

**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:

<u>Employed</u>	<u>Contract</u>	<u>Volunteer</u>	
_____	_____	_____	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.

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

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.

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

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.

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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