

APPLICATION FOR AMBULANCE PROVIDERS

1. Expiration Date or Effective Date (if new business): _____
2. Full Name of Service: _____
3. Street Address: _____
4. City: _____ County: _____ State: _____ Zip Code: _____
5. Mailing Address (if different): _____
6. Phone #: _____ FAX#: _____
7. Email address: _____ Web address www. _____
8. Name of Contact Person: _____ Title: _____
Phone # for Contact Person: _____
9. Type of Organization:
 Individual Partnership LLC Corporation- FEIN# _____
10. Is your service? For Profit Not for Profit
11. Date your service legally established: _____^{*}
*** If less than 3 years we will need resume for all owners/managers**

Number of years in this type of business: _____
Number of year's current ownership: _____
Number of year's current management in place: _____
12. Have you ever operated under a different name? Yes No
If yes, what name: _____
13. Is your service a subsidiary or division of another company? Yes No
If yes, please explain: _____
14. Is your service involved in any of the following? Yes No (If yes, please check)
 Air Ambulance Water Rescue Activities or operations other than EMS
 Special Event EMS Offshore EMS Mock Disaster participant

If checked yes to any of the above, please explain: _____

26. Radius of your operations:
 0-50 miles _____% 50-150 miles _____% over 150 miles _____%
27. What major cities does your operation travel to and how many times a year?

28. How often is a maintenance report completed on each ambulance and the equipment?
 By Run By Shift Daily Other (please explain) _____
29. Who maintains your vehicles? _____
Name of Company

Address City State Zip
30. Are maintenance records kept in files? Yes No
31. Please explain maintenance schedule for vehicles: _____

32. Are your vehicles locked when unattended? Yes No
33. How much above the posted speed limits will your ambulance travel during a true emergency mode? _____
34. Does your service allow third parties (other than patient or personnel) to ride in the ambulance? Yes No
35. Does your service maintain an accident review committee? Yes No
36. Does your service maintain accident files? Yes No If yes, for how long? _____
37. Fleet History/ Vehicle Count:

	Current Year	Previous Year	Previous Year	Previous Year	Previous Year
Ambulances					
Wheelchair Van(s)					
Passenger Van(s)					
Gurney/Stretcher Van(s)					
Corporate Vehicle(s)					
Service (all other units)					
Totals					

38. What is your minimum driver age? _____
39. Number of currently employed drivers: _____ Full Time _____ Part Time
40. What was the percentage of your driver turnover in the past 12 months? _____%.
41. Does your service review drivers motor vehicle reports? Yes No
How often? Annually Every 2-3 years More than 3 years
42. What does your service consider as an acceptable driver motor vehicle report? _____

43. Does your service provide an Ambulance Drivers Training Program? Yes No
If yes, which program(s) are drivers required to attend?
 Defensive Drivers Course: Film Hands-on Training
 Emergency Vehicle Operators Course (EVOC)
 Highway Patrol Training Fail Safe Drivers Training
 Road Safety Drive Cam GPS
 Other: _____
44. Please explain your Driver Training Program:

45. When adding new drivers, does your service require previous ambulance driving experience?
 Yes No If yes, how much experience do you require? _____
46. Are disciplinary measures utilized when accidents are determined to be your driver's fault?
 Yes No If yes, what are they? _____
47. What is the total replacement value of your Portable Equipment? \$ _____
48. Does your service carry Workers Compensation and Employer's Liability Coverage?
 Yes No If yes, please complete the following:
Name of Workers Compensation carrier: _____
Policy #: _____ Policy Period: _____
Employers Liability Limits:
Bodily Injury by Accident \$ _____, Each Accident
Bodily Injury by Disease \$ _____, Policy Limit
Bodily Injury by Disease \$ _____, Each Employee

COVERAGE SELECTION and SIGNATURE PAGE

Professional Liability/General Liability Limits (include a copy of your dec page)

\$1,000,000 any one claim/ \$2,000,000 annual aggregate professional liability incl. general liability

Is above coverage on claims made? Yes No If yes, what is the retro date: _____

Automobile Liability Limits (include a copy of your dec page)

\$1,000,000 combined single limit bodily injury & property damage

Is an **Umbrella** policy desired? Yes No

\$1,000,000 each occurrence/ \$1,000,000 annual aggregate

\$2,000,000 each occurrence/ \$2,000,000 annual aggregate

Other (please list)_____

Deductible Options (check one)

Automobile comprehensive and collision

\$500 \$1000 \$2000

Has any insurance carrier canceled or refused to renew any insurance within the past three years?

Yes No If yes, please give details: _____

Important: In order to process your application we will need **4 years current valued** loss runs from the insurance company. You can request these directly from the insurance company and/or the insurance agent your coverage was placed with at the time. If no losses occurred we still need a report from the insurance company showing no losses.

I declare that the information I have completed in this application along with any attachments is true and accurate to the best of my knowledge. I also understand that by withholding pertinent information or submitting false information could void any future policy that may be issued as a result of this application.

Applicants Signature

Title (please print)

Date

Name (please print) _____

Return To:

Cindy Elbert Insurance Services, Inc.

15182 North 75th Ave, #100

Peoria, AZ 85381

Phone: (602) 942-3900

FAX: (602) 942-4300

www.ambulanceinsurance.com

Email: info@ambulanceinsurance.com

Location Information

***Please complete for each location**

Location# _____ Building # _____

Building occupied as? Office Crew Quarters Garage Other _____

Location Street Address: _____

City: _____ State _____ Zip _____ Building Age: _____

Are you a owner, tenant or lessee? Total square footage of building: _____

Total square ft you occupy: _____ # of stories: _____ Basement? yes no

Building Construction: frame stucco brick block steel other: _____

Any other businesses in the building? yes no What Kind? _____

Do you have a burglar alarm? yes no What Kind?: _____

Does this location have sprinklers? yes no

Do you have fire extinguishers and smoke detectors? yes no

Is Property Coverage needed? Yes No If yes, please complete below:

Building value: \$ _____ (Complete value if you own the building)

Contents, Furniture, Fixtures & Equipment (inside) Value: \$ _____

Computer Hardware Value: \$ _____ Computer Software Value: \$ _____

Deductible: \$250 \$500 \$1,000

Certificate Holder: _____

Address: _____

Attn: _____ Phone#: _____ FAX#: _____

Additional Insured

Mortgagee

Loss Payee

