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Cortland, NY 13045
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AMBULANCE SERVICE COMPANIES
PROPERTY/CASUALTY INSURANCE APPLICATION

General Information

Date of Survey: _____ Date proposal is needed: _____ Insurance Renewal Date: _____

Legal Name of Organization: _____
(please include all organizations that are to be included as insureds)

_____ FEIN: _____

Mailing Address: _____ County: _____

Telephone: _____ Fax: _____

Website Address: _____ E-Mail Address: _____

Owner/President: _____ Phone #: _____ E-Mail: _____

Safety/Operations Manager: _____ Phone #: _____ E-Mail: _____

Human Resources Manager: _____ Phone #: _____ E-Mail: _____

Inspection Contact: _____ Phone #: _____ E-Mail: _____

Insurance Agent Information

Agent's Name: _____ CSR or Other Contact _____

Name of Agency: _____

Address: _____

Agency Telephone: _____ Fax #: _____ E-Mail: _____

Do you currently write this account? ☐ Yes ☐ No

If so, for how long? _____ With What Carrier? _____

Is the account Sub-Brokered? ☐ Yes ☐ No

If Yes, please indicate Agency Name: _____

Business Information

In business for how long? _____

Type of Organization: ☐ Individual ☐ Partnership ☐ Corporation ☐ Joint Venture ☐ Other: _____

Is the company a private for-profit ambulance service? ☐ Yes ☐ No

If no, please describe: _____

Within the last 24 months, or anticipated next 12 months, does the applicant plan to:

☐ Purchase or acquire another operation or entity ☐ Expand the number of locations

☐ Add additional service contracts, increase operations over 25% ☐ Expand operations into other states

If yes, please describe: _____

_____

Do you own any other businesses? ☐ Yes ☐ No

If so, please describe: _____

Do you require a motor carrier filing? (Ex. Form E) ☐ Yes ☐ No

If yes, please attach a copy of form.

Business Information (continued)

With respect to insurance for the insured, has any insurance policy been canceled or non-renewed, or an application for insurance been declined, or refused in the past five years? (Not applicable in Missouri) ☐ Yes ☐ No

If yes, please describe and supply copy of notices: _____

_____

Gross Annual Revenue: $ _____

% from Medicaid /Medicare: _____

% from Insurance Companies: _____

% from Private Pay: _____

% from Contract: _____

What is your primary service area: County(s)/Parish(s): _____

State(s): _____

Does the organization service any major metropolitan areas? ☐ Yes ☐ No

If yes, please describe: _____

Do you operate in other states? ☐ Yes ☐ No

If so, what states? _____

Provide the call volume:

	Total Number of Calls	Ambulance Calls	Percentage of Calls Running Lights & Sirens	Paratransit/ Wheelchair Calls
Projected Year				
Current Year				
1st Prior Year				
2nd Prior Year				

Highest level of EMS service provided: ☐ Advanced Life Support ☐ Advanced First Aid/Cardiopulmonary Resuscitation Only ☐ Basic Life Support ☐ No Emergency Medical Service

Does the company own any aircraft or watercraft? ☐ Yes ☐ No

If yes, please describe: _____

Does the company perform any aircraft or watercraft transportation? ☐ Yes ☐ No

If yes, please describe: _____

Are any medical clinical services offered (ie: blood pressure screening or training) ☐ Yes ☐ No

If yes, please describe: _____

Indicate the procedures used in the Employee Selection process:

☐ Written Application
☐ Physical Examination
☐ Written Test
☐ Road Test
☐ Other (describe): _____
☐ Pre-Employment Drug Testing
☐ Criminal Background Check
☐ Reference Checks
☐ Motor Vehicle Record Check

Real and Personal Property

☐ N/A

Please complete the schedule below. If the coverage is blanket, be sure to show a breakout of the building and contents values at each location.

Current Carrier: ______________________ Current Premium: $______________

Loc . No.:	Address:	
Building Limit: $	Personal Prop. Limit: $	Occupancy Type:
Construction Type: ☐ Type 1-Frame ☐ Type 2-Joisted Masonry ☐ Type 3-Non-combustible ☐ Type 4-Masonry non-combustible ☐ Type 5-Modified fire resistive ☐ Type 6-Fire resistive	Building Protection: (Check all that apply) ☐ Local Alarm ☐ Central Station Alarm ☐ Burglar Alarm ☐ Fire Extinguishers ☐ Sprinklers (_____%)	☐ Heat Detection ☐ Smoke Detection ☐ Motion Detection ☐ Security Guard/Service ☐ Cameras ☐ Full Intrusion Perimeter Alarm ☐ Other: ________

Own/Lease:	Building Info:		Year:	Updated/Inspected	Additional Occupancies
☐ Own	Number of Stories:	______	Roof:	____/____	________
☐ Lease	Building Sq. Ft.:	______	Plumbing:	____/____	________
	Sq. Ft. You Occupy:	______	Wiring:	____/____	________
	Year Built:	______	HVAC:	____/____	________

Loc . No.:	Address:	
Building Limit: $	Personal Prop. Limit: $	Occupancy Type:
Construction Type: ☐ Type 1-Frame ☐ Type 2-Joisted Masonry ☐ Type 3-Non-combustible ☐ Type 4-Masonry non-combustible ☐ Type 5-Modified fire resistive ☐ Type 6-Fire resistive	Building Protection: (Check all that apply) ☐ Local Alarm ☐ Central Station Alarm ☐ Burglar Alarm ☐ Fire Extinguishers ☐ Sprinklers (_____%)	☐ Heat Detection ☐ Smoke Detection ☐ Motion Detection ☐ Security Guard/Service ☐ Cameras ☐ Full Intrusion Perimeter Alarm ☐ Other: ________

Own/Lease:	Building Info:		Year:	Updated/Inspected	Additional Occupancies
☐ Own	Number of Stories:	______	Roof:	____/____	________
☐ Lease	Building Sq. Ft.:	______	Plumbing:	____/____	________
	Sq. Ft. You Occupy:	______	Wiring:	____/____	________
	Year Built:	______	HVAC:	____/____	________

Loc . No.:	Address:	
Building Limit: $	Personal Prop. Limit: $	Occupancy Type:
Construction Type: ☐ Type 1-Frame ☐ Type 2-Joisted Masonry ☐ Type 3-Non-combustible ☐ Type 4-Masonry non-combustible ☐ Type 5-Modified fire resistive ☐ Type 6-Fire resistive	Building Protection: (Check all that apply) ☐ Local Alarm ☐ Central Station Alarm ☐ Burglar Alarm ☐ Fire Extinguishers ☐ Sprinklers (_____%)	☐ Heat Detection ☐ Smoke Detection ☐ Motion Detection ☐ Security Guard/Service ☐ Cameras ☐ Full Intrusion Perimeter Alarm ☐ Other: ________

Own/Lease:	Building Info:		Year:	Updated/Inspected	Additional Occupancies
☐ Own	Number of Stories:	______	Roof:	____/____	________
☐ Lease	Building Sq. Ft.:	______	Plumbing:	____/____	________
	Sq. Ft. You Occupy:	______	Wiring:	____/____	________
	Year Built:	______	HVAC:	____/____	________

Type 1-Frame - Buildings where the exterior walls are wood or other combustible materials including construction where combustible materials are combined with other materials such as brick veneer, stone veneer, wood iron-clad, stucco on wood.

Type 2-Joisted Masonry - Buildings where the exterior walls are constructed of masonry materials such as adobe, brick, concrete, gypsum block, hollow concrete block, stone, tile or similar materials and where the floors and roof are combustible.

Type 3-Non-Combustible - Buildings where the exterior walls and the floors and roof are constructed of, and supported by metal, asbestos, gypsum or other non-combustible materials.

Type 4-Masonry Non-Combustible - Buildings where the exterior walls are constructed of masonry materials as described in Code 2, with the floors and roof of metal or other non-combustible materials.

Real and Personal Property (continued)

Type 5-Modified Fire Resistive - Buildings where the exterior walls and the floors and roof are constructed of masonry or fire resistive material with a fire resistance rating of one hour or more but less than two hours.

Type 6-Fire Resistive - Buildings where the exterior walls and the floors and roof are constructed of masonry or fire resistive materials having a fire resistance rating of not less than two hours.

For additional locations please complete and attach a separate Property Supplement.

☐ Please indicate if Blanket Coverage is desired.

Indicate the coinsurance percentage desired: ☐ 80% ☐ 90% ☐ 100% ☐ Other _____

Indicate the property deductible desired: ☐ $500 minimum ☐ $1000 ☐ $2500 ☐ Other _____

Are there any other buildings at locations listed above that are not being quoted? ☐ Yes ☐ No

If yes, please explain: _____

_____

Please list name and address of any mortgagee (MTG) or loss payee (LP) for each location:

Location Number	Type	Name and Address
1.	☐ MTG ☐ LP	
2.	☐ MTG ☐ LP	
3.	☐ MTG ☐ LP	
4.	☐ MTG ☐ LP	
5.	☐ MTG ☐ LP	

Flood and Earthquake Coverage

Please indicate amounts of NFIP coverage, if any, is currently carried at each location:

Loc. No.	NFIP Coverage
1.	
2.	
3.	
4.	
5.	

General Liability

Current General Liability Carrier: _____ ☐ Occurrence ☐ Claims-Made Retroactive Date: _____

Current Limits of Liability: $_____ Occurrence Current Premium: $ _____

$_____ Aggregate Current Deductible: $ _____

Desired coverage: *General Liability Deductible Options are not available.*

Limits of Liability: ☐ $ 500,000 Occurrence/$1,000,000 Aggregate ☐ Occurrence ☐ Claims-made Retroactive Date: _____

☐ $1,000,000 Occurrence/$2,000,000 Aggregate ☐ Occurrence ☐ Claims-made Retroactive Date: _____

☐ $1,000,000 Occurrence/$3,000,000 Aggregate ☐ Occurrence ☐ Claims-made Retroactive Date: _____

☐ $_____ ☐ Occurrence ☐ Claims-made Retroactive Date: _____

General Liability (Continued)

Please Provide any General Liability locations not listed in the Property Section:

	Address	Occupancy Type	Square Footage
Location 1			
Location 2			
Location 3			
Location 4			
Location 5			

Please Provide the number of employees:

	Full Time Medical Employees	Part Time Medical Employees	Full Time Non-Medical Employees	Part Time Non-Medical Employees
Projected Year				
Current Year				
1st Prior Year				
2nd Prior Year				

Does the insured currently carry Employer's Liability Coverage on all employees? ☐ Yes ☐ No

Does the company lease or rent any real property to others? ☐ Yes ☐ No

If yes, please describe (include area square footage):_____

Does the company sell, rent out, or distribute any durable or expendable medical equipment or supplies? ☐ Yes ☐ No

If yes, please indicate yearly gross receipts: $ _____

Describe the type of equipment and supplies: _____

_____

Who is responsible for Maintenance? _____ Telephone #_____

Does the company sell or distribute pharmaceuticals of any sort? ☐ Yes ☐ No

If yes, please indicate annual sales: $_____

Describe the type of pharmaceuticals: _____

_____

Does the company install, service or repair medical equipment or devices of any sort for others? ☐ Yes ☐ No

If yes, please indicate annual receipts: $ _____

Describe the type of medical equipment or devices: _____

_____

Are you involved in Community Paramedicine/Community Health? ☐ Yes ☐ No

If yes, please provide a brief explanation of services provided _____

_____

How many visits do you make annually? _____

What is the annual revenue generated from Community Paramedicine/Community Health? _____

Sexual or Physical Abuse Liability Insurance

Current Sexual or Physical Liability Carrier:_____ ☐ Occurrence ☐ Claims-Made Retroactive Date: _____

Current Limits of Liability: $_____ Each Incident Current Premium: $ _____

$_____ Aggregate Current Deductible: $ _____

Type of Coverage (i.e., Occurrence or Claims Made) for Sexual or Physical Abuse Liability Insurance will follow the Type of Coverage requested for General Liability.

Does the company have a written policy addressing abusive acts? ☐ Yes ☐ No

Are the employees required to sign an acknowledgement of receipt and understanding of the abusive act policy? ☐ Yes ☐ No

Has any claim been made or suit filed against the company and/or its employees in the past five years alleging a sexual or physical abuse related matter? ☐ Yes ☐ No

If yes, please describe:_____

_____

Does the company have knowledge of any matter(s) involving a sexual or physical abuse related matter which would cause a reasonable person to believe that a claim or suit might result? ☐ Yes ☐ No

If yes, please describe:_____

_____

Medical Professional Liability

Current Medical Professional Liability Carrier:_____ ☐ Occurrence ☐ Claims-Made Retroactive Date: _____

Current Limits of Liability: $_____ Each Incident Current Premium: $ _____

$_____ Aggregate Current Deductible: $ _____

Desired coverage: *Medical Professional Liability Deductible Options are not available.*

Limits of Liability: ☐ $ 500,000 Each Incident/$1,000,000 Aggregate ☐ Occurrence ☐ Claims-made Retroactive Date: _____

☐ $1,000,000 Each Incident/$2,000,000 Aggregate ☐ Occurrence ☐ Claims-made Retroactive Date: _____

☐ $1,000,000 Each Incident/$3,000,000 Aggregate ☐ Occurrence ☐ Claims-made Retroactive Date: _____

☐ $_____ ☐ Occurrence ☐ Claims-made Retroactive Date: _____

Does the company utilize a Medical Director? ☐ Yes ☐ No

If yes, provide the following: Name:_____ ☐ Employee ☐ Contracted Service

What are the medical credentials of your Medical Director? _____

Is a record kept for each request for service? ☐ Yes ☐ No

Is a PCR completed for each transport? ☐ Yes ☐ No

Are all medical transports documented, with regular quality review by the Medical Director or other qualified person or group? ☐ Yes ☐ No

If not reviewed by the medical director, who is responsible for review?_____

Is documentation maintained showing all medical equipment purchases, maintenance, calibration, and service? ☐ Yes ☐ No

Does the company provide prisoner or psychiatric transports? ☐ Yes ☐ No

If so, how many annually? _____

Please describe the patient restraint policy in place, with regard to this type of transport: _____

_____

Has the applicant entered into any written contracts requiring waiver of subrogation or primary/non-contributory wording? ☐ Yes ☐ No

If so, please describe: _____

Medical Professional Liability (Continued)

Please describe your Patient Handling Training, including how often it is conducted: _____

_____

Does the company maintain and monitor records on an on-going basis to confirm that all employees and new hires meet appropriate state certification requirements? ☐ Yes ☐ No

Does your service have a Medical Equipment Failure policy? ☐ Yes ☐ No

If yes, does it address checking, charging and replacing batteries for medical equipment? ☐ Yes ☐ No

Does the company lend or lease agents, servants or employees to others? ☐ Yes ☐ No

If yes, attach a copy of the insurance provisions and hold harmless conditions of the contract.

Does the company borrow or lease agents, servants or employees from others? ☐ Yes ☐ No

If yes, attach a copy of the insurance provisions and hold harmless conditions of the contract.

Has any claim been made or suit filed against the company and/or its employees in the past five years alleging negligence in the rendering, or failure to render, medical or professional health care services? ☐ Yes ☐ No

If yes, please describe: _____

_____

Does the insured have any knowledge of any matter which would cause a reasonable person to believe that a claim or suit against the company is likely to arise alleging negligence in the rendering, or failure to render, medical or professional health care services? ☐ Yes ☐ No

If yes, please describe: _____

_____

With respect to medical professional liability insurance, has the company received notice of any claims by a state regulatory agency in the past five years? ☐ Yes ☐ No

If yes, please describe: _____

_____

Stretcher Information:

Type	Brand	Number Used
X-Frame		
Power Cot		
Bariatric Cot		
Other		

Does your service have a mandatory lift assist policy? ☐ Yes ☐ No

Please describe your policy for patient securement: _____

_____

Wheelchair Information: ☐ Not Applicable

Do all your wheelchairs meet the WC19 standard? ☐ Yes ☐ No

Do all your wheelchair tie downs and lap belts meet the WC18 standard? ☐ Yes ☐ No

What type of tie downs are utilized for the patient? ☐ 4 point ☐ Strap ☐ Docking

Is a wheelchair checklist mandatory for all drivers to utilize? ☐ Yes ☐ No

Are wheelchair reminder stickers inside the vans? ☐ Yes ☐ No

What is the training requirement for all wheelchair van drivers, and is there refresher training? Please describe: _____

_____

_____

Medical Professional Liability (Continued)

Dispatching Information:

Does the company use a priority dispatch system? ☐ Yes ☐ No

What type of dispatch software does your company use? _____

Does your company dispatch to any other companies or public entities? ☐ Yes ☐ No

If yes, describe: _____

What is the required experience and training for your dispatchers? Please describe: _____

_____

Employment Practices Liability Insurance ☐ N/A

Current Employment Practices Liability Carrier: _____ ☐ Occurrence ☐ Claims-Made Retroactive Date: _____

Current Limits of Liability: $_____ Each Incident Current Premium: $ _____

$_____ Aggregate Current Deductible: $ _____

Desired coverage: *Employment Practices Liability Deductible Options are not available*

Limits of Liability: ☐ $ 500,000 Each Incident/$1,000,000 Aggregate ☐ Occurrence ☐ Claims-made Retroactive Date: _____

☐ $1,000,000 Each Incident/$2,000,000 Aggregate ☐ Occurrence ☐ Claims-made Retroactive Date: _____

☐ $1,000,000 Each Incident/$3,000,000 Aggregate ☐ Occurrence ☐ Claims-made Retroactive Date: _____

☐ $ _____ ☐ Occurrence ☐ Claims-made Retroactive Date: _____

Note: *Occurrence coverage not available.*

Does the Company have a written Employment Practices handbook? ☐ Yes ☐ No

Has any claim been made or suit filed against the company and/or its employees in the past five years alleging a wrongful act, error or omission* in an employment-related matter? ☐ Yes ☐ No

If yes, please describe: _____

_____

Does the company have knowledge of any matter(s) involving employment discrimination, wrongful termination, sexual harassment, or any other employment-related matter which would cause a reasonable person to believe that a claim or suit might result? ☐ Yes ☐ No

If yes, please describe: _____

_____

* Discrimination, coercion, harassment, or humiliation based on race, ethnic or national origin, marital status, medical condition, gender, age, physical appearance, physical or mental impairment, sexual orientation, or political affiliation; sexual harassment; termination of employment including retaliatory or constructive discharge; breach of employment contract; failure to employ; deprivation of a career opportunity; failure to promote; disciplinary action; demotion or evaluation; infliction of emotional distress.

Employee Benefits Liability ☐ N/A

Current Employee Benefits Liability Carrier: _____ ☐ Occurrence ☐ Claims-Made Retroactive Date: _____

Current Limits of Liability: $_____ Each Incident Current Premium: $ _____

$_____ Aggregate Current Deductible: $ _____

Desired coverage: *Employee Benefits Liability Deductible Options are not available.*

Limits of Liability: ☐ $ 500,000 Each Incident/$1,000,000 Aggregate ☐ Occurrence ☐ Claims-made Retroactive Date: _____

☐ $1,000,000 Each Incident/$2,000,000 Aggregate ☐ Occurrence ☐ Claims-made Retroactive Date: _____

☐ $1,000,000 Each Incident/$3,000,000 Aggregate ☐ Occurrence ☐ Claims-made Retroactive Date: _____

☐ $ _____ ☐ Occurrence ☐ Claims-made Retroactive Date: _____

Does the company have an Employee Benefits handbook? ☐ Yes ☐ No

Employee Benefits Liability (Continued)

Has any claim been made or suit filed against the company and/or its employees in the past five years alleging an error or omission in the administration* of your benefit programs? ☐ Yes ☐ No

If yes, please describe: _____

_____

Does the company have knowledge of any matter(s) involving employee benefits, benefits administration, the handling of benefit claims, or any other benefits-related matter which would cause a reasonable person to believe that a claim or suit might result? ☐ Yes ☐ No

If yes, please describe: _____

_____

* Determining who is eligible to participate; enrolling new participants; terminating participants; determining benefits; processing claims; collecting funds and applying them as required; preparing reports required by government agencies; giving advice to participants or prospective participants; providing reports, booklets, pamphlets, memos or messages to participants.

Business Automobile

Current Business Automobile Carrier: _____

Current Limit of Liability: $_____ Combined Single Limit Current Premium: $ _____

Current Liability Deductible: $ _____

Indicate Desired Limits Below: *Automobile Liability Deductible Options are not available.*

$_____ Auto Liability

$_____ Medical Payments

$_____ PIP/No-Fault (Medical Expense Benefits – Applies Only in PA)

$_____ Additional PIP (Increased Medical Expense Benefits – Applies Only in PA)

$_____ Uninsured Motorists/ Underinsured Motorists Bodily Injury

☐ Stacking ☐ Non-Stacking

$_____ Uninsured Motorists/ Underinsured Motorists Property Damage

Please indicate the desired deductible for these vehicles:

Comprehensive	☐ $2000 (minimum)	☐ $3000	☐ $5000	☐ Other $ _____
Collision	☐ $2000 (minimum)	☐ $3000	☐ $5000	☐ Other $ _____

Provide the number vehicles:

Vehicle Type	Projected Year	Current Year	1st Prior Year	2nd Prior Year
Ambulances				
Wheelchair Vans				
Private Passenger Vehicles				
Fly-Car Vehicles				
Other Vehicles - Describe:				

Business Automobile (Continued)

Describe usage of vehicles:

Vehicle Type	Percentage of Total Calls	Maximum Radius	Maximum Number of Passengers	Average Number of Passengers
Ambulances				
Wheelchair Vans				
Private Passenger Vehicles				
Fly-Car Vehicles				
Other Vehicles - Describe:				

Definitions:

Ambulance: Any motor vehicle designed, appropriately equipped and used for the purpose of carrying sick or injured persons by an entity registered or certified as an ambulance service by the department of health.

Fly Car: Any motor vehicle designed, appropriately equipped and used for the purpose of transporting equipment and personnel belonging to an entity registered or certified as an ambulance service by the department of health.

Wheelchair Van: Any motor vehicle designed or modified and appropriately equipped for the transportation of wheel chair bound individuals, when used in that capacity by a volunteer or commercial transportation agency.

Invalid Coach / Ambulette: Any motor vehicle designed or modified and appropriately equipped for the transportation of stretcher bound individuals with out the aid of medical personnel, when used in that capacity by a volunteer or commercial transportation agency.

Does the company lease or loan vehicles to others (providers, churches, etc.)? ☐ Yes ☐ No

If yes, please describe:_____

Does the company allow owners/employees to take company owned vehicles home or on personal business? ☐ Yes ☐ No

If yes, are family members allowed to use the vehicle? ☐ Yes ☐ No

Vehicle maintenance procedures:

Are daily vehicle inspection reports completed? ☐ Yes ☐ No

Are periodic maintenance checks done by a mechanic? ☐ Yes ☐ No

Are vehicle maintenance records kept? ☐ Yes ☐ No

Does the company employ its own mechanics? ☐ Yes ☐ No

Does the company store or service the vehicles of others? ☐ Yes ☐ No

Business Automobile (continued)

List all vehicles on the schedule below. An entry in each field is required. If there are any vehicles for which physical damage coverage is not wanted, indicate N/C (no coverage) in the cost new column.

Vehicle Schedule								
Veh No.	Year	Make, Model, Type	Cost New	Vehicle Identification Number	Location Number	Number of Seats	Plate #	Unit #
1.			$					
2.			$					
3.			$					
4.			$					
5.			$					
6.			$					
7.			$					
8.			$					
9.			$					
10.			$					
11.			$					
12.			$					
13.			$					
14.			$					
15.			$					

If there are any additional vehicles, please attach a Vehicle Schedule Supplement.

Are any vehicles equipped with Onboard Monitoring (Black Box, VER, GPS)? ☐ Yes ☐ No

If yes, please describe the equipment: _____

_____

Which vehicles are equipped: _____

_____

How often is the data reviewed, and by whom: _____

Please list name and address of any additional insured (AI) or loss payee (LP) for each vehicle:

Vehicle Number	Type	Name and Address
	☐ AI ☐ LP	
	☐ AI ☐ LP	
	☐ AI ☐ LP	
	☐ AI ☐ LP	
	☐ AI ☐ LP	

Driver Information

Does the company review motor vehicle reports? ☐ Yes ☐ No

How often? ☐ Annually ☐ Every 2-3 yrs ☐ More than 3 years

Does the company have written criteria for acceptable Motor Vehicle Reports? ☐ Yes ☐ No

Do all drivers have a license commensurate with state or local law (commercial drivers license, etc.)? ☐ Yes ☐ No

Please provide the name and title of the person in charge of driver training: _____

Are employees required to take a Driver Training/Vehicle Operators Course commensurate with jobs? ☐ Yes ☐ No

How often? ☐ At hire only ☐ Annually ☐ Semi-Annually ☐ Other Describe: _____

Please describe driver training program utilized:

At-Hire: _____

Refresher: _____

Remedial: _____

Are emergency drivers required to take an Emergency Vehicle Operators Course (EVOC)? ☐ Yes ☐ No

Does a file exist for each driver containing documentation for all of the above information? ☐ Yes ☐ No

Is there a formal accident review/investigation procedure in place? ☐ Yes ☐ No

If yes, please describe: _____

_____

Provide the number of drivers employed:

	Full Time	Part Time	Contract	Turnover Percentage
Projected Year				
Current Year				
1st Prior Year				
2nd Prior Year				

Portable Equipment ☐ Not Applicable

Replacement Cost coverage normally will be provided for all portable equipment. This equipment will be covered while on premises and while away from the premises, including while in transit, in storage, or in use.

Please indicate the desired Limit of Insurance for Portable Equipment: $ _____

Please indicate the desired deductible: ☐ $500 minimum ☐ $1000 ☐ $2500 ☐ Other $ _____

Current Carrier: _____ Current Premium: $ _____

Indicate below any scheduled equipment for which replacement cost coverage is desired.

Description	Amount of Insurance	Deductible
_____	$ _____	$ _____
_____	$ _____	$ _____
_____	$ _____	$ _____

Crime/Fidelity

☐ Not Applicable

Current Carrier: _____ Current Premium: $_____

FIDELITY

☐ Employee Theft Blanket

Limit of Insurance (maximum $500,000) $ _____

Number of Class I Employees (direct contact with funds) _____

Number of Class II Employees (all others) _____

☐ Employee Theft Position Schedule

Position	Limit of Insurance (maximum $500,000)
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____

☐ Faithful Performance of Duty Coverage ($10,000)

☐ Forgery or Alterations (maximum $500,000) $ _____

☐ Computer Fraud and Funds Transfer Fraud (maximum $100,000) $ _____

MONEY AND SECURITIES

Note: $5,000 money and securities coverage is provided under the Property Coverage Extensions.

If this limit is insufficient, please indicate the desired amount of additional insurance: $ _____

GENERAL CRIME INFORMATION

List all persons managing funds: Name _____ Title _____

Name _____ Title _____

Name _____ Title _____

Do the persons managing funds turn over this function to another for a period of 2 weeks every year to prevent theft? ☐ Yes ☐ No

Are Invoices or Requisitions kept? (This documents what item or service is being paid for, who the vendor is, and who authorized the item or service). ☐ Yes ☐ No

Are Invoices or Requisitions, Check Register and Bank Statement cross-checked against each other? ☐ Yes ☐ No

Largest amount of petty cash kept on hand? $ _____

Is money ever stored in the building overnight? ☐ Yes ☐ No

If yes, amount and how stored: _____

All receipts are deposited in a bank within: ☐ 2 days ☐ 1 week ☐ Over 1 week

Are all incoming checks immediately stamped "For Deposit Only"? ☐ Yes ☐ No

Do all outgoing checks require 2 signatures? ☐ Yes ☐ No

If no, do checks over a certain amount require 2 signatures? ☐ Yes ☐ No

If yes, please indicate amount $ _____

To whom and how often is there a report of receipts and disbursements? _____

By whom and how often are the accounts examined? _____

When were the accounts last examined? _____

Is an outside audit performed? ☐ Yes ☐ No

If Yes, by whom, how often, and when was the last audit performed? _____

_____

Umbrella and Excess Liability

☐ Not Applicable

Current Umbrella/Excess Liability Carrier: _____

Current Limit of Insurance: $ _____ Current Premium: $ _____

Current Deductible or Retention Limit: $ _____

Desired Limit of Insurance (max $10 million): $ _____

Umbrella Liability Deductible or Retention Limit Options not available.

Note: these limits will apply to Excess Liability [Commercial General Liability, Medical Professional Liability, Employment Practices Liability, Employee Benefits Liability, Auto Liability, Employer's Liability, as applicable] and Umbrella Liability. The minimum required underlying limits are: Commercial General Liability – $1 million per occurrence/$2 million annual aggregate; Medical Professional Liability, Employment Practices Liability and Employee Benefits Liability – $1 million each incident/$2 million annual aggregate; Auto Liability – $1 million per occurrence; Employer's Liability – $1 million bodily injury by accident/$1 million bodily injury by disease-each employee/$1 million bodily injury by disease-policy limit.

Please indicate the underlying coverage information for Employer's Liability. If this information is not provided, Excess Employer's Liability coverage will not be included under any policy that is dependant upon the information contained in this survey:

Insurer*: _____ Policy Number: _____

Policy Period: _____

Employers Liability (Coverage B) Limits: $ _____ Bodily Injury by Accident

$ _____ Bodily Injury by Disease – Each Employee

$ _____ Bodily Injury by Disease – Policy Limit

**Excess Employer's Liability is subject to approval of the insurer providing the underlying coverage.*

Prior Insurance Record

Coverage	Policy Term	Insurance Company	Policy Number	Premium
Property / Inland Marine				
Property / Inland Marine				
Property / Inland Marine				
PL/General Liability				
PL/General Liability				
PL/General Liability				
Umbrella/ Excess				
Umbrella/ Excess				
Umbrella/ Excess				
Auto				
Auto				
Auto				

Attachments

Attachments to this application must include the following:

- Five years of currently valued, within 60 days, hard copy loss runs, including loss details and descriptions (for all lines requested)
- Copy of declarations pages to verify claims made or occurrence coverage (General Liability, Professional Liability, Employment Practices Liability, Employee Benefits Liability)
- A complete drivers list with drivers names, license numbers, dates of birth and date of hire
- Copies of motor vehicle reports for all drivers (preferred to be run within 30 days of review)
- Copy of **Employer's Liability declarations page if excess Employer's Liability is requested**

A quotation will not be offered if the attachments are not included with the application.

APPLICATION SIGNATURES & STATE FRAUD STATEMENTS

NOTICE: ANY PERSON WHO, KNOWINGLY OR WITH INTENT TO DEFRAUD OR TO FACILITATE A FRAUD AGAINST ANY INSURANCE COMPANY OR OTHER PERSON, SUBMITS AN APPLICATION OR FILES A CLAIM FOR INSURANCE CONTAINING FALSE, DECEPTIVE OR MISLEADING INFORMATION MAY BE GUILTY OF INSURANCE FRAUD.

NOTICE TO ALABAMA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

NOTICE TO ALASKA APPLICANTS: A person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

NOTICE TO ARIZONA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

NOTICE TO ARKANSAS, LOUISIANA, RHODE ISLAND AND WEST VIRGINIA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO CALIFORNIA APPLICANTS: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE TO COLORADO APPLICANTS: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

NOTICE TO DELAWARE APPLICANTS: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

NOTICE TO IDAHO APPLICANTS: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO INDIANA APPLICANTS: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete or misleading information commits a felony.

NOTICE TO KANSAS APPLICANTS: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral or telephonic communication statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

NOTICE TO KENTUCKY APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

NOTICE TO MAINE APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

NOTICE TO MARYLAND APPLICANTS: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO MINNESOTA APPLICANTS: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

APPLICATION SIGNATURES & STATE FRAUD STATEMENTS

NOTICE TO NEW HAMPSHIRE APPLICANTS: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NOTICE TO NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO NEW MEXICO APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

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 or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

NOTICE TO OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO OREGON APPLICANTS: Any person who, knowingly and with intent to defraud or facilitate a fraud against any insurance company or other person, submits an application, or files a claim for insurance containing any false, deceptive, or misleading material information may be guilty of insurance fraud.

NOTICE TO PENNSYLVANIA APPLICANTS: 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 fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTICE TO PUERTO RICO APPLICANTS: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

NOTICE TO TENNESSEE AND VIRGINIA APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE TO TEXAS APPLICANTS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE TO UTAH APPLICANTS: Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE TO VERMONT APPLICANTS: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

NOTICE TO WASHINGTON APPLICANTS: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

THE UNDERSIGNED REPRESENTS THAT HE/SHE HAS MADE A GOOD FAITH EFFORT TO ASCERTAIN COMPLETE AND ACCURATE ANSWERS TO THE QUESTIONS SET FORTH IN THIS APPLICATION AND THAT THE INFORMATION PROVIDED IN THIS APPLICATION, INCLUDING ANY ATTACHMENTS, IS TRUE, ACCURATE, AND COMPLETE TO THE BEST OF THEIR KNOWLEDGE AND BELIEF.

Applicant's Signature:_____ Date: _____

Name and title (please print): _____

Insurance Broker's Signature:_____ Date: _____

APPLICABLE IN NEW YORK - NEW YORK CLAIMS-MADE INSURANCE NOTICE
IF ANY LIABILITY COVERAGE IN YOUR POLICY IS PROVIDED ON A CLAIMS-MADE BASIS THEN COVERAGE IS LIMITED TO LIABILITY FOR ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST AN INSURED AND REPORTED IN WRITING WHILE THE POLICY IS IN FORCE, DURING A RENEWAL OF THE POLICY, OR DURING ANY EXTENDED REPORTING PERIOD. VARIOUS PROVISIONS IN THE POLICY MAY RESTRICT COVERAGE. PLEASE READ THE ENTIRE POLICY CAREFULLY TO DETERMINE RIGHTS, DUTIES, AND WHAT IS AND IS NOT COVERED.

Applicant's Signature:_____ Date: _____

Name and title (please print): _____