Master Index

Northland INSURANCE

APPLICATION – EMERGENCY MEDICAL TECHNICIANS
General Liability/Professional Liability

GENERAL INFORMATION

1. Named Insured _____
(The name shown first is the first Named Insured and is responsible for premium payment, cancellation, and changes, refer to policy wording.)

2. Mailing Address _____
Street City County State ZIP Code

3. Accounting Records (Contact/Phone Number) _____

4. Location of Premises: ❑ At mailing address
❑ Other _____

5. Interest of Named Insured in premises: ❑ Owner ❑ General Lessee ❑ Tenant ❑ Other _____

6. Type of Service:
❑ Private ❑ Fire Department ❑ Ambulance District
❑ City, Township, Village ❑ Public Hospital ❑ Funeral Home
❑ County ❑ Private Hospital ❑ Volunteer (not assoc. with above)

7. Years under current ownership _____ Operate as: ❑ Non Profit ❑ For Profit

8. Applicant is: ❑ Individual ❑ Partnership ❑ Corporation ❑ Governmental Unit
❑ Trust ❑ Other _____

9. Effective Date Desired _____ Term Desired _____

10.

PRIOR INSURANCE CARRIER INFORMATION FOR THE PAST THREE YEARS		
Year	**Carrier/Policy Number/Premium**	**Coverage**

Missouri applicants: DO NOT answer this question.
Has insurance of this type been cancelled, refused, or nonrenewed by any company during the past 3 years?
❑ No ❑ Yes - If so, give name of company, date, and reason. _____

11. SPECIFIC LOSS INFORMATION: Include all allegations, suits, or incidents *(past 5 years)* which could result in a claim, regardless of whether or not covered by insurance.

Date	Description	Paid	Reserve
		$	$
		$	$
		$	$

12. Describe any risk management or safety committee activities. _____

13.

COVERAGE/LIMITS DESIRED		
❑ Premises - Operations	$ _____	General Aggregate
❑ Products-Completed Operations	$ _____	Products-Completed Operations Aggregate Limit
	$ _____	Each Occurrence Limit
❑ Personal & Advertising Injury	$ _____	Personal & Advertising Injury Limit
❑ Damage to Premises Rented to You	$ _____	Damage to Premises Rented to You Limit
❑ Medical Payments	$ _____	Medical Payments Limit
❑ Contractual Liability (No Separate Limit)		
❑ Professional Liability	$ _____	Each Occurrence Limit
	$ _____	Aggregate

Is Loading and Unloading Coverage desired? ❑ Yes ❑ No
Is Loading and Unloading included on this insured's auto policy? ❑ Yes ❑ No
Is 24 hour coverage for Good Samaritan Acts desired? ❑ Yes ❑ No

OPERATIONS

1. Number of units maintained: Ambulances _____ Wheelchair Vans _____ Other _____
2. Are any vehicles hospital owned? ❑ Yes ❑ No
3. Radius of operations: Miles _____

4.

NUMBER OF CALLS - ANNUALLY		
Type of Call	**Number (annually)**	**Percentage of Total**
Emergency (ambulance only)		
Non-Emergency (ambulance only)		
Medical Transport (vans, private passenger vehicles		
Air Ambulance calls		
TOTAL		

5. What percentage of medical transport calls are wheelchair transport?_____
6. What medical certification is required of staff handling wheelchair calls? ❑ N/A - No wheelchair calls
   ❑ Paramedic ❑ EMT ❑ No certification required

	Yes	No
7. Is training on wheelchair tie-down procedures given to all staff handling wheelchair transport?	❑	❑
8. Does service provide heavy rescue/extrication?	❑	❑
9. Do you provide any over-water operations?	❑	❑
10. Does service have special rapid telemetry with the hospital?	❑	❑
11. Is a call report completed on each and every call/run?	❑	❑
12. Do you adhere to medical protocol as established by the OSHA Bloodborne Pathogens Standard?	❑	❑
13. Has any Insured ever experienced a claim as a result of allegations that they contribute to the spread of contagious disease?	❑	❑
14. Are your call reports reviewed for completeness, legibility and professional content?	❑	❑

15. Calls are dispatched by: ❑ 911 ❑ In-house by employees/volunteers
    ❑ Outside source (explain) _____
    _____

16. If dispatching duties are performed in-house:
    a. Years of dispatching experience required for employment. _____
    b. Describe in-house training for dispatchers, including length of training time involved. _____
    c. Do you perform dispatch duties for any other entity (police, fire)? ❑ Yes ❑ No
17. Are all calls coming into your service tape recorded? ❑ Yes ❑ No
    If yes, indicate the system being utilized and how long tapes are kept. _____

	Yes	No
18. Do you screen calls to determine whether or not an ambulance will be dispatched? *If yes, attach a copy of written procedures.*	❑	❑
19. Has the service entered into any written contractual agreements to perform ambulance service for a governmental entity, hospital, or nursing home?	❑	❑
a. If yes, is legal advice sought to write and approve?	❑	❑
b. Does agreement require you to hold a third party harmless?	❑	❑
20. Is your service operating under an exception, variance, or probation relating to a provision of license, or applicable state law or code?	❑	❑

If yes, explain. _____

STAFF

1. Number of crew members: Per Call, Per Vehicle _____ Total _____
2. Crew members are: ❑ Paid ❑ Volunteer
3. List the number of individuals certified in each area: _____ First Responders
   _____ Paramedics _____ Advanced First Aid (Red Cross)
   _____ EMTs (Class _____) _____ Nurses _____ Other - specify _____
4. Are all drivers/attendants required to obtain continuing education/training? ❑ Yes ❑ No
   If yes, describe. _____
5. Number of hours your employees/volunteers: Work per shift _____ Are off duty between shifts _____

	Yes	No	
6. Do you contract with a medical advisor?	❑	❑	
7. Does the medical advisor carry medical malpractice insurance?	❑	❑	*Limits*: _____
8. Are references checked on new hires?	❑	❑	
9. Are MVRs checked on new hires?	❑	❑	

I DECLARE THAT THE STATEMENTS MADE IN THIS APPLICATION ARE COMPLETE AND TRUE.

Any person who, with the intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud and subject to fines and/or imprisonment.

Signature of Applicant | Title | Date

Signature of Producing Agent | Date

Agent Name and Address