



Ambulance Services, Medical Transport Renewal Application

Applicant Information

1. Applicant name:

2. Principal business address (attach separate sheet if more than one location):

Street: County:

City: State: Zip:

Phone: Website:

3. Please state sources and amounts of total revenue:

	last 12 months	next 12 months
Charitable contributions		
Government funding		
Fee for services		
Other – specify: <input style="width: 50%;" type="text"/>		
Total gross revenue:		

Operations and Activities

4. Type of operations (check all that apply):

<input type="checkbox"/> Air ambulance	<input type="checkbox"/> Ground ambulance	<input type="checkbox"/> Wheelchair transport
<input type="checkbox"/> Special event emergency medical service		

If other, please specify:

5. Radius of operation (miles):

6. Does a board certified/eligible physician oversee the operations? If No, please explain in the comments section. Yes No

7. a. Number of non-emergency transports for the last 12 months:

b. Number of non-emergency transports for the next 12 months:

c. Number of emergency transports for the last 12 months:

d. Number of emergency transports for the next 12 months:

8. a. Total number of air ambulances:

b. Total number of ground ambulances:

c. Total number of vans:

9. Are vehicles equipped with (check all that apply):

<input type="checkbox"/> Cardiac Monitors	<input type="checkbox"/> Pacemakers	<input type="checkbox"/> Defibrillators
<input type="checkbox"/> Ventilators	<input type="checkbox"/> Intubation kits	<input type="checkbox"/> Oxygen
<input type="checkbox"/> Pulse Oximeters	<input type="checkbox"/> Emergency Cardiac Drugs	



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10. Is there a formal documented program for scheduled inspections and preventative maintenance on all vehicle and equipment? If No, explain in the comments section. Yes No

Staffing Information

11.

Type of healthcare provider	Number of employees	Number of independent contractors	Annual billable hours in last 12 months	Annual billable hours projected for next 12 months
Physicians				
EMT				
Paramedic				
Nurse				
Other (specify):				
Totals:				

12. a. Are all the above individuals licensed in accordance with applicable state and federal regulations? If No, please explain in the comments section. Yes No

Insurance and Claims History

13. Has the applicant notified Hiscox Inc. of all matters that may result in a potential claim including any litigation, administrative proceedings, demand letters, formal or informal investigations or inquiries which have occurred within the expiring policy period? Yes No None to Report
If No, please attach a detailed explanation or explain in the Comments Section.



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Comments Section

Notice to New York applicants: any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any material thereto, commits a fraudulent insurance act, which is a crime.

The applicant hereby acknowledges that he/she/it is aware that the limit of liability shall be reduced, and may be completely exhausted, by the costs of legal defense and, in such event, the Insurer shall not be liable for the costs of legal defense or for the amount of any judgment or settlement to the extent that such exceeds the limit of liability.

The applicant further acknowledges that he/she/it is aware that legal defense costs that are incurred shall be applied against the deductible amount.

I DECLARE that, after inquiry, the above statements and particulars are true and I have not suppressed or misstated any material fact and that I agree that this application shall be the basis of the contract with the Underwriters.

Name of applicant:

Signature of person authorized to execute on behalf of the applicant:

Name/title of person authorized to execute on behalf of the applicant:

Date:

This application form duly completed, together with any supplementary information, must be signed in ink or by electronic signature by the person indicated. Signing of this form does not bind the applicant or the Underwriters to complete this insurance.

A copy of this application should be retained for your records.