ADMIRAL INSURANCE COMPANY
6455 East Johns Crossing, Suite 240
Duluth, GA 30097
Phone: 770-476-1561 — Fax: 770-418-9597
Internet: http://www.admiralins.com

AMBULANCE SERVICES
PROFESSIONAL LIABILITY APPLICATION

ANSWER ALL QUESTIONS, IF THE ANSWER IS NONE, STATE NONE. IF THE QUESTION IS NOT APPLICABLE, STATE NOT APPLICABLE (N/A). IF THE SPACE PROVIDED IS INSUFFICIENT TO FULLY ANSWER THE QUESTION, PLEASE ATTACH A SEPARATE SHEET. NOTE: APPLICATIONS MUST BE DATED AND SIGNED BY OWNER, PARTNER, OFFICER OR ADMINISTRATOR. PLEASE TYPE OR PRINT IN INK.

PART I — GENERAL INFORMATION

1. Name of applicant: _____

2. Mailing Address : _____
(street) (city/state) (zip)

3. Location Address (es): _____
(street) (city/state) (zip)

4. County (parish) of each location: _____

5. Office telephone number: (_____) - _____ - _____ Office fax number: (_____) - _____ - _____

6. Person to contact for survey: _____

7. Date entity established: _____/_____/_____

8. Entity is: ___ Individual ___ Corporation ___ Partnership
___ Professional Association/Corporation ___ Other: (describe) _____

9. Type of Service: (check where applicable)

___ Private (proprietary) ___ City owned & operated
___ Rescue squad ___ Fire Department
___ Chair care (invalid coach) ___ County owned & operated
___ Public service ___ Hospital based
___ First responder ___ Other: (describe) _____

10. Proposed effective date: _____/_____/_____

11. Requested Limits of Liability (if available):
Professional Liability $_____ $_____
General Liability $_____ each occurrence
$_____ general aggregate

12. Annual gross receipts or budget: Estimated next twelve (12) months $_____
Last twelve (12) months $_____

13. Annual Remuneration Estimated next twelve (12) months $_____
Last twelve (12) months $_____

14. Total premises square footage occupied by Applicant: _____

PART II — EXPOSURES

15. Number of ambulances maintained: (a) Operational _____ (b) Standby _____

16. Radius of operations: _____ Hours of operation: _____

17. Number of crew members: Per vehicle: _____ Total: _____

18. Are all crew members qualified? _____

19. Qualifications of crew members:
    ____ Red Cross ____ National Ambulance Training Institute ____ Paramedics
    State the number of Paramedics: Full time _____ Part time _____

20. Number of annual calls (approximately) last year:
    (a) To emergencies _____
    (b) Transporting to and from hospitals _____

    Estimated number this year:
    (a) To emergencies _____
    (b) Transporting to and from hospitals _____

21. Total number of emergency runs: Estimated next twelve (12) months _____
    Last twelve (12) months _____

22. Total number of scheduled patient transport(s) (non emergency) runs:
    Estimated next twelve (12) months _____
    Last twelve (12) months _____

23. Radius of operations: _____

24. Number of patient encounters at special events (if any): _____ (see question #21)

25. Total number is ambulances at each location per shift: _____

26. Are ambulances equipped with cardiac telemetry? _____Yes _____No
    If yes, to what command center? _____
    Who provides medical orders? _____

27. Does your service provide Air and Watercraft ambulance services? _____Yes _____No
    If yes, please describe: _____
    _____

28. Does your service provide water rescue services? _____Yes _____No
    If yes, please describe: _____
    _____

29. Does your service provide mobile intensive care? _____Yes _____No

30. Does your service provide mobile neo-natal intensive care? _____Yes _____No

31. Does your service routinely provide first aid services to any sporting event, carnival, fair, etc. _____Yes _____No
If yes, state type, location, and number of patient encounters: _____
_____

32. Qualifications and number of EMS personnel:

Employed	*Contract*	*Volunteer*	
_____	_____	_____	Advanced First Aid and /or Red Cross
_____	_____	_____	CRP Certificate only
_____	_____	_____	EMT Basic
_____	_____	_____	EMT Advanced or Intermediate (IV)
_____	_____	_____	EMT Paramedic
_____	_____	_____	Nurse (RN or LPN)
_____	_____	_____	Physicians or Surgeons*
_____	_____	_____	Other (describe): _____

**** Attach list and indicate specialty***

33. Explain procedures for refusal or transfer by an:

Adult: _____
_____

Minor: _____
_____

34. Explain criteria for "No–Transport" by service: _____
_____
_____

35. Do you enter into contractual agreements? If yes, enclose copies of all such contracts ____Yes ____No

36. List prior professional liability insurers for the past five (5) years, starting with the most recent year. If none, so state.

Insurer	*Policy Number*	*Limits of Liability*	*Premium*	*Effective Date*	*Claims- Made Yes/No*
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

If claims-made, what is the most recent retroactive date? _____/_____/_____

37. List prior general liability insurers for the past five (5) years, starting with the most recent year. If none, so state.

Insurer	*Policy Number*	*Limits of Liability*	*Premium*	*Effective Date*	*Claims- Made Yes/No*
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

If claims-made, what is the most recent retroactive date? _____/_____/_____

38. Have any claims been made or occurrences reported during the past six (6) years against any of the proposed insureds or against any entity, in which any proposed insured has or has had an interest? ____Yes ____No

    If yes, please describe, indicate status of the claim or suit, and any amount(s) paid or reserved (attach an additional sheet if necessary). _____
    _____

39. Does any proposed insured have any knowledge of an event, circumstance or occurrence (other than any listed in #37 above) prior to the effective date of the proposed policy or does any proposed insured foresee that a claim may be brought as a result of said event, circumstance or occurrence? ____Yes ____No

    If yes, describe the event and indicate the reason for anticipation of a claim. _____
    _____
    _____

I understand and agree this application and any and all supplemental attached hereto may be a part of any policy issued and any such policy will be issued in reliance upon the representation made herein. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the Company, result in the voiding of insurance issued in reliance on this application and/or denial of claims under any policy issued.

I authorize and consent to investigation of information bearing upon moral character, professional reputation and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release to the Company providing insurance coverage any documents, records or other information bearing upon the foregoing.

I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

The Applicant and all owners, employees, and contractors are licensed or duly authorized in all states or jurisdictions where professional services are provided. The Applicant warrants the truth of all answers to the above questions and that the Applicant has not withheld any information, which is calculated to influence the judgement of the insurance company in considering this application.

IMPORTANT: This application must be signed by the Applicant. Signing this application does not bind the Company to complete the insurance.

_____

Signature of Applicant(s) Title/Position Date

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SUPPLEMENTAL INFORMATION
FORM FOR AMBULANCE DRIVERS AND ATTENDANTS
(TO BE USED IN CONJUNCTION WITH FORM AC-0081)

AMBULANCE DRIVERS AND ATTENDANTS

3. Name of applicant: _____

4. Number of ambulances maintained: (a) Operational _____ (b) Standby _____

3. Radius of operations: _____ Hours of operation: _____

4. Number of crew members: Per vehicle: _____ Total: _____

5. Are all crew members qualified? _____

6. Qualifications of crew members:
   Red Cross ❒
   National Ambulance Training Institute ❒
   Paramedics ❒ State Number of Paramedics _____ Full time _____ Part time _____

7. Number of annual calls (approximately) last year:
   (c) To emergencies _____
   (d) Transporting to and from hospitals _____

   Estimated number this year:
   (b) To emergencies _____
   (c) Transporting to and from hospitals _____

The applicant declares that the above statements and representations are true and correct and that no facts have been suppressed or misstated. The completion of this Supplemental Information Sheet shall be in addition to the information contained in the Ambulance Services Professional Liability application, and will be made a part of the policy.

_____

Signature of Applicant(s) Title/Position Date