HAMILTON

Clear Form

AMBULANCE AND NON-EMERGENCY TRANSPORT APPLICATION

Instructions:

- Please print or type clearly all responses and answer all questions as instructed.
- If you need more space than is given, continue in the comments section of this application or attach a separate sheet of paper.
- Coverage will not be bound until this application is completed and signed, and all required documents are provided.

Required documents, in addition to this application:

- Loss runs, dated within 60 days of submission, covering the past five years
- Declarations page from current insurance carrier, showing retroactive date if claims-made coverage
- Most recent state survey reports, licensure reports and accreditation survey reports as applicable
- Current license
- Resume of owner or administrator

APPLICANT INFORMATION

Legal name of Applicant:	
Mailing Address: (Street, City, State, Zip Code):	
Location Address: (Street, City, State, Zip Code):	

(If there are multiple locations, please attach a list separately)

Date Established:		**Website:**					
Legal Structure:	For Profit ☐	Non-Profit ☐	Government ☐	Other (explain)			
Sole proprietorship ☐	Corporation ☐	Partnership ☐	Joint Venture ☐				

Main Contact (name, position):		**Telephone Number:**	

COVERAGE REQUESTED (Attach current Dec Page or Policy, if applicable)

Policy Period:				
Professional Liability Limits:	Per Claim:	$	Aggregate:	$
General Liability Limits:	Per Claim:	$	Aggregate:	$
Deductible: $	**Retroactive Date:** (declarations page required)			
Other Coverage requests:				

OPERATIONS

1. Years of operation:		**Under current ownership:**	
2. Licensing (please include copies of licenses):			
Has an Applicant's license ever been suspended, revoked or placed under probation?	Yes ◯	No ◯	

(if yes, provide a detailed explanation in a separate attachment with date of reinstatement)

HAMILTON

3. Please check the category which best describes your organization (check all that apply if you offer multiple services).		
☐	Ambulette or Medical Van Service	Services include transporting clients/patients from residential facilities/homes to physician offices. Drivers are typically non-medical professionals with basic First Aid and/or CPR training.
☐	Non-emergency Medical Transportation	Services include medical facility-to-facility by ambulance. EMT Basic or Intermediate personnel may accompany patients. This category encompasses Basic Life Support (BLS) and Advanced Life Support (ALS) services as defined by Medicare.
☐	Emergency Transportation	Services include response to 911 calls or equivalent. EMT Basic, Intermediate and/or Paramedics may accompany patients.
☐	Air Transport	Services include emergency (Medevac) and/or non-emergency transfers by helicopter or fixed-wing aircraft. Physicians, nurses, or EMTs may accompany patients.
☐	Other	Please provide a description of your organization if it does not **readily** reflect one of the above categories.

4. Please state sources and amounts of total revenue, and number of calls for each category				
	Revenues		**Number of Calls**	
Operations	**Last 12 Months**	**Next 12 Months**	**Last 12 Months**	**Next 12 Months**
Ambulette/Medical Vans	$	$		
Basic Life Support (BLS)	$	$		
Advanced Life Support (ALS)	$	$		
Emergency Transport	$	$		
Air Ambulance	$	$		
Total Gross Revenues and Calls	**$**	**$**		

5. How are calls dispatched?			
○ 911	○ In-house	○ Other (please describe) :	

6. Is your service involved in (check one):		
Water rescue operations	○ Yes	○ No
Wheelchair vans	○ Yes	○ No
Aircraft fixed wing or helicopter	○ Yes	○ No
Other vehicles	○ Yes	○ No
If "Yes" to any of the above, please describe in detail in the space below:		

7. Do you offer any CPR, First Aid, or other medical training/ certification?	○ Yes	○ No

8. Please indicate the number of vehicles used in the stated operations:	
Ambulances	
Wheelchair vans	
Aircraft fixed wing or helicopter	
Other vehicles (please describe):	
Total number of vehicles:	

9. Radius of operations (in miles):	

HAMILTON

10. How often do you perform a maintenance report on all vehicles and equipment?			
☐	By shift	☐	Daily
☐	Other (please explain):		

11. Please indicate which of the following your driver training program includes:			
☐	Driver orientation	☐	First aid
☐	Defensive driving	☐	CPR
☐	Passenger assistance training	☐	Emergency vehicle operator course (EVOC)

12. Name of your auto and/or aircraft liability insurance carrier for the upcoming policy year:			
Carrier:			
Limits of liability:			
a. Does your auto liability policy specifically exclude claims arising from loading and unloading patients?		◯ Yes	◯ No
b. Does your auto liability policy remain silent on the applicability of coverage for claims arising from loading and unloading patients?		◯ Yes	◯ No

STAFF

13. Please provide the number of:						
	Employees		Independent Contractors		Volunteers	
	Full-time	Part-time	Full-time	Part-time	Full-time	Part-time
Drivers						
EMT Basic						
EMT Intermediate						
EMT Paramedic						
Physicians						
RNs						
Other (describe):						

14. Please provide the name of the applicant's medical director:		
Does the applicant's medical director have direct patient care?	◯ Yes	◯ No
If "Yes", Full-time (FT) or Part-time (PT)	◯ FT	◯ PT

15. Please indicate all of the hiring/screening procedures used for professionals and paraprofessionals who provide patient care services at your facility:			
☐	Check of educational background or residency program, when applicable		
☐	Check of previous employers	☐ In writing	☐ By telephone
☐	Criminal background check	☐ State	☐ Federal
☐	Drug screening		
☐	Alcohol screening		
☐	Verify any pending license suspensions or revocations, or any pending disciplinary actions by other facilities		
☐	Require information on any professional liability or work-related claim that has previously been made against any individual?		
☐	Verify any pending license suspensions or revocations, or any pending disciplinary actions by other facilities		
☐	Require information on any professional liability or work-related claim that has previously been made against any individual?		
☐	Driver's license verification		

HAMILTON

☐	Motor vehicle record (MVR) verification	☐ Every 6 months	☐ Every Year	☐ Other	
☐	If Other, explain:				

INSURANCE AND LOSS HISTORY

16. Professional Liability Insurance History (Past 5 years)

Insurer	Dates covered	Limits of Insurance	Deductible	Premium	Claims-made or Occurrence
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	
If the current policy is claims-made, what is the current retroactive date?					

17. General Liability Insurance History (Past 5 years)

Insurer	Dates covered	Limits of Insurance	Deductible	Premium	Claims-made or Occurrence
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	
If the current policy is claims-made, what is the current retroactive date?					

For any "Yes" answers to the following questions, please provide detailed information in the Supplemental Information section of this application or provide separate attachments.

18. Has any insurance company ever rescinded, cancelled or non-renewed any similar insurance for the applicant?	◯ Yes	◯ No
19. Has the applicant or any of its employees ever been charged with or convicted of a crime?	◯ Yes	◯ No
20. Has any claim been made or suit been filed against the applicant or any other person proposed for this insurance? **If "Yes", please complete supplemental claim/incident form for each.**	◯ Yes	◯ No
21. Do you have knowledge of information which might reasonably be expected to give rise to a claim of physical abuse or molestation? **If "Yes", please complete supplemental claim/incident form for each.**	◯ Yes	◯ No
22. Is the applicant or any person proposed for this insurance aware of any known losses, claims or suits that have not yet been reported? **If "Yes", please complete supplemental claim/incident form for each.**	◯ Yes	◯ No
23. Is the applicant or any person proposed for this insurance aware of any act, error, omission, fact, circumstance, or records request from any attorney which may result in a claim? **If "Yes", please complete supplemental claim/incident form for each.**	◯ Yes	◯ No

SUPPLEMENTAL INFORMATION

Please use this section to provide additional details for Questions 18-23, or for any other questions requiring additional space for answers.

HAMILTON

FRAUD WARNING

NOTICE TO ALABAMA, ALASKA, ARIZONA, ARKANSAS, CALIFORNIA, CONNECTICUT, DELAWARE, GEORGIA, IDAHO, ILLINOIS, INDIANA, IOWA, KANSAS, MARYLAND, MASSACHUSETTS, MICHIGAN, MINNESOTA, MISSISSIPPI, MISSOURI, MONTANA, NEBRASKA, NEVADA, NEW HAMPSHIRE, NORTH CAROLINA, NORTH DAKOTA, OREGON, RHODE ISLAND, SOUTH CAROLINA, SOUTH DAKOTA, TEXAS, UTAH, VERMONT, WASHINGTON, WEST VIRGINIA,WISCONSIN, AND WYOMING APPLICANTS: In some 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, for the purpose of misleading, conceals information concerning any fact material thereto, may commit a fraudulent insurance act which is a crime in many states.

NOTICE TO COLORADO APPLICANTS: 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 policy holder 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.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: **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.

NOTICE TO FLORIDA APPLICANTS: 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.

NOTICE TO HAWAII APPLICANTS: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

NOTICE TO KENTUCKY APPLICANTS: 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.

NOTICE TO LOUISIANA APPLICANTS: 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.

NOTICE TO MAINE APPLICANTS: 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.

NOTICE TO NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an

application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO NEW MEXICO APPLICANTS: 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.

NOTICE TO NEW YORK APPLICANTS: Any person who knowingly and with intent to defraud an 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 $5,000 and the stated value of the claim for each such violation.

NOTICE TO OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he/she 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.

NOTICE TO OKLAHOMA APPLICANTS: 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.

NOTICE TO PENNSYLVANIA APPLICANTS: Any person who knowingly and with intent to defraud any insurance company, or other person, files an application for insurance or statement of a 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 the person to criminal and civil penalties.

NOTICE TO TENNESSEE APPLICANTS: 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.

NOTICE TO VIRGINIA APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposeof defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

The Applicant acknowledges that the answers provided herein are based on a reasonable inquiry and/or investigation. The Applicant warrants that the above statements and particulars together with any attached or appended documents are true and complete and do not misrepresent, misstate or omit any material facts.

The Applicant agrees to notify us of any material changes in the answers to the questions on this questionnaire which may arise prior to the effective date of any policy issued pursuant to this questionnaire and the Applicant understands that any outstanding quotations may be modified or withdrawn based upon such changes at our sole discretion.

Completion of this form does not bind coverage. Applicant's acceptance of the company's quotation is required prior to binding coverage and policy issuance.

All written statements and materials furnished to the company in conjunction with this application are hereby incorporated by reference into this application and made a part of this application.

Applicant Signature _____ **Title:** _____

(Must be signed by an owner, principal, partner or officer) **Date:** _____