1417 N State Street, Bellingham, WA 98225 Ph: 360-671-0500 Fx: 360-671-3959 E: info@bell-uw.com

AMBULANCE SUPPLEMENTAL APPLICATION

Automobile/General Liability/Medical Malpractice

Date:

Agency: _____ Phone: _____

Agency Branch: _____ Fax: _____

Producer: _____ Email: _____

A. Items Required for Quoting

Please include the following with all applications:

- ☐ Current MVRs for all drivers
- ☐ Complete drivers list including date of hire & current level of medical certification
- ☐ Complete vehicle list & equipment schedule. Must define vehicle type & usage & provide values if physical damage is requested.
- ☐ Currently valued company loss runs for prior 4 years
- ☐ Complete schedule of all locations with full building descriptions for each

B. General Information

Applicant Legal Name: _____ FEIN#: _____

DBA: _____ DOT#: _____

Mailing Address: _____

Physical Address: _____

Applicant is: ☐ Individual ☐ Partnership ☐ Corporation ☐ LLC/LLP ☐ Other _____

Years in Business: _____ If under 3 years, date business started _____ Proposed Effective Date: _____

Contact for Inspection: _____

Ph: _____ Fax: _____ Email: _____

1. Has your business been involved in consolidations of separate entities or had a change in ownership over the past five years?
   ☐ Yes ☐ No
   If Yes, please explain:

2. Is the applicant involved in operations or activities other than Emergency Medical Transport, First Response Emergency Services or Paratransit (non-emergency non-medical transport)? ☐ Yes ☐ No
   If Yes, please explain:

C. Coverage History

Current Carrier: _____ Premium: _____

Please list prior carrier information for the past 4 years.

Prior Carrier	Limits of Insurance	Premium	Policy Term

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Coverage History (continued)

1. Is this account currently written by your agency? ☐ Yes ☐ No
2. Is this a mid-term replacement? ☐ Yes ☐ No If Yes, please explain:

3. Has the insured had their coverage cancelled or non-renewed in the last five years? ☐ Yes ☐ No If Yes, please explain:

4. Has the insured maintained commercial insurance for the past 12 consecutive months? ☐ Yes ☐ No If No, please explain:

D. Coverages/Limits Requested

Please list all auto coverages requested. Hired Auto Physical Damage, Hired Auto Liability and Non-Owned Auto Liability may require a supplemental application.

	LIMIT/DEDUCTIBLES		
Auto Liability	$	Deductible $	☐BI ☐ PD ☐ BI/PD
Personal Injury Protection (PIP)	☐ Statutory ☐ Increased Limits	☐ Other _____	
Medical Payments	$		
Uninsured/Underinsured Motorists (UM/UIM)	$		
Comprehensive	Deductible $		
Specified Perils	Deductible $		
Collision	Deductible $		
Hired Auto Physical Damage	☐ If Any ☐ COH $	Limit $	Deductibles $
Non-Owned Liability	Number of Employees: _____		

	LIMIT/DEDUCTIBLES		
General Liability			
Each Occurrence	$	Deductible $	☐BI ☐ PD ☐ BI/PD
General Aggregate	$		
Products Aggregate	$		
Fire Damage Legal Liability	$		
Medical Payments	$		
Employee Benefits Liability	$	*Retro Date: _____	
Employers Liability (Stop Gap)	$		
Abuse & Molestation	$	*Retro Date: _____	
Medical Malpractice			
Each Occurrence	$	Deductible $	☐BI ☐ PD ☐ BI/PD *Retro Date: _____
General Aggregate	$		

**Include the Retro Date If coverage has been written on a claims-made form.*

	LIMIT/DEDUCTIBLES	
Umbrella/XS limits	$	Each Occurrence
	$	Annual Aggregate

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E. Automobile Information

1. Provide the count of commercial vehicles by year for the past 4 years:
   Expiring _____ 1st Prior _____ 2nd Prior _____ 3rd Prior _____

2. Define the service area, including all metro areas served by your business:

3. In the following table please provide the number of annual calls per vehicle, by type of call and type of vehicle. Provide this information for the expiring term and the estimate for the coming policy term.

	Projection for coming policy term		Actual from expiring policy term	
	Number of Vehicles	Avg calls per veh	Number of Vehicles	Avg calls per veh
Paratransit with wheelchair lift		NA		NA
Passenger vans w/out lift (ambulatory)		NA		NA
First Responder (no patient transport)				
Ambulance Class I				
Ambulance Class II				
Ambulance Class III				
Service or Private Passenger Type (PPT)		NA		NA

4. What is the estimated annual mileage traveled for all commercial vehicles? _____

5. What was the actual mileage traveled for all units in the expiring term? _____

6. Are the vehicles equipped with Driver Performance Monitoring Equipment? ☐ Yes ☐ No
   If Yes, please define the type of equipment and number of units equipped:

7. What are your hours of operation? _____

8. What are the maximum hours allowed per shift per employee? _____

9. Are drivers/attendees allowed to work multiple shifts? ☐ Yes ☐ No
   If Yes, please explain precisely how shifts are managed and the maximum hours an individual could be capable of working:

10. Do you require third party riders (non-patient/non-EMS personnel) to sit in the front passenger seat unless the patients well-being requires the rider to be in the back of the ambulance? ☐ Yes ☐ No

11. Do you allow EMT students to ride along on calls? ☐ Yes ☐ No
    If Yes, how many annually:

12. Do you ever allow volunteer or municipal fire fighters or police officers to operate one of your vehicles while your employees are providing medical treatment to a patient? ☐ Yes ☐ No

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F. Dispatch Questions

1. Are your dispatchers Emergency Medical Dispatch Certified? ☐ Yes ☐ No

2. Is your dispatch center a Public Safety Answering Point (PSAP)? ☐ Yes ☐ No
   If No:

   ☐ PSAP directly dispatches your units
   ☐ PSAP refers calls to your service for internal dispatch
   ☐ You do not interact with a PSAP

3. Is a record kept of each request for service? ☐ Yes ☐ No

4. Is a Patient Care Report (PCR) completed for each transport in which medical care, evaluation or observation has been performed?
   ☐ Yes ☐ No

5. Do you have protocols in place stating when Emergency Warning Systems (EWS) must be and may be activated? ☐ Yes ☐ No

G. Driver Questions

1. Can you please indicate the number of employees who have received Emergency Vehicle Operator Course training and certification by type.

Training Level	No Medical Training	Basic EMT/EMR	EMT	Advanced EMT	Paramedic
EVOC/CEVO Certified					
Other Driver Training (specify below)					
No certification or specific driver training					
Describe other Driver Training Courses					

2. Is EVOC training provided on site or from a third party training facility? ☐ Yes ☐ No
3. If a third party facility, what is the name of the school: _____
4. How frequently are employees required to take the course: _____
5. Does the insured have a drug testing program in place for:
   Pre-employment testing ☐ Yes ☐ No Post accident testing ☐ Yes ☐ No

4. Please provide the following information for the person who is responsible for new employee hiring, orientation & training:
   Name: _____ Title: _____

5. What is the average wage rate and how are drivers/attendants compensated:

Hourly Wage $ _____ Salary$ _____ weekly Other _____ per _____

6. What is the average annual employee turnover rate: _____%
7. What is the number of Full Time employees? _____
8. What is the number of Part Time employees? _____
9. Which of the following is a standard part of your pre-employment review?
   ☐ Written Application ☐ MVR Check ☐ Criminal Background Check
   ☐ Ride Along Driving Test ☐ Psychological Testing ☐ Job Specific Physical Examination
   ☐ Obtain evidence of Pertinent Certification Licensure

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H. General Liability

1. Does the applicant have ownership or interest in any other entity not declared in the General Information section of this application? ☐ Yes ☐ No
   If Yes, please explain:

2. Does the applicant loan or lease space to any other entity? ☐ Yes ☐ No
   If Yes, please provide details of the exposures:

3. Has the applicant entered into any written or verbal contracts that require a hold harmless, waiver of subrogation or primary/non-contributory wording? ☐ Yes ☐ No
   If Yes, please explain and provide a copy of the agreement:

4. Does the applicant operate from a fixed terminal location? ☐ Yes ☐ No
   If No, please explain:

5. If the applicant operates from more than one terminal location please answer the following for each location:
   a. Is the location fenced? ☐ Yes ☐ No
   b. What is the yard capacity for number of vehicles? _____
   c. What are the adjacent exposures? _____
   d. Are there on-site fuel storage or re-fueling facilities on the premises? ☐ Yes ☐ No
      If No, how are the tanks protected from vehicular collision:

6. Does the applicant provide any auto or equipment repair services for others? ☐ Yes ☐ No
   If Yes,
   Please attach the ACORD Garagekeepers application
   What are the gross receipts from this operation? _____
   What is the nature of the repair/service work being provided? _____

7. Does the applicant provide any Vocational Training for other than employees? ☐ Yes ☐ No
   If Yes,
   a. What is the total number of students per year? _____
   b. What certifications or degrees are offered? _____
   c. What are the annual receipts from this operation? _____
   d. If classes are conducted on site what is the capacity of the classroom provided in number of students? _____
   e. How often are classes conducted? _____ For what duration? _____

8. If the applicant is involved in any operations not already described please provide the exposure and an explanation of those operations.

Description of Operations	ISO Class Code	Exposure Basis	Exposure
Building or Premises - LRO	61212	Area	
Vacant Land	49451	Acreage	
Warehouse - Private	68707	Area	
Other			
Other			

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I. Medical Malpractice

1. In the following table please provide the number of annual calls by type of attendant certification.

Attendant Certification	Basic Life Support (BLS)	Advanced Life Support (ALS)	Critical Care	Non-Medical Transportation
None				
Basic EMT/EMR				
EMT				
EMT Advanced				
Paramedic				
Nurse				

2. Mark all of the following activities which make up a portion of your business and indicate for each the percentage of your total operations.

☐ Air Ambulance _____% ☐ Water Rescue _____% ☐ Off-Shore EMS _____%

☐ Tactical Medic Service % ☐ Confined Space Rescue % ☐ Aerial Rescue %

☐ Prisoner Transport %

3. Do you provide contracted or standby medical service for any of the following special events?

☐ Car/Motocross Races ☐ Horse Races ☐ Concerts

☐ High School/College Sports ☐ Professional Sports ☐ Night Clubs

☐ Other _____

4. Do you have a Medical Director on staff? ☐ Yes ☐ No

If No,

a. Where is the service provided? _____

b. Are you required to name them as an Additional Insured on the policy? ☐ Yes ☐ No

c. Name the organization providing the Medical Director _____

If Yes,

a. Is your Medical Director board certified in emergency medicine ☐ Yes ☐ No

b. Does your Medical Director provide consulting services for any other Emergency Response companies or organizations not owned and controlled by you? ☐ Yes ☐ No

5. Does the insured currently carry a Commission on Accreditation of Ambulance Services (CAAS) designation? ☐ Yes ☐ No

6. Do you have a violent patient restraint policy? ☐ Yes ☐ No

7. Do you have a mandatory lift assist policy? ☐ Yes ☐ No

8. What, if any, is the protocol for lifting and transporting Bariatric patients?

9. What proportion of your vehicles are equipped with Power Assist Cots (PACs)? _____

10. What type and model do you use?

☐ Stryker Model ☐ Ferno Model ☐ Other _____

11. Does the applicant utilize a Wheelchair Tie-Down Occupant Restraint System (WTORS) on all paratransit vehicles? ☐ Yes ☐ No
If Yes, name the system:

12. At what frequency are employees operating these vehicles trained in the use of these systems?

☐ Time of Hire ☐ Semi-Annually ☐ Annually

☐ Post-Accident ☐ Other _____

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THE FOLLOWING SECTIONS NEED ONLY BE COMPLETED IF THE APPLICANT IS REQUESTING COVERAGE FOR EMPLOYEE PRACTICES LIABILITY AND/OR ABUSIVE ACTS COVERAGE.

J. Employment Practices Liability

1. Has the company completed within the last 12 months or is the company considering within the next 12 months any layoffs or early retirement programs including reorganizations or facility closings? ☐ Yes ☐ No
   If Yes, when did or when will the layoffs occur and how many employees were or will be laid off:

2. Does the company have any planned transactions or events within the next 12 months that would increase the number of employees by more than 25%? ☐ Yes ☐ No
   If Yes, what is the projected estimated increase in total employee count:

3. Have there been during the last five years, or are there now pending, any employment related civil, criminal, administrative or arbitration proceedings (including any proceeding initiated before the Equal Employment Opportunity Commission) brought against the Company, "additional entities" or any person proposed for this insurance in their capacity as either Director, Officer, or employee of the Company or its "additional entities"? ☐ Yes ☐ No
   If Yes, please offer a complete explanation:

4. Have there been during the last five years, or are there now pending, any criminal, administrative or arbitration proceedings by any customer, client or other third party against the Company, "additional entities", or any person proposed for this insurance alleging discrimination, sexual harassment or violations of civil rights based upon discrimination or harassment? ☐ Yes ☐ No
   If Yes, please provide a complete explanation:

5. Does the applicant currently carry Employment Practices Liability coverage? ☐ Yes ☐ No
   If Yes, we will need the following additional information on the existing coverage:
   a. Name of current Insurer: _____
   b. Current Policy Limits: _____ Effective Date: _____
   c. If coverage is written on a claim made form, the original Retro Date: _____
   d. Limits of coverage requested: _____
   e. Has any claim been made or notice given to any Insurer over the past five years with respect to an incident involving Employment Practices Liability? ☐ Yes ☐ No
      If Yes, please offer a complete explanation:

If coverage is bound for this coverage we will require a more complete application form to be completed and returned with the applicant's signature. That application will be provided at time of quote.

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K. Abusive Acts Coverage

1. Do the employment and volunteer applications include questions concerning whether the individual has ever been convicted of any crime, including any sex-related crime? ☐ Yes ☐ No
2. Is there a written policy with procedures for screening and performing background checks of all prospective employees?
   ☐ Yes ☐ No
3. Have procedures been developed and publicized to employees for reporting and investigating alleged incidents of abusive acts?
   ☐ Yes ☐ No
4. Are application references checked and documentation maintained? ☐ Yes ☐ No
5. Is there a written policy addressing abusive acts? ☐ Yes ☐ No
   If Yes, how often is it communicated to all employees:
6. Is documentation maintained on awareness training of staff and students including how to recognize signs of abuse and what to do if someone reports abuse? ☐ Yes ☐ No
   If Yes, how often is the training conducted?:
7. Has the applicant or any employees of the applicant had any claim or suit brought against them as a result of abusive acts?
   ☐ Yes ☐ No
8. Does the applicant have knowledge of any fact, circumstance or situation which it has reason to suppose might give rise to a claim or allegation of an abusive act? ☐ Yes ☐ No
9. Does the applicant currently carry Abusive Acts coverage? ☐ Yes ☐ No
   If Yes, we will need the following additional information on the existing coverage:
   a. Name of current Insurer: _____
   b. Current Policy Limits: _____ Effective Date: _____
   c. If coverage is written on a claim made form, the original Retro Date: _____
   d. Limits of coverage requested: _____
   e. Has any claim been made or notice given to any Insurer over the past five years with respect to an incident involving Employment Practices Liability? ☐ Yes ☐ No
      If Yes, please offer a complete explanation:

L. Insured/Producer Signature

APPLICANT PLEASE READ

FRAUD WARNING: Any person who knowingly and with intent to defraud or deceive any insurer or another 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 and subjects the person to criminal and civil penalties. APPLICANT'S STATEMENT: By signing below, I acknowledge that I have read the above application and declare that to the best of my knowledge and belief all of the foregoing statements and answers are a just, true and full exposition of all of the facts and circumstances with regard to the risk to be insured.

Applicant's Signature: _____ Date: _____

Producer's Signature: _____ Date: _____