

U.S. Risk, LLC | 14241 Dallas Parkway, Suite 850, Dallas, Texas 75254

**NON-EMERGENCY AMBULANCE AND TRANSPORTATION SERVICES PROFESSIONAL AND GENERAL LIABILITY APPLICATION
CLAIMS MADE AND REPORTED BASIS**

Please email this completed application to the U.S. Risk underwriter you are working with.

For contact information, please visit the [U.S. Risk HealthcarePros webpage](#).

Desired effective date: _____

GENERAL INFORMATION

1. Complete name of applicant facility (if other than parent firm, supply full details of ownership entity; attach an additional sheet if necessary):

Address: _____

City: _____ State: _____ County: _____ ZIP: _____

Contact Name: _____ Title: _____

Contact Email Address: _____ Phone: _____

Website URL: _____

List all other locations: _____

2. Applicant is:

a. Individual Partnership Corporation Professional Association Other: _____

b. Not-for-Profit For-Profit Both

3. Date established: _____

APPLICANT SERVICES

1. What service is provided to your client? _____

2. How are you contacted to provide your service?

Funeral home Fire department Hospital Individual client Physician office Surgery center

3. What is your usual final destination? _____

4. IF YOU OPERATE A **NON-EMERGENCY** AMBULANCE SERVICE:

a. Are the signed physician orders transported on board the ambulance with the patient? Yes No

b. Name of all medical facilities the applicant is affiliated with:

c. What types of ambulance transport services are provided?

d. Are medical technicians trained and certified? Yes No

5. Please indicate the number and type of your employees and/or volunteers. If none, state "none."
- a. Emergency Medical Technicians: _____
 - b. Nurses, Licensed Practical: _____
 - c. Nurses, Registered: _____
 - d. Paramedics: _____
 - e. Are all of the above medical personnel licensed in accordance with applicable state and federal regulations? Yes No
If no, please attach an explanation.
 - e. No medical personnel in attendance—driver only: _____
 - f. Other: _____
If Other, specify: _____

6. Please list the number and type of independent contractors who provide professional services on your behalf. If none, state "none."
- a. Emergency Medical Technicians: _____
 - b. Nurses, Licensed Practical: _____
 - c. Nurses, Registered: _____
 - d. Paramedics: _____
 - e. Do you supervise any individuals who are not your own employees? Yes No
If yes, please attach a detailed explanation of responsibilities and relationships to the entity which employs these individuals.
 - e. No medical personnel in attendance—driver only: _____
 - f. Other: _____
If Other, specify: _____

APPLICANT PROCEDURES

1. Do you render professional services directly to patients? Yes No
If yes, please describe these services in detail and indicate whether you are supervised and by whom:

Detailed Description of Professional Services	Percent of Time	Supervised?	Title of Supervisor
_____	_____ %	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____ %	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____ %	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

2. Do you render professional services that do not involve contact with a patient? Yes No
If yes, please describe these services in detail:

APPLICANT AFFILIATIONS

1. Are you employed by or under contract to any governmental entity? Yes No
If yes, please attach an explanation, including details of your responsibilities.
2. Are you associated with any agency or organization that engages in advertising for, or solicitation of, patients? Yes No
If yes, please attach a detailed explanation and copies of **all** relevant advertisements.

SERVICE BOUNDARY

1. What is the radius of operations of the non-emergency ambulance or transportation service? _____
2. Does the radius of operations include air ambulance service? Yes No
- a. How much of operations is provided for non-emergency air ambulance? _____
 - b. Does the staff include attending flight physicians? Yes No
If yes, do they carry attending flight physician's insurance? Yes No What limits? _____

ANNUAL NUMBERS

1. What are your gross annual revenues? \$ _____



2. Please state the **annual** number of patient encounters (the number of patients transported by the ambulance service):
Last 12 months: _____ Estimated next 12 months: _____
3. Please state the **annual** number of calls for emergencies:
Last 12 months: _____ Estimated next 12 months: _____
4. Please state the **annual** number of calls for transporting patients to and from a hospital or other institution that are not accident cases:
Last 12 months: _____ Estimated next 12 months: _____

DESCRIPTION OF VEHICLE(S)

1. Are the vehicles you use specifically built to transport clients? Yes No
If no, what conversions were made? _____
2. Vehicles are best described as:
 Vans Buses Passenger cars Other (specify): _____
3. Safety features or equipment in all vehicles:
 Lifts Wheelchair accessible Standard tie-downs Ratchet tie-downs Stepwell lights Emergency exits
 Other (specify): _____
4. Number of vehicles including maximum passenger capacity currently in use: _____
5. Is vehicle equipped with any life saving apparatus? Yes No
If yes, fully explain:

RISK MANAGEMENT

1. Who assists client into vehicle? _____
2. Are all drivers license checked for currency? _____
3. Are MVRs checked for all drivers? Yes No
4. Do you keep detailed records of all pick up and deliveries of clients? Yes No
5. Are drivers trained in proper use of safety devices in vehicles? Yes No
6. Does your automobile liability policy specifically exclude claims arising from loading and unloading of clients? Yes No
7. Do you allow volunteers to operate any vehicle? Yes No
If yes, fully explain:

APPLICANT HISTORY (Attach detailed explanation for any "yes" answers.)

1. Have you or any of your employees:
 - a. Ever been the subject of disciplinary or investigatory proceedings or reprimand by an administrative or governmental agency, hospital or professional association? Yes No
 - b. Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? Yes No
 - c. Ever been treated for alcoholism or drug addiction? Yes No
 - d. Ever had any state professional license refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? Yes No
 - e. Ever had any insurance company or Lloyd's cancel, decline, refuse to renew or accept only on special terms their malpractice insurance? Yes No

EXISTING INSURANCE

Do you currently carry the following:

1. Professional Liability Insurance? Yes No

If yes, list the Professional Liability Insurance carried by the firm for each of the past five years including periods of no coverage:

Policy Period FROM MM/DD/YY	Policy Period TO MM/DD/YY	Insurance Company	Limit of Liability	Deductible	Policy Form: Claims Made OR Occurrence?	Premium
_____	_____	_____	\$ _____	\$ _____	_____	\$ _____
_____	_____	_____	\$ _____	\$ _____	_____	\$ _____
_____	_____	_____	\$ _____	\$ _____	_____	\$ _____
_____	_____	_____	\$ _____	\$ _____	_____	\$ _____
_____	_____	_____	\$ _____	\$ _____	_____	\$ _____

If claims made, what is the retroactive date/prior acts date on your current policy? _____

2. Commercial General Liability Insurance? Yes No

If yes, list the Commercial General Liability Insurance currently carried by the firm:

Policy Period	Carrier	Limit of Liability BI/PD	Deductible	Policy Form: Claims Made OR Occurrence?	Premium
_____	_____	\$ _____	\$ _____	_____	\$ _____

If claims made, what is the retroactive date/prior acts date on your current policy? _____

CLAIMS HISTORY

1. During the past five (5) years, have there been any professional or general liability claims or incidents made against you, any employee or former employee, the applicant or anyone proposed for this insurance? Yes No

ATTACH CURRENTLY VALUED COMPANY LOSS RUNS FOR THE PRIOR FIVE (5) YEARS.

2. Are you, or anyone proposed for this insurance aware of any fact(s), incident(s), act(s), event(s), circumstance(s) or occurrence(s) that may result in a claim(s) being made against you? Yes No

If yes, provide full details:

3. Have there been any prior complaints or incidents reported arising out of alleged or actual physical or sexual abuse or molestation?
 Yes No

If yes, fully describe the circumstances and follow-up action taken:



APPLICANT SIGNATURE PANEL

THE APPLICANT DECLARES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE INCEPTION DATE OF THE POLICY PERIOD, IT WILL IMMEDIATELY NOTIFY THE UNDERWRITERS OF SUCH CHANGE. SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERWRITERS TO OFFER, NOR THE APPLICANT TO ACCEPT, INSURANCE; BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE INSURANCE AND MADE A PART OF THE POLICY SHOULD A POLICY BE ISSUED.

Notice applicable in most states: 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 material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

I/We hereby declare that the above statements and particulars are true and I/we agree that this application shall be the basis of the contract with the insurance company.

Authorized signature

Date

Typed or printed name: _____

Title: _____