ___ Corporation ___ Partnership __ Professional Association/Corporation
___ Other. (Describe) _____

1.9 Type of Service: (Check where applicable)

__ Private (Proprietary) __ City owned & operated
__ Rescue Squad __ Fire Department
__ Chair Car(Invalid Coach) __ County owned & operated
__ Public Service __ Hospital Based
__ First Responder __ Other, describe_____

1.10 Proposed effective date _____

1.11 Requested Limits of Liability (if available):

Professional Liability $ _____/$_____
General Liability $ _____ each occurrence
$ _____ general aggregate

1.12 Annual Gross Receipts or Budget: Estimated next twelve months- $ _____
Last twelve months- $ _____

1.13 Annual Remuneration: Estimated next twelve months- $ _____

1.14 Total Premises Square Footage Occupied by Applicant: _____

PART II. EXPOSURES

2.1 Total number of emergency runs: _____ last year, estimated _____ next year.

2.2 Total number of scheduled patient transport (non emergency) runs: _____ last year, estimated _____ next year

2.3 Radius of operations:_____.

2.4 Number patient encounters at special events (if any):____ (see question 2.11)

2.5 Total number of ambulances at each location per shift _____.

2.6 Are ambulances equipped with cardiac telemetry? ___ Yes ___ No
If yes, to what command center?_____
Who provides medical orders?_____

2.7 Does your service provide Air or Watercraft ambulance services? ___Yes ___ No
If yes, please describe_____

2.8 Does your service provide water rescue services? ___ Yes ___ No
If yes, please describe:_____
_____

2.9 Does your service provide mobile intensive care? ___ Yes ___ No

2.10 Does your service provide mobile neo-natal intensive care? ___ Yes ___ No

2.11 Does your service routinely provide first aid services to any sporting event, carnival, fair, etc? ___ Yes ___ No
If yes, state type, location, and number of patient encounters: _____
_____
_____

2.12 Qualifications and number of EMS Personnel:

Employed	Contract	Volunteer	
____	____	____	Advanced First Aid and/or Red Cross
____	____	____	CPR Certificate only
____	____	____	EMT Basic
____	____	____	EMT Advanced or Intermediate (IV)
____	____	____	EMT Paramedic
____	____	____	Nurse(RN or LPN)
____	____	____	Physicians or Surgeons*
____	____	____	Other, describe _____

* Attach list and indicate specialty.

2.13 Does the applicant desire to provide coverage for independent contractor(s) (including them as additional insured(s) on your policy while working on your behalf? ___ Yes ___ No

2.14 Explain procedures for refusal or transfer by an adult:_____
_____
_____
For refusal for transport by a minor:_____
_____
_____

2.15 Explain criteria for "No-Transport" by service:_____
_____
_____

2.16 Do you enter into contractual agreements? ___ Yes ___ No
If yes, enclose copies or all such contracts.

PART III. HISTORY

3.1 List prior professional liability insurers for the past five years, starting with the most recent year. If none, so state.

Insurer	Policy Number	Limits of Liability	Premium	Eff. Date	Claims-Made Yes	No
1.						
2.						
3.						
4.						
5.						

If claims-made, what is the most recent retroactive date?_____

3.2 List prior general liability insurers for the past five years, starting with the most recent year. If none, so state.

Insurer	Policy Number	Limits of Liability	Premium	Eff. Date	Claims-Made Yes	No
1.						
2.						
3.						
4.						
5.						

If claims-made, what is the most recent retroactive date?_____

3.3 Have any claims been made or occurrences reported during the past six years against any of the proposed insureds or against any entity in which any proposed insured has or has had an interest? ___ Yes ___ No
If yes, please describe, indicate status of the claim or suit, and any amount(s) paid or reserved (attach an additional sheet if necessary).

3.4 Does any proposed insured have any knowledge of an event, circumstance or occurrence (other than any listed in 3.3 above) prior to the effective date of the proposed policy, or does any proposed insured foresee that a claim may be brought as a result of said event, circumstance or occurrence? ___ Yes ___ No
If yes, describe the event and indicate the reason for anticipation of a claim.

I understand and agree this Application and any and all supplements attached hereto may be made a part of any policy issued, and any such policy will be issued in reliance upon the representation made herein. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the Company, result in the voiding of insurance issued in reliance on this Application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, professional reputation and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release to the company providing insurance coverage and Mid-Continent General Agency, Inc. any documents, records or other information bearing upon the foregoing.

I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

Applicant and all owners, employees, and contractors are licensed or duly authorized in all states or jurisdictions where professional services are provided. Applicant warrants the truth of all answers to the above questions, and that applicant has not withheld any information which is calculated to influence the judgment of the insurance company in considering this application.

IMPORTANT: THIS APPLICATION MUST BE SIGNED BY THE APPLICANT. SIGNING THIS FORM DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE.

Date _____ Applicant Signature / Title _____