Ambulance New Business Supplemental Application

3250 Interstate Drive, Richfield, OH 44286-9000
800-929-1500 Fax: 330-659-8907 www.natl.com

National Interstate Insurance Company | National Interstate Insurance Company HI
Triumphe Casualty Company | Vanliner Insurance Company

GENERAL INFORMATION

BROKER INFORMATION

Today's Date: ______ Incept Date: ______ Quote Date: ______

Agency: ______ Producer: ______

Address: ______

City: ______ State: ______ Zip: ______

Phone: ______ Email: ______

Are you the incumbent? Yes No For how long? ______

APPLICANT INFORMATION

Applicant's Legal Name: ______

DBA (if applicable): ______

Address: ______

City: ______ State: ______ Zip: ______

Phone: ______

Email: ______ Website: ______

Business Type: Individual Partnership Corporation LLC Joint Venture FEIN: ______

Are you a for-profit ambulance service? Yes No Years in Business: ______

If no, please describe: ______

Have you owned a similar business or had any change in ownership, management or the name of your business in the past 5 yrs? Yes No

If yes, please explain: ______

Is your business a subsidiary of another entity or does your business have any subsidiaries? Yes No

If yes, please provide details: ______

Owner(s) active in the business? Yes No Owner's Name: ______ Years of Experience: ______

Key Management Personnel:

Title	Name	Yrs in Position	Phone	Email
President/CEO				
Operations Manager				
Safety Director				

CURRENT CARRIER

Indicate Current Carrier and Expiring Premium for each coverage requested.

	Auto Liability & Physical Damage	Medical Professional Liab	General Liability	Real & Personal Property	Portable Equipment	Umbrella / Excess Coverage
Current Carrier						
Current Premium	$	$	$	$	$	$

COVERAGE & LIMITS

1. Auto Liability Coverage: Yes No

Desired Limits (Please provide Acord applications for desired ancillary coverages and limit requirements.)

Auto Liability: $ ____________

Uninsured/Underinsured Motorist: $ ____________

Symbols: 1* 2* 7 ***If symbol 1 or 2 please provide evidence of contractual obligation.***

Hired/Non-Owned

2. Automobile Physical Damage: Yes No

Desired Deductible: $ ____________ Collision

Total Stated Amount: $ ____________ Comprehensive

3. Medical Professional Liability: Yes No

Desired Limits:
- $500,000 each incident / $1,000,000 aggregate
- $1,000,000 each incident / $2,000,000 aggregate
- $1,000,000 each incident / $3,000,000 aggregate

Occurrence Claims Made

Retroactive Date: ____________

4. General Liability: Yes No

Desired Limits:
- $500,000 each incident / $1,000,000 aggregate
- $1,000,000 each incident / $2,000,000 aggregate
- $1,000,000 each incident / $3,000,000 aggregate

Stop Gap Employers Liability:* Yes No

*Only available for those insureds who have employees in one or more of the following states:
North Dakota, Ohio, Washington, and Wyoming

5. Employee Benefits Liability: Yes No Retroactive Date: ____________

Desired Limits:
- $500,000 each incident / $500,000 aggregate
- $500,000 each incident / $1,000,000 aggregate
- $1,000,000 each incident / $1,000,000 aggregate

6. Real and Personal Property: Yes No ***If yes, please provide property Acord #140***

7. Portable Equipment: Yes No

Desired Limit: $ ____________

Desired Deductible: $ ____________

8. Workers' Comp Coverage: Yes No ***If yes, please complete the Supplemental Workers' Compensation Application.***

9. Umbrella: Yes No

Desired Limit: $ ____________ in excess of scheduled primary limits

BUSINESS INFORMATION

1. Revenue: $ ____________ Revenue from MIH or Community Paramedicine: $ ____________

2. What is your primary service area? Cities: ____________

Counties: ____________

States: ____________

3. Hours of Operation: ____________

4. Total Number of Employees: ____________ Full Time: ________ Part Time: ________

BUSINESS INFORMATION - continued

5. Number of full and part time employees/volunteers that drive or provide patient care:

_______ Paramedics
_______ Registered Nurses
_______ Emergency Medical Tech (EMT-B)
_______ Emergency Medical Responder (EMR, First Responder)
_______ Critical Care Paramedics
_______ Advanced EMT (EMT-A or EMT-1)
_______ Non-Emergency Medical Tech
_______ Other (Patient Care Providers)

6. Indicate the procedures used in the employee screening and hiring process (check all that apply):

Written Application | Road Test | Physical Abilities Testing | Background Check | Motor Vehicle Record Check
Written Test | Physical Exam | Pre-Employment Drug Testing | Reference Check | Other _______

7. Indicate the highest level of EMS Service provided:

Basic Life Support | Advanced First Aid / Cardiopulmonary Resuscitation Only
Advanced Life Support | No Emergency Medical Services

8. Do you provide or are you involved in activities beyond EMS? Yes No

If yes, please describe: _______

9. Indicate services provided (check all that apply):

Conscious Sedation | Capnography or Capnometry | Specialized Cardiac Transport | Manual Defibrillation
Neo-Natal Transport | Pulse Oximetry | IV Therapy or Monitoring | Thrombolytic Therapy
12-Lead EKG Monitoring | Endotracheal Intubation | Telemetry | MIH-CP

Other, please describe: _______

10. Call Volume

	Emergency Ambulance Calls	Non-Emergency Amb Calls	Non-Medical Calls	Total Calls
Projected				
Current Year				
1st Prior Year				
2nd Prior Year				
3rd Prior Year				
4th Prior Year				

Emergency Ambulance Calls: Transports dispatched as, or switched mid-transport to, emergency status with lights & sirens activated
Non-Emergency Calls: Transports conducted in ambulances or ambulettes with some BLS onboard; no lights & sirens
Non-Medical Calls: Transports conducted in wheelchair vans or private passenger vehicles with no BLS on board

11. Number of Vehicles ***(Please attach a current vehicle list with year, make, model, type, VIN and the stated amount.)***

	Ambulances	Wheelchair/ Transit Vans, Ambulettes	Private Passenger & Service	Other	Total Vehicles	Total Mileage
Projected						
Current Year						
1st Prior Year						
2nd Prior Year						
3rd Prior Year						
4th Prior Year						

12. Vehicle Types

Vehicle Type	% of Total Calls	Max Radius	Max No. of Passengers	Avg No. of Passengers
Ambulances	%			
Wheelchair/Transit Vans	%			
Private Passenger/Service	%			
Other	%			

BUSINESS INFORMATION - continued

13. Patient Handling

Type of Stretcher	Brand	Quantity
Standard Cot		
Power Cot		
Bariatric Cot		
Other		

a. Do you have a lift assist policy? Yes No

b. Do you use/require knee, hip, chest and over the shoulder safety restraints? Yes No

14. Engineering Control

Engineering Control	Brand	Quantity
Specialty Vehicles (Bariatric Units)		
Ramps with Winches		
Lateral Transfer Aids		
Motorized Stair Chairs		
Other		

15. Name the wheelchair tie-down occupant restraint system (WTORS) you use: ____________

16. Do you transport prisoners or others whose pick up site is determined by their legal status? Yes No

17. Onboard Monitoring (OBM) - (Automated Event Records (AER), Cameras, GPS, Telematics)

Brand name of system(s) and type (camera or GPS): ____________

Number of vehicles currently installed with the system: ____________

Employee responsible for the management of the OBM: ____________

18. Do you use a priority dispatch system? Yes No

If yes, please explain: ____________

19. Do you perform any aircraft or watercraft transportation? Yes No

If yes, please describe: ____________

20. Do you own an aircraft or watercraft? Yes No

If yes, please describe: ____________

MANDATORY UNDERWRITING QUESTIONS

1. Has any company provided notice of cancellation/non-renewal or other wise cancelled/refused to renew your insurance? Yes No

If yes, please explain: ____________

2. Do you provide Workers' Compensation for all employees? Yes No

If yes, provide Workers' Comp Carrier: ____________

3. Have you ever filed for or contemplated filing for bankruptcy or had bankruptcy proceedings initiated against you by another party? Yes No

If yes, please explain: ____________

4. Has your operating authority ever been suspended or revoked or have you received notice of intent to suspend? Yes No

If yes, please explain: ____________

5. Do you allow 24-hour shifts? Yes No

If yes, what percentage of shifts are 24-hours in length? ____________

6. Do you have designated areas for employees to rest during extended shifts (12 hours or more)? Yes No

7. What procedures are in place to ensure an employee can opt-out of a transport due to fatigue? ____________

____

8. Do you have a formal fatigue management program? Yes No

If yes, please provide copy of written protocol for managing fatigue

9. Do you allow for secondary employment? Yes No

If yes, please explain how this is tracked: ____________

10. Max # of hours per week per employee: ____________

11. Hours required between shifts: ____________

AUTOMOBILE / PHYSICAL DAMAGE LIABILITY / DRIVER INFORMATION

1. Do you lease or loan vehicles to others (providers, churches, etc)? Yes No

If yes, please explain: ______________________

2. Do you allow owners or employees to take company owned vehicles home or on personal business? Yes No

If yes, please explain: ______________________

3. Vehicle maintenance procedures:

a. Do you have a written maintenance program? Yes No

b. Are daily vehicle inspection reports completed and reviewed? Yes No

c. Are periodic maintenance checks done by a mechanic? Yes No

e. Are vehicle maintenance records kept? Yes No

f. Do you employ your own mechanics? Yes No

g. Do you store or service the vehicles of others? Yes No

4. Total number of drivers: ________ How many are over age 65? ________ How many are under age 23? ________

5. In the past year, how many drivers were hired? ________ How many were terminated? ________

6. How often are MVRs run and reviewed? ______________________

7. Do you have a written criteria for acceptable MVRs? Yes No

8. Are all drivers properly licensed? Yes No

9. Do you have a written driver training program? Yes No

10. Do all drivers receive a Defensive Driver Training Course with their job description? Yes No

How often is the course repeated? ______________________

What percentage is in-class vs on-the-road training? ______________________

11. Have all drivers been driving a similar vehicle for 3+ years?

12. Do all drivers have at least 5 years U.S. driving experience? Yes No

13. Is a disciplinary plan documented for all drivers? Yes No

If yes, please describe: ______________________

14. Do you have a written accident reporting procedure? Yes No

If yes, please describe: ______________________

15. What procedures are employees required to following when approaching an intersection, with or without lights & sirens?

____

16. Are guest passengers (family members, friends of driver, etc.) authorized passengers? Yes No

MEDICAL PROFESSIONAL LIABILITY

1. Do you utilize a Medical Director? Yes No If yes, provide the following:

a. Name: ______________________ Phone: ______________________

b. Licensed to Practice Medicine Yes No

c. Board Certified Yes No Certification: ______________________

d. Formal Job Description Yes No

e. Direct Patient Care Provided Yes No

If yes, describe circumstances: ______________________

2. Are all medical transports documented with regular quality review by the Medical Director? Yes No

If not reviewed by a Medical Director, who is qualified and responsible for review? ______________________

3. Is documentation maintained showing all medical equipment purchases, maintenance, calibration and service? Yes No

4. Do you maintain and monitor records on an ongoing basis to confirm that all employees and new hires meet appropriate state certification requirements? Yes No

5. Do you lend or lease employees to others? If yes, how often? ______________________ Yes No

If yes, attach a copy of the insurance provisions and hold harmless conditions of the contract.

6. Do you borrow or lease employees from others? If yes, how often? ______________________ Yes No

If yes, attach a copy of the insurance provisions and hold harmless conditions of the contract.

7. Has any claim been made or suit filed against you and/or your employees in the past 5 years alleging negligence in the rendering or failure to render medical or professional health care services? Yes No

If yes, please explain: ______________________

MEDICAL PROFESSIONAL LIABILITY - continued

8. Do you have any knowledge of any matter which would cause a reasonable person to believe that a claim or suit against you is likely to arise alleging negligence in the rendering or failure to render medical or professional health care services? Yes No

If yes, please explain:

9. With respect to medical professional liability insurance, has the company received notice of any claims by a state regulatory agency in the past 3 years? Yes No

If yes, please explain:

GENERAL LIABILITY

1. If Stop Gap Coverage is requested, do you currently carry Employer's Liability Coverage on all employees? Yes No

2. Do you have notice of any claims for violations of state or local regulations in regard to any public area? Yes No

If yes, please explain:

3. Do you lease or rent any real property to others? Yes No

If yes, please explain and include the square footage:

4. Do you enter into any written or verbal agreements to provide service? ***If written, please attach a copy.*** Yes No

If verbal, please explain:

5. Do you sell, rent or distribute any durable or expendable medical equipment or supplies? Yes No

If yes, indicate yearly gross receipts: $

Describe the type of equipment and supplies:

6. Do you sell or distribute pharmaceuticals of any kind? Yes No

If yes, indicate annual sales: $

Describe the type of pharmaceuticals:

7. Do you install, service or repair medical equipment or devices of any kind for others? Yes No

If yes, indicate annual receipts: $

Describe the type of medical equipment or devices:

8. Are you involved in Community Paramedicine/Health or Mobile Integrated Health? Yes No

If yes, please provide a brief description of the services provided:

How many visits are conducted annually for this service?

EMPLOYEE BENEFITS LIABILITY

1. Do you have an Employee Benefits Handbook? Yes No

2. Has any claim been made or suit filed against you and/or your employees in the past 5 years alleging an error or omission in the administration* of your benefits program? Yes No

If yes, please explain:

3. Do you have knowledge of any matter(s) involving employee benefits, benefits administration, the handling of benefit claims, or any benefits-related matter which would cause a reasonable person to believe that a claim or suit might result? Yes No

If yes, please explain:

*Determining who is eligible to participate; enrolling new participants; terminating participants; determining benefits; processing claims; collecting funds and applying them as required; preparing reports by government agencies; giving advice to participants or prospective participants; providing reports, booklets, pamphlets, memos or messages to participants.

SUBMISSION REQUIREMENTS

- **5 years of currently valued loss runs** for all lines requesting a quote. (Within 90 days of incept.)
- **Current vehicle list** with make, model, year, VIN and stated amount.
- **Current driver list** with dates of hire, dates of birth, license numbers, and years of experience driving a similar type vehicle.
- **Currently valued MVRs** for all employees in a driving position.
- **Schedule of equipment** with model and stated amounts.
- Copy of most recent **audited financials**
- The table of contents for the following manuals you may have: Employment Practices Handbook, Employee Benefits Handbook, Maintenance Program, Driver Training Program, Intersection Procedures, Accident Reporting Procedures and Daily Vehicle Inspection.

FRAUD WARNINGS

AL - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines or confinement in prison, or any combination thereof.

AR - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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 claiming with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DC - WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FL - Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

KY - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

LA - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MD - Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who 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.

ME - 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, or denial of insurance benefits.

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

NM - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NY - 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of a claim for each such violation.

OH - Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OK - WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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.

RI - Any person who knowingly presents false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

TN - It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

VA - It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

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 include imprisonment, fines and denial of insurance benefits.

WV - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ALL OTHER STATES - Any person who knowingly and with intent to defraud any insurance company or other person, files an application of insurance containing any false information, or conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent act which is a crime.

In the State of Illinois, the Religious Freedom Protection and Civil Union Act became effective June 1, 2011. Our policies of insurance comply with this Act, which provides that two persons of the same or opposite sex who form a civil union are entitled to the same benefits and protections provided to spouses.

APPLICANT'S STATEMENT - Important! Read before signing.

I, the undersigned (applicant), hereby applies for a policy of insurance as set forth in the application on the basis of information and statements contained in the application, all supporting and supplementary documents, and this application statement. The supporting and supplementary documents and this Applicant's Statement are incorporated into and part of the application. The application, all supporting and supplementary documents, and this Applicant's Statement shall be referred to below as the "Application Materials". If a policy is issued, the Application Materials shall be deemed to be attached to and part of the policy.

Applicant understands and acknowledges the following:

> That insurer's receipt and consideration of the Application Materials does not obligate insurer to provide a quotation for insurance to applicant.
>
> That any quotations provided will be issued subject to underwriting approval, and will not constitute an offer by the insurer to insure at the quoted rates or prices unless and until such approval has been issued.
>
> That if the initial premium is paid with a check, the coverage provided by the policy is conditioned upon the check being honored when presented for payment, and that if the check is not honored, the policy shall be deemed void from inception due to a lack of consideration.

Applicant declares that it has carefully reviewed the information and statements made in the Application Materials and that such information and statements are true and correct. Applicant agrees that any policy of insurance that may be issued now or in the future will be issued in reliance on the information, statements, warranties, and representations contained therein, and that the policy and renewals thereof may be declared null and void by insurer if the Application Materials, or future statements or documents provided by or on behalf of Applicant, contain information that is incomplete, false, or misleading.

If Applicant applies for a commercial auto policy that is not rated based on mileage, payroll, or other measure of exposure, Applicant warrants and represents that all vehicles owned by, leased to, or used by the Applicant have been disclosed in the Application Materials or otherwise disclosed in writing to insurer, regardless of whether Applicant intends to schedule such vehicles on the policy issued by insurer. If Applicant applies for a commercial auto policy that is exposure rated, Applicant warrants and represents that all mileage, payroll, or other measure of exposure relating to Applicant's operations have been disclosed in the Application Materials or otherwise disclosed in writing to insurer for all applicable periods of time.

Applicant understands that an inquiry may be made that will provide information concerning general reputation, financial stability and other pertinent financial data, credit history, driving experience, vehicle usage, and other information considered by insurer in deciding to issue a policy, in determining the rates therefore, and in adjusting claims. Applicant authorizes insurer to obtain such reports in connection with this policy and all renewals thereof. Upon written request, Applicant will be informed of the source of any reports considered by the insurer.

Any person, who knowingly and with intent to defraud any insurance company or other person, files an application for insurance containing any false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act which is a crime.

Agency Name: ______________________________

Signature: ______________________________ Date: __________

Broker's Authorized Signature

Applicant's Name: ______________________________

Signature: ______________________________ Date: __________

Applicant's Authorized Signature