NON-EMERGENCY AMBULANCE AND TRANSPORTATION SERVICES PROFESSIONAL AND GENERAL LIABILITY APPLICATION
CLAIMS MADE AND REPORTED BASIS

Please email this completed application to the IGP Specialty underwriter you are working with.
For contact information, please visit our Healthcare Program webpage.

Desired effective date: _____

GENERAL INFORMATION

1. Complete name of applicant facility (if other than parent firm, supply full details of ownership entity; attach an additional sheet if necessary):

   _____

   Address: _____
   City: _____ State: _____ County: _____ ZIP: _____
   Contact Name: _____ Title: _____
   Contact Email Address: _____ Phone: _____
   Website URL: _____
   List all other locations:

2. Applicant is:
   a. ☐ Individual ☐ Partnership ☐ Corporation ☐ Professional Association ☐ Other: _____
   b. ☐ Not-for-Profit ☐ For-Profit ☐ Both
3. Date established: _____

APPLICANT SERVICES

1. What service is provided to your client? _____
2. How are you contacted to provide your service?
   ☐ Funeral home ☐ Fire department ☐ Hospital ☐ Individual client ☐ Physician office ☐ Surgery center
3. What is your usual final destination? _____
4. IF YOU OPERATE A **NON-EMERGENCY** AMBULANCE SERVICE:
   a. Are the signed physician orders transported on board the ambulance with the patient? ☐ Yes ☐ No
   b. Name of all medical facilities the applicant is affiliated with:
   c. What types of ambulance transport services are provided?
   d. Are medical technicians trained and certified? ☐ Yes ☐ No

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5. Please indicate the number and type of your employees and/or volunteers. If none, state "none."
   a. Emergency Medical Technicians: _____
   b. Nurses, Licensed Practical: _____
   c. Nurses, Registered: _____
   d. Paramedics: _____
   e. No medical personnel in attendance—driver only: _____
   f. Other: _____
   If Other, specify: _____
   e. Are all of the above medical personnel licensed in accordance with applicable state and federal regulations? ☐ Yes ☐ No
   If no, please attach an explanation.

6. Please list the number and type of independent contractors who provide professional services on your behalf. If none, state "none."
   a. Emergency Medical Technicians: _____
   b. Nurses, Licensed Practical: _____
   c. Nurses, Registered: _____
   d. Paramedics: _____
   e. No medical personnel in attendance—driver only: _____
   f. Other: _____
   If Other, specify: _____
   e. Do you supervise any individuals who are not your own employees? ☐ Yes ☐ No
   If yes, please attach a detailed explanation of responsibilities and relationships to the entity which employs these individuals.

APPLICANT PROCEDURES

1. Do you render professional services directly to patients? ☐ Yes ☐ No
   If yes, please describe these services in detail and indicate whether you are supervised and by whom:

Detailed Description of Professional Services	Percent of Time	Supervised?	Title of Supervisor
	%	☐ Yes ☐ No	
	%	☐ Yes ☐ No	
	%	☐ Yes ☐ No	

2. Do you render professional services that do not involve contact with a patient? ☐ Yes ☐ No
   If yes, please describe these services in detail:

APPLICANT AFFILIATIONS

1. Are you employed by or under contract to any governmental entity? ☐ Yes ☐ No
   If yes, please attach an explanation, including details of your responsibilities.
2. Are you associated with any agency or organization that engages in advertising for, or solicitation of, patients? ☐ Yes ☐ No
   If yes, please attach a detailed explanation and copies of **all** relevant advertisements.

SERVICE BOUNDARY

1. What is the radius of operations of the non-emergency ambulance or transportation service? _____
2. Does the radius of operations include air ambulance service? ☐ Yes ☐ No
   a. How much of operations is provided for non-emergency air ambulance? _____
   b. Does the staff include attending flight physicians? ☐ Yes ☐ No
   If yes, do they carry attending flight physician's insurance? ☐ Yes ☐ No What limits? _____

ANNUAL NUMBERS

1. What are your gross annual revenues? $ _____

2. Please state the **annual** number of patient encounters (the number of patients transported by the ambulance service):
   Last 12 months: _____ Estimated next 12 months: _____
3. Please state the **annual** number of calls for emergencies:
   Last 12 months: _____ Estimated next 12 months: _____
4. Please state the **annual** number of calls for transporting patients to and from a hospital or other institution that are not accident cases:
   Last 12 months: _____ Estimated next 12 months: _____

DESCRIPTION OF VEHICLE(S)

1. Are the vehicles you use specifically built to transport clients? ☐ Yes ☐ No
   If no, what conversions were made? _____
2. Vehicles are best described as:
   ☐ Vans ☐ Buses ☐ Passenger cars ☐ Other (specify): _____
3. Safety features or equipment in all vehicles:
   ☐ Lifts ☐ Wheelchair accessible ☐ Standard tie-downs ☐ Ratchet tie-downs ☐ Stepwell lights ☐ Emergency exits
   ☐ Other (specify): _____
4. Number of vehicles including maximum passenger capacity currently in use: _____
5. Is vehicle equipped with any life saving apparatus? ☐ Yes ☐ No
   If yes, fully explain:

RISK MANAGEMENT

1. Who assists client into vehicle? _____
2. Are all drivers license checked for currency? _____
3. Are MVRs checked for all drivers? ☐ Yes ☐ No
4. Do you keep detailed records of all pick up and deliveries of clients? ☐ Yes ☐ No
5. Are drivers trained in proper use of safety devices in vehicles? ☐ Yes ☐ No
6. Does your automobile liability policy specifically exclude claims arising from loading and unloading of clients? ☐ Yes ☐ No
7. Do you allow volunteers to operate any vehicle? ☐ Yes ☐ No
   If yes, fully explain:

APPLICANT HISTORY *(Attach detailed explanation for any "yes" answers.)*

1. Have you or any of your employees:
   a. Ever been the subject of disciplinary or investigatory proceedings or reprimand by an administrative or governmental agency, hospital or professional association? ☐ Yes ☐ No
   b. Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? ☐ Yes ☐ No
   c. Ever been treated for alcoholism or drug addiction? ☐ Yes ☐ No
   d. Ever had any state professional license refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? ☐ Yes ☐ No
   e. Ever had any insurance company or Lloyd's cancel, decline, refuse to renew or accept only on special terms their malpractice insurance? ☐ Yes ☐ No

EXISTING INSURANCE

Do you currently carry the following:

1. Professional Liability Insurance? ☐ Yes ☐ No

   If yes, list the Professional Liability Insurance carried by the firm for each of the past five years including periods of no coverage:

Policy Period **FROM** MM/DD/YY	Policy Period **TO** MM/DD/YY	Insurance Company	Limit of Liability	Deductible	Policy Form: Claims Made **OR** Occurrence?	Premium
			$	$		$
			$	$		$
			$	$		$
			$	$		$
			$	$		$

   If claims made, what is the retroactive date/prior acts date on your current policy? _____

2. Commercial General Liability Insurance? ☐ Yes ☐ No

   If yes, list the Commercial General Liability Insurance currently carried by the firm:

Policy Period	Carrier	Limit of Liability BI/PD	Deductible	Policy Form: Claims Made **OR** Occurrence?	Premium
		$	$		$

   If claims made, what is the retroactive date/prior acts date on your current policy? _____

CLAIMS HISTORY

1. During the past five (5) years, have there been any professional or general liability claims or incidents made against you, any employee or former employee, the applicant or anyone proposed for this insurance? ☐ Yes ☐ No

   ATTACH CURRENTLY VALUED COMPANY LOSS RUNS FOR THE PRIOR FIVE (5) YEARS.

2. Are you, or anyone proposed for this insurance aware of any fact(s), incident(s), act(s), event(s), circumstance(s) or occurrence(s) that may result in a claim(s) being made against you? ☐ Yes ☐ No

   If yes, provide full details:

3. Have there been any prior complaints or incidents reported arising out of alleged or actual physical or sexual abuse or molestation?
   ☐ Yes ☐ No

   If yes, fully describe the circumstances and follow-up action taken:

APPLICANT SIGNATURE PANEL

THE APPLICANT DECLARES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE INCEPTION DATE OF THE POLICY PERIOD, IT WILL IMMEDIATELY NOTIFY THE UNDERWRITERS OF SUCH CHANGE. SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERWRITERS TO OFFER, NOR THE APPLICANT TO ACCEPT, INSURANCE; BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE INSURANCE AND MADE A PART OF THE POLICY SHOULD A POLICY BE ISSUED.

Notice applicable in most 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 conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

I/We hereby declare that the above statements and particulars are true and I/we agree that this application shall be the basis of the contract with the insurance company.

Authorized signature _____ Date _____

Typed or printed name: _____ Title: _____

