

**Emergency and Non-Emergency  
Medical Transport  
Paramedics, EMTS and First Responders  
General Liability and Professional Liability  
Supplemental Application  
(Complete in addition to ACORD)**

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1. Name of Applicant: \_\_\_\_\_  
Website Address: \_\_\_\_\_  
Insured Contact Name: \_\_\_\_\_ Insured Contact Phone No.: \_\_\_\_\_  
Insured Contact Email Address: \_\_\_\_\_

2. Type of Organization: a.  Emergency: \_\_\_\_\_%  
 Non - Emergency (Ambulance) \_\_\_\_\_%  
 Non - Emergency (Transport) \_\_\_\_\_%  
b.  Volunteer  Individual  Partnership  Corporation  For-Profit  Non-Profit  
c.  Municipality (Fully describe interest, control, financial support): \_\_\_\_\_  
\_\_\_\_\_  
d.  Other (Please explain): \_\_\_\_\_

3. Date Established: \_\_\_\_\_

4. What states are you licensed or certified in? Provide details of what your license/certification allows you to do:  
\_\_\_\_\_

5. Are you affiliated with any other entity?  Yes  No  
If yes, describe: \_\_\_\_\_

6. Population of area served: \_\_\_\_\_ Radius of Operation (Miles): \_\_\_\_\_

7. Sales (If applicable): \$ \_\_\_\_\_ # Volunteer Members: \_\_\_\_\_ # Paid Members: \_\_\_\_\_

8. Have you had previous insurance for this enterprise?  Yes  No  
If yes, **please attach 3 years of General Liability, Professional and Commercial Auto loss runs.**

9. During the **past three (3) years**, have any claims been presented to your current or prior insurance carrier(s)?  Yes  No  
**If yes, please provide description of claim(s), date of loss, amount(s) paid and reserved on Attachment to A13.**

10. Is the applicant, or any other person for whom insurance is being requested, aware of any circumstances which may result in a claim?  Yes  No  
**If yes, please provide full details on Attachment to A13.**

11. Has the applicant, or any other person for whom coverage is being requested, had any application for liability insurance denied, policy cancelled or non-renewed in the **past three (3) years**?  Yes  No  
**If yes, please provide full details on Attachment to A13.**

12. Type of Service:  
 Air Ambulance  Alarm Monitoring  Ambulance  Disaster Recovery  Dispatch Service for Others  
 Emergency Service at Special Events  Fire Department with Ambulance  Fire Department without Ambulance  
 First Responder  Individual EMT  Paramedic  
 Rescue Squad with Ambulance  Rescue Squad without Ambulance  Search and Rescue  
 Special Events  Other (Please specify): \_\_\_\_\_

13. Number of: Operational Ambulances \_\_\_\_\_ EMTs \_\_\_\_\_ First Responders \_\_\_\_\_  
 Stand-By Ambulances \_\_\_\_\_ Paramedics \_\_\_\_\_ Chair Cars/Vans/Mini Vans \_\_\_\_\_
14. Do you use subcontractors?  Yes  No
15. Do you transport prisoners or psychiatric patients?  Yes  No
16. Do all non-emergency transport drivers have current CPR or AED certification?  Yes  No
17. Current Auto Insurer: \_\_\_\_\_ Limits: \$ \_\_\_\_\_ / \_\_\_\_\_

**VEHICLE SCHEDULE MUST BE ATTACHED.**

18. Are you owned, operated by or affiliated with a hospital, nursing home or assisted living facility?  Yes  No

19.

Additional Insured	Describe Interests of Additional Insureds

20. Are there written procedures in place requiring the documentation of all incidents?  Yes  No
21. Do you have any of the following written procedures and training in place?
- Loading and unloading  Yes  No
  - Wheelchair locking and tie-down  Yes  No
  - Emergency/accident reporting procedures  Yes  No
  - HIPAA regulation and policies  Yes  No
22. Do you perform background checks on all employees that include criminal background checks, sex offender registry and references?  Yes  No
23. Have you had any incidents or claims brought against you for sexual molestation or any other allegation of misconduct?  Yes  No

**If you are a volunteer fire department with paramedics, EMTs and First Responders, or an Individual, please complete the following in addition to the above:**

- What type of entity do you provide services for? \_\_\_\_\_
- What type of emergency services do you perform? \_\_\_\_\_
- Do you have any supervisory duties?  Yes  No
- If yes, please describe: \_\_\_\_\_
- Are you a Nurse Practitioner, Advanced Practical Nurse or Physician's Assistant?  Yes  No
- Please forward a copy of your current certification and/or licenses.

**FRAUD WARNING: 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 IS GUILTY OF INSURANCE FRAUD. THIS IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.**

**(FOR NEW YORK INSURED: AN ACT OF INSURANCE FRAUD SHALL BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED \$5,000 AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.)**

\_\_\_\_\_  
 Applicant's Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Title

\_\_\_\_\_  
 Producing Agent