

APPLICATION FOR WORKERS' COMPENSATION

Expiration Date or Effective Date (if new business): _____

Full Name of Service: _____

Street Address: _____

City: _____ County: _____ State: _____ Zip Code: _____

Mailing Address (if different): _____

Phone #: _____ FAX#: _____

Email address: _____ Web address www. _____

Name of Contact Person: _____ Title: _____

Phone # for Contact Person: _____

Type of Organization: Individual Partnership LLC Corporation

FEIN# _____

Is your service? For Profit Not for Profit Date your service legally established: _____

Please include a copy of your current Insurance policy Dec page, experience mod worksheet, and 4 years current valued loss history

Classification	Code	# of Employees		Estimated Annual Payroll
		Full Time	Part Time	
Driver	_____	_____	_____	\$ _____
Clerical	_____	_____	_____	\$ _____
Sales	_____	_____	_____	\$ _____
Other	_____	_____	_____	\$ _____

Employers Liability Limits Desired (each accident/policy limit/each employee)

\$100/\$500/\$100

\$500/\$500/\$500

\$1mil/\$1mil/\$1mil

Officers, Partners and/or Relatives included or excluded

Name	DOB	Title/Relationship	% of ownership	Include or		Remuneration
				Exclude		
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

1. Any employees under 16 or over 60 years of age Yes No
2. Any Seasonal employees Yes No
3. Is there any volunteer or donated labor Yes No
4. Any employees with Physical Handicaps Yes No
5. Do employees travel out of State Yes No
6. Are Athletic Teams Sponsored Yes No
7. Group medical provided Yes No
8. Do you provide 24 hour 365 day a year service Yes No
If no, what are your hours of operation? _____
9. Does your service contract to provide primary 911 response Yes No
10. Total Estimated number of annual ambulance calls: _____
_____ % of total ambulance calls are BLS Non-Emergency
_____ % of total ambulance calls are ALS Emergency
_____ % of total ambulance calls are 911 Emergency
Total Estimated number of annual paratransit calls: _____
11. Does your service perform pre-employment screenings that include evaluation of the potential employee's ability to meet all of the physical challenges of the job?
 Yes No
12. Pre-employment application required Yes No
13. Previous job reference checked Yes No
14. Physical required after employment Yes No
15. Drug testing after employment Yes No
16. New employee orientation Yes No
Describe program: _____

17. Does your company staff training program include the following items:
Importance of personal safety Yes No
Correct body mechanics Yes No
Correct lifting techniques Yes No
Use of personal protective equipment Yes No
18. Does the staff training program documents show when each employee received the training and what the training consisted of? Yes No
19. Is seatbelt use mandated at all times Yes No

20. Describe what disciplinary action is taken when employees do not follow established policies and procedures _____

21. Does the service follow OSHA standards for the following?

Bloodborne pathogens Yes No Hazard communication Yes No

Vehicle maintenance Yes No Sanitation Yes No

Portable fire extinguishers Yes No Personal protective equipment Yes No

22. Breakdown the highest number of employees at a single location at one time (please attach additional list if more than 4 locations)

Location #1: _____ Location #2: _____

Location #3: _____ Location #4: _____

23. Does your service provide a Drivers Training Program? Yes No

If yes, which program(s) are drivers required to attend?

Defensive Drivers Course: Film Hands-on Training GPS

Emergency Vehicle Operators Course (EVOC) Road Safety Drive Cam

Describe your Driver Training Program:

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

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