

Specialty Lines

UNDERWRITERS

1233 North Mayfair Road, Suite 208 • Milwaukee, WI 53226
Phone: 414-778-3560 • Fax: 414-778-3598

ALLIED MEDICAL AMBULANCE/NON-EMERGENCY TRANSPORT SUPPLEMENTAL APPLICATION

SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION

GENERAL INFORMATION:

1. Number of volunteer members: _____ Number of Paid members: _____
Population of area served: _____ Radius of operation (mi.): _____
2. Is your service involved in:
- | | |
|---|--|
| Air Ambulance Operations | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Water Rescue Operations | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Off-shore EMS | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Activities or Operations other than EMS | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Special Event EMS | <input type="checkbox"/> No <input type="checkbox"/> Yes |

If "Yes," to any of the above, provide details: _____

Number of:		Number of hours of annual training for each:
EMTS – A		
EMTS – P		
Nurses		
Other		

Number of:		Number of:	
EMTS		Non-emergency Calls	
Paramedics		Ambulances	
Emergency Calls		Vans	
		Air Ambulance	

3. Do you administer any anesthesia? No Yes
4. Any physician, nurse practitioner or CRNA exposure? No Yes
Please provide number _____ and explain duties: _____
5. Do you contract your services to others on an independent contractor basis? No Yes
6. If "Yes," please advise to whom you contract your work: _____
7. Name of your Auto Liability Insurance Carrier for the upcoming policy year? _____
- a. Does your Auto Liability policy specifically exclude claims arising from loading and unloading of patients? No Yes
- b. Does your Auto Liability policy remain silent on the applicability of coverage for claims arising from loading and unloading of patients? No Yes
- c. If "No," please explain: _____

DECLARATION AND SIGNATURE:

The undersigned declares that to the best of his/her knowledge the statements in this application and its attachments are true. The company is hereby authorized to make any investigation and inquiry deemed necessary in regard to this application.

Applicant's Signature

Sub-Producer

Title/Date

Producer

SIGNING THIS FORM DOES NOT BIND THE APPLICANT OR THE COMPANY OR THE UNDERWRITING MANAGER TO COMPANY THE INSURANCE. Application MUST be currently signed, completed and dated to be considered for quotation.

During the past five (5) years, have any claims been presented to your current or prior insurance No Yes carrier or to you? If "Yes," complete the following (use a separate sheet if necessary):

Date of loss	
Current reserve or amount paid	
Description of loss	
Date of loss	
Current reserve or amount paid	
Description of loss	

Has applicant, or any other person for whom insurance is being requested, been aware of any circumstances which may result in a claim? No Yes
 If "Yes," provide full details: _____

Has any license or accreditation ever been suspended, denied or revoked? No Yes
 Of what professional association(s) is Insured a member in good standing? _____

Staff:	Full Time	Part Time	Contracted/Employed
Administrators			
MD/Physicians			
Nurses			
Homemakers/Nurse Aids			
Psychologists			
Counselors			
Therapists			
Students or volunteers			
Other (specify)			

Check the hiring procedures that apply or are performed by this operation:
 Criminal Background Checks Verification of certification or professional licensing
 Drug, alcohol and sexual abuse screening or testing Reference Checks
 Questioning of employees in their previous involvement as defendants in professional malpractice litigation.

Schedule of Physicians – on Staff or Contracted:

Name & Specialty	Board Certified	Board Eligible	Hours/Week Worked	Volunteer Contracted or Employed	Has Malpractice Insurance
					<input type="checkbox"/> No <input type="checkbox"/> Yes
					<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you want the physician to be covered under the Center's policy?					<input type="checkbox"/> No <input type="checkbox"/> Yes
Are any drugs or medications administered or prescribed? If "Yes," please explain: _____					<input type="checkbox"/> No <input type="checkbox"/> Yes
Is electroshock therapy utilized? If "Yes," how many per year? _____					<input type="checkbox"/> No <input type="checkbox"/> Yes

Schedule of Location: (if more than three locations, attach a separate sheet of locations)

#1 Address	
Types of Services Provided	

#2 Address	
Types of Services Provided	
#3 Address	
Types of Services Provided	
Are there any camp, adventure/wilderness, ropes courses or any type of recreational programs? If "Yes," describe and submit brochure or detailed narrative of activities.	<input type="checkbox"/> No <input type="checkbox"/> Yes
Are there any animal exposures on premises? <input type="checkbox"/> Owned? <input type="checkbox"/> Non-owned? If "Yes," please explain, including number of animals and type/breed: _____ _____	<input type="checkbox"/> No <input type="checkbox"/> Yes
Are there any swimming or boating activities?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Is pool fenced with a self-locking gate?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Diving board?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Slide?	<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> Residential or Inpatient – complete supplemental application	
<input type="checkbox"/> Foster Care or Adoption – complete supplemental application	
Check the coverages and limits that the applicant would like quoted:	
What coverages:	<input type="checkbox"/> GL <input type="checkbox"/> Professional <input type="checkbox"/> Property (attach acord app) <input type="checkbox"/> Excess _____ <input type="checkbox"/> 100/100 <input type="checkbox"/> 300/300 <input type="checkbox"/> 500/500 (attach acord app) <input type="checkbox"/> 1/1 <input type="checkbox"/> 1/2 <input type="checkbox"/> 1/3
Do you want physical abuse/sexual molestation coverage to protect you for alleged acts of your employees? At what limits:	<input type="checkbox"/> 25/50 <input type="checkbox"/> 50/100 <input type="checkbox"/> 100/300 <input type="checkbox"/> 250/250 <input type="checkbox"/> 500/500 <input type="checkbox"/> Other _____

Please attach a copy of the following with your submission:

- (If Prior Acts coverage is desired) Prior Acts supplement, available on the website: www.colonyins.com
- Five years of currently dated loss runs (if in business less than five years, please attach a resume of the owner/director)
- Brochure(s) available or other information pertaining to the programs offered

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* 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 fact material thereto, may be committing a fraudulent insurance act, and may be subject to a civil penalty or fine.

* not applicable in all states