AMBULANCE INSURANCE BROKERS

a division of

COLONIAL INSURANCE
ESTABLISHED 1956

5251 Hampstead High Street, Unit 200
Montgomery, Alabama 36116

www.EMS-INS.com
email: 911@EMS-INS.com
p. 334.270.6805 f. 334.270.6797

General Information

Date of Application: _____ Expiration Date: _____
Legal Name/Named Insured: _____
Mailing Address: _____
Physical Address: _____
Phone:_____ Fax: _____ Website: _____
Owner(s): _____ Phone: _____ Email: _____
Safety Manager: _____ Phone: _____ Email: _____
Inspection: _____ Phone: _____ Email: _____
Type of Entity: ☐Corporation ☐Individual ☐Partnership ☐Joint Venture ☐LLC ☐Other _____
FEIN: _____ Years in Business: _____

Operations Information

1. Have you experienced any ownership changes, mergers, acquisitions or dispositions in the past 3 years and do you anticipate any in the coming 12 months? ☐Yes ☐No *If yes please explain _____
2. 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 attach an explanation on a separate sheet.
3. Is the Named Insured involved in any air operations? ☐Yes ☐No
4. Is the Named Insured involved in any operations other than EMS? ☐Yes ☐No
5. Has any insurance policy for the insured been cancelled or non-renewed in the past five years? ☐Yes ☐No
6. Indicate the procedures used in the Employee Selection Process:
   ☐Written Application ☐Physical Examination ☐Written Test
   ☐Road Test ☐Pre-Employment Drug Test ☐Criminal Background Check
   ☐Reference Checks ☐Motor Vehicle Record Check ☐Other: _____
7. Annual Revenue: _____
   % from Medicaid/Medicare: _____
   % from Insurance Companies: _____
   % from Private Pay: _____
   % from Contract: _____
8. What is your primary service area: County(s)/Parish(s): _____
   State(s): _____
9. Do you service any major metropolitan areas? ☐Yes ☐No
   If yes, please describe: _____
10. Do you operate in other states? ☐Yes ☐No
    If yes, please describe: _____
11. Do you own any aircraft or watercraft? ☐Yes ☐No
12. Do you perform any aircraft or watercraft transportation? ☐Yes ☐No
13. Do you offer any medical clinical services?(i.e. blood pressure screening or training) ☐Yes ☐No

14. Call Volume:

	Total Number of Calls	Emergency Calls	Non-Emergency Calls	Non-Medical Calls
Current Year(est.)				
1st Prior Year				
2nd Prior Year				
3rd Prior Year				

Definitions:

Emergency - The assignment was dispatched as a true emergency
Non-emergency – The assignment was not dispatched as a true emergency
Non-Medical – Any Ambulette and/or Wheelchair transportation

15. Highest level of EMS service provided: ☐Advanced Life Support ☐Advanced First Aid/CPR Only ☐Basic Life Support ☐No Emergency Medical Service

16. Does your service perform the following:

☐Advanced Life Support ☐ Basic Life Support ☐Capnography or Capnometry
☐Conscious Sedation ☐Endotracheal Intubation ☐IV Therapy or Monitoring
☐Manual Defibrillation ☐Mechanical Ventilation ☐Pulse Oximetry
☐Telemetry ☐Thrombolytic Therapy ☐12-Lead EKG Monitoring

General Liability Information

1. Employee Summary:

	Paramedic	EMT	Registered Nurses	Non-Medical employees	Other
Current Year	FT: PT:	FT: PT:	FT: PT:	FT: PT:	FT: PT:
1st Prior Year	FT: PT:	FT: PT:	FT: PT:	FT: PT:	FT: PT:
2nd Prior Year	FT: PT:	FT: PT:	FT: PT:	FT: PT:	FT: PT:
3rd Prior Year	FT: PT:	FT: PT:	FT: PT:	FT: PT:	FT: PT:

2. Does the insured currently carry Employer's Liability Coverage on all employees? ☐Yes ☐No
3. Does your service have a Medical Equipment Maintenance Program? (i.e. AEDs, gurneys, etc.) ☐Yes ☐No
4. Do you have notice of any claims for violations of state or local regulations in regard to any public area? ☐Yes ☐No
5. Does your service rent or lease any real property to others? ☐Yes ☐No
6. Does your service enter into any written or verbal agreements to provide service? ☐Yes ☐No
7. Does your service sell, rent out, or distribute any durable or expendable medical equipment or supplies? ☐Yes ☐No
   If yes, please describe and provide annual receipts: _____
8. Does your service sell or distribute pharmaceuticals of any sort? ☐Yes ☐No
   If yes, please describe and provide annual receipts: _____
9. Does your service install, service or repair medical equipment or devices of any sort for others? ☐Yes ☐No
   If yes, please describe and provide annual receipts: _____
10. Does your service have a Medical Equipment Failure policy? ☐Yes ☐No
    If yes, does it address checking, charging, & replacing batteries for medical equipment? ☐Yes ☐No
11. Do you have a violent patient restraint policy? ☐Yes ☐No
12. Does your service have a securement policy and audit controls in place for all medications? ☐Yes ☐No

13. Stretcher Summary:

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

14. Does your service use knee, hip, chest & over the shoulder safety restraints on your stretchers? ☐Yes ☐No
15. Does your service have a mandatory lift assist policy? ☐Yes ☐No
16. Explain training for patient securement: _____

_____

17. Select the engineering controls used at your service & give the brand & number of each:

Engineering Control	Brand	Number
Specialty Vehicles(Bariatric Units)		
Ramps with winches		
Lateral Transfer Aids		
Motorized Stair Lifts		
Lift Stretchers		
Other:		

18. Provide the wheelchair tie-down occupant restraint system (WTORS) you use: ☐N/A – No Wheelchair

_____

19. Does your WTORS meet SAE J2249 ISO 10542 standards? ☐N/A – No Wheelchair ☐Yes ☐No
    If no, please provide your internal documentation outlining the manner in which you use the system to tie down a wheelchair and restrain its occupant.
20. 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.
21. Does your service use a priority dispatch system? ☐Yes ☐No If yes, please describe: _____
22. 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 PSAP
23. 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
24. How many years of experience or what qualifications do you require of you dispatchers prior to hiring? _____

_____

25. Describe your in-house training for dispatchers, including length of training: _____

_____

26. What dispatch software do you use? _____

Medical Professional Liability Information

1. Does your service have a Medical Director? ☐Yes ☐No / ☐Employee ☐Contracted Service
   If yes, please provide the following: Name: _____ Phone: _____

2. Are all medical transports documented, with regular quality review by the Medical Director? ☐Yes ☐No
   If not reviewed by the Medical Director, who is responsible for review? _____
3. What percentage of your trip tickets & 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 review? Name: _____ Title: _____
4. Is a record kept for each request for service? ☐Yes ☐No
5. Is a PCR completed for each transport in which medical care, evaluation or observation has been performed? ☐Yes ☐No
6. Is documentation maintained showing all medical equipment purchases, maintenance, calibration & service? ☐Yes ☐No
7. Does your service provide any specialized medical transport service, such as neo-natal transport or specialized cardiac transport? ☐Yes ☐No If yes, please describe: _____
8. Does your service maintain & monitor records on an on-going basis to confirm that all employees and new hires meet appropriate state certification requirements? ☐Yes ☐No
9. Does your service lend or lease agents, servants, or employees to others? ☐Yes ☐No
10. Does your service borrow or lease agents, servants, or employees from others? ☐Yes ☐No
11. Has any claim been made or suit been filed against your service &/or its employees in the past five years alleging negligence in the rendering, or failure to render, medical or professional health care services? ☐Yes ☐No
12. Does the insured have any knowledge of any matter which would cause a reasonable person to believe that a claim or suit against the company is likely to arise alleging negligence in the rendering, or failure to render, medical or professional health care services? ☐Yes ☐No
13. With respect to medical professional liability insurance, has your service received notice of any claims by a state regulatory agency in the past five years? ☐Yes ☐No

Vehicle Information

1. Vehicle Summary:

Vehicle Type	Current Year	1st Prior Year	2nd Prior Year	3rd Prior Year
Ambulances				
Wheelchair Vans				
First Responder/ Fly Car				
Private Passenger Vehicles				
Invalid Coach/Ambulette				
Other:				

2. 95% of your calls are within a ☐50 ☐100 ☐over 100 mile radius.
3. In an ambulance, what is your average number of passengers excluding your EMT's? _____ Maximum _____
4. Does your service lease or loan vehicles to others? ☐Yes ☐No
5. Does your service allow owners/employees to take company owned vehicles home or on personal business? ☐Yes ☐No
6. Vehicle Maintenance Procedures:
   Are daily vehicle inspection reports completed? ☐Yes ☐No
   Are periodic maintenance checks done by a mechanic? ☐Yes ☐No
   Are vehicle maintenance records kept? ☐Yes ☐No
   Does your service employ its own mechanics? ☐Yes ☐No
   If no, who performs the maintenance on your fleet? _____
   Are they certified by the manufacturer? ☐Yes ☐No
   Does your service store or service vehicles of others? ☐Yes ☐No
   Is a condition report completed on each transport vehicle & its equipment on each shift? ☐Yes ☐No
   Do you perform any aftermarket vehicle modifications? ☐Yes ☐No
7. Is previous driving experience required on new hires? ☐Yes ☐No If yes, how many years _____

8. Please provide the name driver training program(s) that you provide or participate in: _____

_____

9. Do you have a minimum & maximum age for drivers? ☐Yes ☐No Minimum _____ Maximum _____
10. At what speed may your emergency vehicles operate with the Emergency Warning Systems (EWS) activated?

_____

11. Does your service review Motor Vehicle Reports (MVRs) annually? ☐Yes ☐No If no, how often _____
12. Does your service have written criteria for acceptable MVRs? ☐Yes ☐No
13. Does your service require all emergency drivers to complete an Emergency Vehicle Operators Course (EVOC)? ☐Yes ☐No
14. Does your service maintain files on each driver? ☐Yes ☐No
15. Do you have protocols stating when EWS is to be activated? ☐Yes ☐No
16. Are your vehicles locked when unattended? ☐Yes ☐No
17. Do you require third party riders (non-patient/non-EMT personnel) to sit in the front passenger seat unless the patients well being requires the rider to be in the back of the ambulance? ☐Yes ☐No
18. Does your service maintain accident files? ☐Yes ☐No
19. Are safety violations (i.e. auto crashes) part of your progressive discipline process? ☐Yes ☐No
20. Is the gross vehicle weight of any vehicle in excess of 10,000 lbs? ☐Yes ☐No

    If yes, please indicate which units on the vehicle schedule.

    If yes, are they equipped with running lights? ☐Yes ☐No
21. Are any vehicles equipped with Onboard Monitoring (OBM) (black box, cameras, GPS, stickers)? ☐Yes ☐No

    If yes, please indicate which units on the vehicle schedule.

    Please attach a copy of the installation or certification evidencing such equipment

    Brand Name: _____

    Date Installed: _____

    Employee responsible for the management of the OBM: _____

22. Vehicle Schedule:

#	Year	Make, Model, Type	Cost New	Vehicle Identification Number	Loc. #	# of Seats
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						

Desired Limits of Liability:

General Liability: ☐$1,000,000/$2,000,000 ☐$1,000,000/$3,000,000
☐ Occurrence ☐Claims Made - Retro Date: _____

Professional Liability: ☐$1,000,000/$2,000,000 ☐$1,000,000/$3,000,000
☐ Occurrence ☐Claims Made - Retro Date: _____

Automobile Liability: ☐$1,000,000

Automobile Physical Damage Deductible: ☐$500 Comp/Coll ☐$1,000 Comp/Coll ☐$_____

Umbrella: ☐$1,000,000 ☐$2,000,000 ☐$_____

Current Limits of Liability:

Current Insurer: _____
General Liability: Limit: _____
Premium: _____ ☐ Occurrence ☐Claims Made - Retro Date: _____

Current Insurer: _____
Professional Liability: Limit: _____
Premium: _____ ☐ Occurrence ☐Claims Made - Retro Date: _____

Current Insurer: _____
Automobile Liability: Limit: _____
Premium: _____

Current Insurer: _____
Automobile Physical Damage Deductible: ☐$500 Comp/Coll ☐$1,000 Comp/Coll ☐$_____
Premium: _____

Current Insurer: _____
Umbrella: ☐$1,000,000 ☐$2,000,000 ☐$_____
Premium: _____