



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:

<u>Employed</u>	<u>Contract</u>	<u>Volunteer</u>	
_____	_____	_____	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	Claims-Made Premium	Eff. Date	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	Claims-Made Premium	Eff. Date	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.

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/Title
