AMBULANCE/NON-EMERGENCY TRANSPORT SUPPLEMENTAL APPLICATION
Submit with Miscellaneous Medical Application

APPLICANT'S INSTRUCTION – PLEASE READ:

1. Please type or print clearly.
2. Answer ALL questions completely leaving no blanks. If any questions, or part thereof, do not apply, print N/A in the space.
3. If additional space is needed to answer any questions fully, please attach a separate page.
4. This application must be completed, dated and signed by a Principal of the Applicant.

I. GENERAL INFORMATION:

a) Name of Applicant/Entity(s)____

____

b) Population of area served:_______________ Radius of operation(mi.)_____________

c) Is your service Involved in:
- Air Ambulance Operations ___No ___Yes
- Water Rescue Operations ___No ___Yes
- Off-shore EMS ___No ___Yes
- Activities or Operations other than EMS ___No ___Yes
- Special Event EMS ___No ___Yes

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

____

____

II. PROFESSIONAL SERVICE/PRODUCT PROFILE:

a) Please provide a full description of services rendered.

____

____

b) Operations: (provide total number of each below category)

	Projected Next Year	Current Year	Last Year
Emergency Calls			
Non-emergency Calls			
Wheelchair transports			
Air Ambulance			
Ambulatory Paratransit			
Other, please describe			
EMTS - A			
EMTS - B			
Paramedics			
Drivers			
RNs			
Total Number of air			

ambulances			
Total number of ground ambulances			
Total number of vans			
Total number of Other -describe			

c) Do you administer any anesthesia? ___Yes ___No
Any physician, nurse practitioner or CRNA exposure? ___Yes ___ No
(If yes, Please explain)

____

d) Do you contract your services to others on an independent contractor basis? ☐Yes ☐No (If yes, Please explain)

____

e) Name of applicant's Auto Liability Insurer:

____

i. Limits of Liability: ____

ii. Does your Auto Liability policy specifically exclude claims arising from loading and unloading patients? ___Yes ___No

iii. Does your Auto Liability policy remain silent on the applicability of coverage for claims arising from loading and unloading of patients? ___Yes ___No

f) Name of applicant's Aircraft Liability Insurer:

____

i. Limits of Liability:____

g) Are vehicles equipped with (check all that apply):

Cardiac Monitors	Pacemakers	Defibrilators
Ventilators	Intubation Kits	Oxygen
Pulse Oximeters	Emergency Cardiac Drugs	

III. RISK MANAGEMENT, VEHICLE MAINTENANCE, SAFETY:

a) Does your service use knee, hip, chest and over the shoulder safety restraints on stretchers? ____ Yes _____ No ____N/A

b) Is proper training provided on Wheelchair tie down procedures and restraint system checked on a regular basis? ____Yes ____No ____N/A

c) Does the maintenance schedule for your fleet meet or exceed the manufacturer's recommendations? ____Yes ____No

d) Do you keep maintenance repair records on file for each vehicle: ____Yes ____No

e) Is a patient care report completed for each transport in which medical care, evaluation or observation has been performed? ____Yes ____ No

f) Does your service maintain accident files? ___Yes ___No

g) Are safety violations (i.e. auto crashes, patient handling events) part of your progressive discipline process? ___Yes ___No

THE UNDERSIGNED IS AUTHORIZED BY THE APPLICANT AND DECLARES THAT THE STATEMENTS SET FORTH HEREIN AND ALL WRITTEN STATEMENTS AND MATERIALS FURINSHED TO THE INSURER IN CONJUNCTION WITH THIS APPLICATION ARE TRUE. SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE INSURER TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THE STATEMENTS CONTAINED IN THIS APPLICATION, ANY SUPPLEMENTAL ATTACHMENTS, AND THE MATERIALS SUBMITTED HEREWITH ARE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED AND HAVE BEEN RELIED UPON BY THE INSURER IN ISSUING ANY POLICY.

THIS APPLICATION AND MATERIALS SUBMITTED WITH IT SHALL BE RETAINED ON FILE WITH THE INSURER AND SHALL BE DEEMED ATTACHED TO AND BECOME PART OF THE POLICY IF ISSUED. THE INSURER IS AUTHORIZED TO MAKE ANY INVESTIGATION AND INQUIRY IN CONNECTION WITH THIS APPLICATION AS IT DEEMS NECESSARY.

THE APPLICANT AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, THE APPLICANT WILL, IN ORDER FOR THE INFORMATION TO BE ACCURATE ON THE EFFECTIVE DATE OF THE INSURANCE, IMMEDIATELY NOTIFY THE INSURER OF SUCH CHANGES, AND THE INSURER MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS OR AUTHORIZATIONS OR AGREEMENTS TO BIND THE INSURANCE

I HAVE READ THE FOREGOING APPLICATION OF INSURANCE AND REPRESENT THAT THE RESPONSES PROVIDED ON BEHALF OF THE APPLICANT ARE TRUE AND CORRECT.

WARNING

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT (S)HE IS FACILITATING A FRAUD AGAINST THE INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY BE GUILTY OF INSURANCE FRAUD.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurer to defraud or attempt to defraud the insurer. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurer or agent of an insurer 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.
DISTRICT OF COLUMBIA: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines and an insurer may deny insurance benefits if false information materially related to a claim made by the applicant.
FLORIDA: 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 the third degree.
LOUISIANA AND MARYLAND: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
MAINE, TENNESSEE, VIRGINIA AND WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurer to defraud the insurer. Penalties may include imprisonment, fines or denial of insurance benefits.
MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
OKLAHOMA: Any 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.
PENNSYLVANIA: 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 commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
NEW YORK AND KENTUCKY: Any person who knowingly and with intent to defraud an insurer or other person files an application for insurance or statement of claims 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. New York applicants are subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation. Pennsylvania applicants are subject to criminal and civil penalties.

Signed: ____.

Date:____

Print Name: ____

Title: ____
(Owner, Partner, Authorized Officer)

If this **Application** is completed in Florida, please provide the Insurance Agent's name and license number. If this **Application** is completed in Iowa or New Hampshire, please provide the Insurance Agent's name and signature only.

Agent's Printed Name: ___________________________________

Florida Agent's License Number: ____________________________

Agent's Signature: ______________________________________