CINDY ELBERT INSURANCE SERVICES

APPLICATION FOR AMBULANCE PROVIDERS

BASIC INFORMATION

1. Named Insured: _____ 2. DBA: _____
3. Mailing Address: _____
4. Physical Address: _____
5. Phone: _____ 6. Fax: _____
7. Website Address: _____
8. Owners Name: _____ 9. Email Address: _____
10. Safety Manager's Name, Cellphone Number & Email Address: _____
11. Type Of Entity: ☐ Corporation ☐ Individual ☐ Partnership ☐ Joint Venture ☐ LLC
12. FEIN/Social Security Number: _____
13. Date business started under current ownership: _____ Is this a new venture? ☐ Yes ☐ No
14. Are ICC, PUC or other filings required? ☐ Yes ☐ No (If yes, provide copies.)
15. Is your business a subsidiary or division of a parent company? ☐ Yes ☐ No

    If yes, name of company: _____

16. Has your business, its owner(s), officers, directors or employees ever been party to any civil, criminal or regulatory proceedings resulting in an administrative sanction or license suspension or revocation? ☐ Yes ☐ No If yes, please explain on a separate sheet.
17. Has your business had a change of ownership in the past 3 years? ☐ Yes ☐ No
    If yes, please explain: _____

OPERATIONAL INFORMATION

1. List the major metropolitan area(s) served:
   A. _____ B. _____
2. The number of ambulance calls in the past 12 months? _____ Emergency Non Emergency _____
   The estimated ambulance calls in the next 12 months? _____ Emergency Non Emergency _____
3. The number of paratransit/wheelchair calls in the past 12 months: _____
   The estimated paratransit/wheelchair calls in the next 12 months: _____
4. Does your service perform the following?
   ☐ Thrombolytic Therapy ☐ Conscious Sedation ☐ Endotracheal Intubation ☐ Capnography or Capnometry
   ☐ Pulse Oximetry ☐ Manual Defibrillation ☐ 12-Lead EKG Monitoring ☐ Telemetry ☐ Mechanical Ventilation
   ☐ IV Therapy or Monitoring
5. Does your service have a Medical Director? ☐ Yes ☐ No

6. Number of full and part time employees/volunteers that drive or provide patient care:
   _____ Paramedics
   _____ Critical Care Paramedics
   _____ Registered Nurses
   _____ Advanced EMT (EMT-A or EMT-I)
   _____ Emergency Medical Tech (EMT-B)
   _____ Emergency Medical Responder (EMR, First Responder)
   _____ Other
   _____ TOTAL

7. What are the vehicle counts for the following classifications:

Type of Auto	As of Today	Renewal Date 1 year ago	Renewal Date 2 years ago
Ambulances			
Paratransit/Wheelchair			
First Responder			
Service (all other autos)			

8. Patient Handling: Stretcher
   a) Select all Stretcher types used at your service and give the brand and number of each type:

Type of Stretcher	Brand	Number
X-Frame		
Fold Away Undercarriage		
Power Cot		
Bariatric Cot		
Other		

   b) Does your service use knee, hip, chest and over the shoulder safety restraints on your stretchers? ☐ Yes ☐ No
   c) Does your service have a mandatory lift assist policy? ☐ Yes ☐ No
   d) Select the engineering controls used at your service and given the brand and number of each type:

Engineering Control	Brand	Number
Specialty Vehicles (Bariatric Units)		
Ramps with Winches		
Lateral Transfer Aids		
Motorized Stair Chairs		
Other		

9. Patient Handling: Wheelchair
   a) Name the wheelchair tie-down occupant restraint system (WTORS) you use:
   _____
   b) Provide product documentation that the WTORS meets SAE J2249 (WTORS) ISO 10542 standards.
   c) If you do not use a commercially developed WTORS, please provide a copy of the section of your SOP that outlines the manner in which you use the system to tie down a wheelchair and restrain its occupant.
   d) Please provide the section of your SOP that addresses the transportation of a scooter and its user.
   _____

10. Do you transport prisoners or others whose pick up site is determined by their legal status? ☐ Yes ☐ No
    If yes, please list the contracts responsible for these transports and provide a copy of your restraint policy including obligations regarding client escape: _____
    _____
    _____

11. Onboard Monitoring (OBM) (black box, cameras, GPS, stickers)
    a) Brand name of system(s): _____
    b) Date the system was installed: _____
    c) Number of vehicles currently installed with the system: _____
    d) Employee responsible for the management of the OBM:
    Name: _____ Phone Number: _____
    Email: _____

12. Dispatch
    a) Is your dispatch center a Public Safety Answering Point (PSAP)? ☐ Yes ☐ No
    If no, please check the following if it applies:
    ☐ PSAP directly dispatches your units
    ☐ PSAP refers calls to your service for internal dispatch.
    ☐ You do not interact with a PSAP.
    b) Check the functions performed by your internal dispatchers:
    ☐ Dispatch emergency requests for your service. ☐ Dispatch non-emergency requests for you service.
    ☐ Schedule routine ambulance transfers. ☐ Schedule wheelchair/paratransit transfers.
    ☐ Screen calls to determine whether or not an ambulance will be sent.
    c) How many years experience are dispatchers required to have prior to hiring? _____
    d) Are your dispatchers Emergency Medical Dispatch Certified? ☐ Yes ☐ No
    e) Describe your in-house training for dispatchers, including length of training: _____
    _____
    _____
    f) The name of the dispatch software used: _____

13. Is your business involved in:
    ☐ Air Ambulance ☐ Water Rescue ☐ Off-Shore EMS ☐ Aerial Rescue ☐ Tactical Medic Services
    ☐ Confined Space Rescue
    Special Events: ☐ Car/Motocross Races ☐ Horse Races ☐ Concerts ☐ High School Sports
    ☐ Professional Sports ☐ Night Clubs ☐ Rave Events
    Total Annual Receipts from the above contracts: _____

14. Is your service involved in activities or operations other than EMS? ☐ Yes ☐ No
    If yes, explain: _____

VEHICLE MAINTENANCE

1. Is a condition report completed on each transport vehicle and its equipment on each shift? ☐ Yes ☐ No
   If no, please explain: _____

2. Does the maintenance schedule for your fleet meet or exceed the manufacturer's recommendations? ☐ Yes ☐ No
   If no please explain: _____

3. Who performs the maintenance on your fleet? _____
   Are they certified by the manufacturer? ☐ Yes ☐ No

4. Do you keep maintenance repair records on file for each vehicle? ☐ Yes ☐ No
   If no, please explain: _____

5. Do you perform any after-market vehicle modifications? ☐ Yes ☐ No
   If no, please explain: _____

HUMAN RESOURCE

1. Please provide the following information for the person who is responsible for new employee orientation:
   Name: _____ Title: _____
   Cell Phone: _____ Email: _____

2. Check all that apply to your employee selection process:
☐ Written Application ☐ Job Specific Physical Examination ☐ Psychological Testing
☐ Criminal Background Check ☐ MVR Check ☐ Obtain evidence of Pertinent Certification Licensure
☐ Post Employment Drug Screening

3. Is previous ambulance driving experience required on new hires? ☐ Yes ☐ No
If yes, how many years?_____

4. Please provide the name of the driver training program(s) that you provide or participate in:
# of Classroom Hours:_____ # of Behind the Wheel Hours:_____

5. What is your employee turnover rate?_____

SAFETY/RISK MANAGEMENT

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

2. Is a trip ticket for billing purposes completed for each transport? ☐ Yes ☐ No

3. Is a patient care report (PCR) completed for each transport in which medical care, evaluation or observation has been performed? ☐ Yes ☐ No ☐ N/A

4. What % of your trip tickets and call reports are reviewed for completeness, legibility and when applicable, clinical content? _____
How frequently are they reviewed? ☐ Daily ☐ Weekly ☐ Other _____
Who is responsible for the reviews?
Name:_____ Title:_____
Phone #: _____ Email: _____

5. At what speed may your ambulances operate with the Emergency Warning Systems (EWS) activated?_____

6. Who determines when the EWS is to be activated?_____

7. Are your vehicles always locked when unattended? ☐ Yes ☐ No

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

9. Does your service maintain accident files? ☐ Yes ☐ No If yes, for how long do your keep the files? _____

10. Are safety violations (i.e. auto crashes) part of your progressive discipline process? ☐ Yes ☐ No

11. Does your service have a Medical Equipment Failure policy? ☐ Yes ☐ No
If yes, does it address checking, charging and replacing batteries for medical equipment? ☐ Yes ☐ No

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

WORKERS' COMPENSATION

Name of Carrier: _____
Policy #: Eff. Dates: _____ to _____
Employers Libility Limit: $_____
Bodily Injury by Accident: $_____ Each Accident
Bodily Injury by Disease: $_____ Policy Limit
Bodily Injury by Disease: $_____ Each Employee

LIMITS / OPTIONS

Automobile Liability Limits (check one)

☐ $500,000 Combined Single Limit Bodily Injury & Property Damage
☐ $1,000,000 Combined Single Limit Bodily Injury & Property Damage

Professional Liability and General Liability Limits (check one)

☐ $500,000 Each Occurrence / $1,000,000 Annual Aggregate
☐ $1,000,000 Each Occurrence / $2,000,000 Annual Aggregate
☐ $1,000,000 Each Occurrence / $3,000,000 Annual Aggregate

Is General Liability or Professional Liability Claims Made? ☐ Yes ☐ No If yes, Retro Date _____

Excess Liability Limits (check one)

☐ $1,000,000
☐ $2,000,000
☐ $3,000,000
☐ $4,000,000
☐ $5,000,000
☐ Other: _____

Inland Marine Coverage (medical equipment, portable equipment and inventory)

Total Value: $_____ Deductible: ☐ $500 ☐ $1,000

Automobile Physical Damage Deductible Options (check one)

☐ $500 ☐ $1,000 ☐ $2,000 ☐ Other_____

Is Property Coverage desired? ☐ Yes ☐ No If yes, complete Location Information Sheet

Has any insurance carrier canceled or refused to renew any insurance within the past three years? ☐ Yes ☐ No
If yes, reason: _____

Date current insurance coverage expires: _____ Date insurance quote needed: _____

Include with the application a copy of your current insurance policies showing coverage, term, limits and premiums.

GENERAL STATEMENT
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 and subjects that person to criminal and civil penalties (In Oregon, the aforementioned actions may constitute a fraudulent insurance act which may be a crime and may subject the person to penalties). (In New York, the civil penalty is not to exceed five thousand dollars ($5,000) and the stated value of the claim for each such violation). (Not applicable in AL, AR, AZ, CO, DC, FL, KS, LA, ME, MD, MN, NM, OK, PR, RI, TN, VA, VT, WA and WV).

APPLICABLE IN AL, AR, AZ, DC, LA, MD, NM, RI and WV
Any person who knowingly (or willfully in MD) presents a false or fraudulent claim for payment of a loss or benefit or who knowingly (or willfully in MD) presents false information in an application for insurance is guilty of a crime and may be subject to fines or confinement in prison.

APPLICABLE IN COLORADO
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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

APPLICABLE IN FLORIDA and OKLAHOMA
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony (In FL, a person is guilty of a felony of the third degree).

APPLICABLE IN KANSAS
Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

APPLICABLE IN MAINE, TENNESSEE, VIRGINIA and WASHINGTON
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 a denial of insurance benefits.

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
Email: info@ambulanceinsurance.com
www.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

VEHICLE SCHEDULE

Year	Make	Mfgr	Type I, II, III or other	VIN Number	Garage Location	Use of Vehicle*	Original Cost New	Today's Value
2000 Example	Ford Example	Horton Example	Type II Example	1FMZA74EG2HA15847 Example (should be 17 digits)	Nowhere, AZ Example	A Example	$75,000 Example	$60,000 Example

***Use of vehicle:** A=Ambulance WCV=Wheelchair Van PV=Passenger Van GV=Gurney/Stretcher Van

C=Corporate Vehicle S=Service Vehicle

LIST OF CERTIFICATE HOLDERS

Certificate Holder:	Address:	Attn:	Phone#:	FAX#:	Interest*	Coverage**
City of Kalamazoo- **Example**	1234 Saturn Drive Nowhere, AZ 12345-**Example**	Jenny Doe **Example**	555-867-5309 **Example**	555-867-5309 **Example**	V **Example**	GL, PL AL **Example**

*Interest: V=Verification of Insurance A=Additional Insured L=Loss Payee M=Mortgagee

**Coverage: GL= General Liability PL=Professional Liability AL=Auto Liability APD=Auto Physical Damage

PC= Property Contents PB=Property Building IM=Portable Equipment

DRIVER LIST

**Please list all drivers, this would include full time, part time, volunteer, infrequent or incidental that are authorized to operate any of the insured's vehicles.

NAME (As it appears on drivers license)	Date of Birth	Driver's License Number	State	Date Employed