CINDY ELBERT INSURANCE SERVICES

A DIVISION OF WORLD

APPLICATION FOR AMBULANCE PROVIDERS

GENERAL INFORMATION

1. Expiration Date or Effective Date (if new venture):_____
2. Named Insured: _____
3. DBA: _____
4. Mailing Address: _____
5. Physical Address: _____
6. Phone: _____ Fax: _____
7. Website: _____
8. Owner's Name: _____ Email:_____
9. Type of Entity: ☐ Corporation ☐ Individual ☐ Partnership ☐ Joint Venture ☐ LLC
10. FEIN: _____
11. Date business started:_____ *Is this a new venture? ☐ Yes ☐ No

***If less than 3 years, we will need resume on all managers/owners.**

12. Are PUC, Form E/F, or MC-90 filings required? ☐ Yes ☐ No (If yes, provide copies.)
13. Is your business a subsidiary or division of a parent company? ☐ Yes ☐ No

If yes, name of company: _____

14. Has your business had a change of ownership in the past 3 years? ☐ Yes ☐ No If yes, please explain:

_____

15. Have you ever been cancelled or non-renewed? ☐ Yes ☐ No If yes, please explain:

_____

16. Have you ever filed for bankruptcy? ☐ Yes ☐ No If yes, please explain:

_____

17. Estimated Annual Revenue: $ _____
18. Hours of Operation:_____

OPERATIONAL INFORMATION

1. What major cities do you transport in? _____

2. **Type/Number of Calls**

	Past 12 Months	Next 12 Months
Emergency Ambulance		
Non-Emergency Ambulance		
Paratransit Ambulatory		
Paratransit Wheelchair		

Emergency Ambulance Calls: Transports dispatched as, or switched mid-transport to, emergency status with lights & sirens activated

Non-Emergency Ambulance Calls: Transports conducted in ambulances; no lights & sirens

Paratransit Ambulatory: Transports conducted not needing a wheelchair

3. Total Estimated Annual Mileage: _____
4. Radius of operation (total to 100%): _____% 0-50 Miles _____% 51-200 Miles _____% 200+ Miles

5. Does your service perform the following? ☐ Automatic External Defibrillation ☐ 12-Lead EKG Monitoring ☐ Telemetry
☐ Pulse Oximetry ☐ Conscious Sedation ☐ Thrombolytic Therapy ☐ Manual Ventilation ☐ Manual Defibrillation
☐ Endotracheal Intubation ☐ IV Therapy/Monitoring ☐ Paralytic Administration ☐ Capnography/Capnometry

6. Indicate the highest level of EMS Service provided: ☐ Basic Life Support ☐ Advanced Life Support

7. Do you utilize a Medical Director? ☐ Yes ☐ No If yes, please provide the following:

a. Name: _____

b. Licensed to Practice Medicine: ☐ Yes ☐ No

c. Board Certified: ☐ Yes ☐ No

d. Formal Job Description ☐ Yes ☐ No

e. For Administrative Duties ☐ Yes ☐ No

f. Are all medical transports documented with regular quality review by the Medical Director? ☐ Yes ☐ No

8. Number of full and part time employees/volunteers:

_____ Paramedics _____ Critical Care Paramedics

_____ Registered Nurses _____ Emergency Medical Tech (EMT)

_____ Ambulatory/Wheelchair Operators _____ Other (office, service, etc.)

_____ Advanced EMT

_____ **TOTAL**

9. Patient Handling:

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

Type of Stretcher	**Brand**	**How Many?**
X-Frame		
Power Cot		
Other		
Lateral Transfer Aids		
Motorized Stair Chairs		

b) Does your service use knee, hip, chest and over the shoulder safety restraints on your stretchers? ☐ Yes ☐ No

10. Name the wheelchair tie-down occupant restraint system (WTORS) you use: _____

11. Do you transport prisoners? ☐ Yes ☐ No

12. Onboard Monitoring (OBM): ☐ Cameras ☐ GPS ☐ Other: _____

a) Brand name of system(s): _____

b) Date installed: _____ Number of Units Equipped: _____

d) Name of employee responsible for the management of the OBM: _____

Phone Number: _____ Email: _____

13. Dispatch

a) Is your dispatch center a Public Safety Answering Point (PSAP)? ☐ Yes ☐ No

b) Check the functions performed by your internal dispatchers:

☐ Dispatch emergency requests for your service ☐ Dispatch non-emergency requests for your 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 of 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 or training:

_____

f) What dispatch software do you use? _____

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

_____

15. Does your service perform Community Paramedicine/Mobile Integrated Health Services? ☐ Yes ☐ No If yes, please explain: _____

16. Is your business involved in any special events? ☐ Yes ☐ No If yes, what kind?

_____

DRIVER INFORMATION

1. In the past year, how many drivers were hired? _____ How many were terminated? _____
2. Is previous ambulance driving experience required on new hires? ☐ Yes ☐ No
   If yes, how many years? _____
3. What is your minimum driver age? _____
4. Number of currently employed drivers: _____ Full-Time _____ Part-Time
5. What was the percentage of your driver turnover in the past 12 months? _____%
6. Please provide the name of the driver training program(s) that you provide or participate in:
   ☐ EVOC ☐ CEVO ☐ Other: _____
   # of Classroom Hours: _____ # of Behind the Wheel Hours: _____
7. What is the training requirement for all drivers, and is there refresher training? Please describe:

_____

8. Does your service review drivers' motor vehicle reports? ☐ Yes ☐ No
   If yes, how often? ☐ Annually ☐ Every 2-3 Years ☐ More than 3 years ☐ Other: _____

VEHICLE MAINTENANCE

1. Is there a pre and/or post-trip vehicle inspection report conducted? ☐ Yes ☐ No
2. What is your maintenance schedule for your vehicles? _____
3. Who performs the maintenance on your vehicles? _____
   a) 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:

_____

SAFETY / RISK MANAGEMENT

1. Safety Manager's Name: _____ Phone Number: _____

   Email: _____
2. Check all that apply to your employee selection process:

☐ Written Application ☐ Job Specific Physical Examination ☐ Psychological Testing
☐ Criminal Background Check ☐ Obtain evidence of Pertinent Certification Licensure ☐ MVR Check
☐ Pre-Hired Drug Screening

3. Do you conduct post-employment drug testing? ☐ Yes ☐ No
4. Is a post-accident drug testing policy in place? ☐ Yes ☐ No
5. Do you allow 24-hour shifts? ☐ Yes ☐ No If yes, what percentage of shifts are 24-hours in length? _____
6. Do you have a formal fatigue management program? ☐ Yes ☐ No
7. Max # of hours per week per employee: _____ & Hours required between shifts: _____

8. What are your procedures for transporting bariatric patients?

_____

9. What procedures are employees required to follow when approaching an intersection, with lights & sirens?

_____

10. Who determines when lights & sirens are activated? _____

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

12. Do you require third party riders to be seated and buckled in the front passenger seat? ☐ Yes ☐ No

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

14. What is your accident review/investigation procedure? Please describe:

_____

15. Do you report all incidents and accidents promptly to your insurance carrier? ☐ Yes ☐ No

16. Are safety violations part of your progressive discipline process? ☐ Yes ☐ No

17. Does your service have a mandatory lift assist policy? ☐ Yes ☐ No

18. 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

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

20. Please describe your Patient Handling Training, including how often it is conducted:

_____

21. Please describe your policy for patient securement:

_____

22. How often do you hold safety meetings? _____

COVERAGE & LIMITS OPTIONS

1. **Auto Liability Coverage:** ☐ Yes ☐ No
   Desired Auto Liability Limit: $ _____
   Uninsured/Underinsured Motorist: $ _____

2. **Automobile Physical Damage:** ☐ Yes ☐ No
   Desired Collision Deductible: $ _____
   Desired Comprehensive Deductible: $ _____

3. **Medical Professional Liability:** ☐ Yes ☐ No
   If Yes: ☐ Occurrence ☐ Claims Made (Retroactive Date: _____)
   Desired Limits: ☐ $1,000,000 each incident / $2,000,000 aggregate
   ☐ $1,000,000 each incident / $3,000,000 aggregate

4. **General Liability:** ☐ Yes ☐ No
   If Yes: ☐ Occurrence ☐ Claims Made (Retroactive Date: _____)
   Desired Limits: ☐ $1,000,000 each incident / $2,000,000 aggregate
   ☐ $1,000,000 each incident / $3,000,000 aggregate
   Stop Gap Employers Liability:* ☐ Yes ☐ No

Only available if you have employees in one or more of the following states: North Dakota, Ohio, Washington, and Wyoming

5. **Abuse Liability:** ☐ Yes ☐ No
   If Yes: ☐ Occurrence ☐ Claims Made (Retroactive Date: _____)
   Desired Limits: $ _____

6. **Employee Benefits Liability:** ☐ Yes ☐ No Retroactive Date: _____

7. **Employment Practices Liability:** ☐ Yes ☐ No Retroactive Date: _____

8. **Cyber Liability:** ☐ Yes ☐ No Retroactive Date: _____

9. **Real and Personal Property:** ☐ Yes ☐ No ***If yes, please fill out the Supplemental Property application***
   Building Coverage: ☐ Yes ☐ No
   Contents Coverage: ☐ Yes ☐ No

10. **Portable Equipment:** ☐ Yes ☐ No
    Desired Limit: $ _____
    Desired Deductible: $ _____

11. **Workers' Comp Coverage:** ☐ Yes ☐ No ***If yes, please fill out the Workers' Comp application***
    Effective Dates: _____ to _____
    Desired Limits: Each Accident / Policy Limit / Each Employee
    ☐ $1,000,000 / $1,000,000 / $1,000,000
    ☐ $500,000 / $500,000 / $500,000
    ☐ $100,000 / $500,000 / $100,000

12. **Umbrella:** ☐ Yes ☐ No
    Desired Limit: $ _____ in excess of scheduled primary limits

SUPPLEMENTAL PROPERTY APPLICATION

1. Business Name: _____

2. Effective date of coverage desired: _____ Building occupied as: _____

3. **Property and Location Information:** Location #: _____ Building #: _____

4. Location Street Address: _____

City: _____ State: _____ Zip: _____ Building Age: _____

5. Do you: ☐ Own ☐ Rent ☐ Lease

6. Total square footage of building: _____

7. Total square footage you occupy: _____

8. Number of stories: _____

9. Is the building sprinklered? ☐ Yes ☐ No

10. Building Construction: ☐ Frame ☐ Joisted Masonry ☐ Non-Combustible ☐ Masonry Non-Combustible ☐ Modified Fire Resistive ☐ Fire Resistive

11. Any other businesses in the building? ☐ Yes ☐ No If yes, what kind? _____

12. Do you have a burglar alarm? ☐ Yes ☐ No If yes: ☐ Central Station ☐ Local Gong

13. Do you have fire extinguishers and smoke detectors? ☐ Yes ☐ No

AMOUNT OF INSURANCE:

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

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

3. Computer Hardware Value: $ _____ Computer Software Value: $ _____

4. Deductible: ☐ $250 ☐ $500 ☐ $1,000

5. Do you have a mortgagee and/or loss payee? ☐ Yes ☐ No If yes, please fill out the following:

Name of Interest	Address	Attn	Interest*	Coverage**

***Interests:** ***M** = Mortgagee* ***LP** = Loss Payee*

****Coverages:** ***B** = Building* ***C** = Contents*

VEHICLE SCHEDULE

	Year	Make	Model/Unit #	VIN	Garaging Location	Use of Vehicle*	Original Cost New	Today's Value
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

***Use of vehicle:** **A** = Ambulance **PWCV** = Paratransit Wheelchair Van **PAML** = Paratransit Ambulatory
PPS = Private Passenger/Service (non-patient transport)

DRIVER SCHEDULE

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

Name (as it appears on license)	Date of Birth	Driver's License #	State Licensed	Date of Hire

SCHEDULE OF LOCATIONS

	Street Address	City, State	Zip Code	Square Footage	Building Occupied As
1.					
2.					
3.					
4.					
5.					

LIST OF CERTIFICATE HOLDERS

Certificate Holder Name:	Address:	Attn:	Interest*	Coverage**

***Interests:** ***V** = Verification of Insurance* ***A** = Additional Insured* ***L** = Loss Payee*

****Coverages:** ***GL** = General Liability* ***AL** = Auto Liability* ***APD** = Auto Physical Damage*
***PC** = Property Contents* ***PB** = Property Building* ***IM**= Portable Equipment*

FRAUD WARNINGS

GENERAL FRAUD STATEMENT (not applicable in Colorado, Florida, Hawaii, Massachusetts, Nebraska, Ohio, Oklahoma, Oregon and Vermont) Any person who knowingly and with intent to defraud any insurance company or another 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 fact material thereto, commits a fraudulent insurance act, which is a crime and subjects the person to criminal and (NY: substantial) civil penalties. In the District of Columbia, Louisiana, Maine, Tennessee and Virginia, and Washington insurance benefits may also be denied.

NOTICE TO COLORADO APPLICANTS: THIS NOTICE IS A PART OF YOUR APPLICATION FOR PROFESSIONAL

LIABILITY INSURANCE: 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.

NOTICE TO FLORIDA APPLICANTS: 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 of the third degree.

NOTICE TO HAWAII APPLICANTS: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment or both.

NOTICE TO OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: A person who knowingly and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO OREGON APPLICANTS: Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact, may be violating state law.

NOTICE TO VERMONT APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto, may be committing a crime, subjecting the person to criminal and civil penalties.

THE APPLICANT DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE.
THE APPLICANT AGREES THAT IF THE INFORMATION SUPPLIED ON THE APPLICATION BY THE APPLICANT CHANGES BETWEEN THE DATE OF THE APPLICATION AND THE EFFECTIVE DATE OF INSURANCE, APPLICANT WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS AND/OR AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

Please forward the completed application to us now. Request the following and once you have received them please send to us:

- *Currently valued loss runs for the past 5 years*
- *Copies of your current insurance policies*

Applicant's Signature: _____ Date: _____

Producer's Signature: _____ Date: _____

Please return signed and completed application to:
Cindy Elbert Insurance Services, Inc.
15182 N. 75th Ave., Ste. 100, Peoria, AZ 85381
Phone: 602-942-3900 | Fax: 602-942-4300 | Email: info@ambulanceinsurance.com