



PROPERTY/CASUALTY RENEWAL SURVEY
INDIANA

P.O. Box 5670
Cortland, NY 13045
Phone: (800) 822-3747
Fax: (607) 756-5051
Email: applications@mcneilandcompany.com

GENERAL INFORMATION

Date of survey: _____ Renewal Date: _____ Date proposal needed: _____

Legal Name of Organization: _____
(Include all organizations that are to be included as insureds including Fire Districts, Fire Companies, Rescue Squads and Auxiliaries)

FEIN: _____

Mailing Address: _____ County: _____

Website Address: _____ Phone #: _____

Chief: _____ Phone # _____ E-Mail: _____

Training Officer: _____ Phone # _____ E-Mail: _____

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

INSURANCE AGENT INFORMATION

Producer: _____ CSR or Other Contact _____

Telephone: _____ Fax: _____ E-mail address: _____

BUSINESS INFORMATION

Which best describes the organization (please check one):

- Fire Suppression only (no EMS) Fire and Rescue/EMS Professional/Trade Association
- Rescue/EMS Squad or Ambulance Squad Relief Association Training Center

The organization is a (please check one):

- Tax District Independent Non-Profit Organization County Department/Organization
- Municipal, Village or Town Department For Profit Organization

If a municipal, village or town department, is the organization a separate legal entity? Yes No

OPERATIONS

Population served on a first-call basis: _____ Annual Revenue: _____

Employees/Volunteers:

Total number of career personnel: _____ Total number of emergency service volunteers: _____

Turn-over rate for career personnel: _____ Total number of part-time FD/EMS personnel: _____

Total number of township trustee & board members: _____

Total number of other township personnel: Full-time: _____ Part-time: _____

Does the organization utilize a licensed physician as its Medical/EMS Director? Yes No

Do you contract out any of your personnel? Yes No

If yes, please provide a copy of the contract.

Emergency Operations: N/A

Annual Fire/Rescue Calls _____

Emergency Ambulance Calls _____ Emergency – The assignment was dispatched as a true emergency

Non-Emergency Ambulance Calls _____ Non-Emergency – The Assignment was not dispatched as a true emergency

OPERATIONS (CONTINUED)

Non-Emergency Operations: N/A

Are you involved in:

- Community Paramedicine Annual Visits: _____ Annual Revenue: _____
- Community Health Check-ups Annual Visits: _____ Annual Revenue: _____
- Wheelchair Transport Annual Calls: _____ Annual Revenue: _____

Do you dispatch for other entities? Yes No

If yes, please complete a Dispatch Supplement form.

Highest Level of EMS services provided?

- Advanced Life Support Basic Life Support No EMS

Stretcher Information:

Type	Brand	Number Used
X-Frame	<input type="checkbox"/> Ferno <input type="checkbox"/> Stryker Other: _____	
Power Cot	<input type="checkbox"/> Ferno <input type="checkbox"/> Stryker Other: _____	
Bariatric Cot	<input type="checkbox"/> Ferno <input type="checkbox"/> Stryker Other: _____	
Other	<input type="checkbox"/> Ferno <input type="checkbox"/> Stryker Other: _____	

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

Please indicate the type of straps used to secure the patient(s)? 2-point 3-point 5-point

Are all bariatric patients transported using a bariatric cot? Yes No

Are two transport teams used to transport all bariatric patients? Yes No

Wheelchair Information:

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

How often are wheelchair van drivers required to complete training? Annually Bi-Annually Remedial Other _____

EMPLOYERS LIABILITY

Please indicate the following underlying coverage information for Employers Liability. If this information is not provided, Excess Employers Liability coverage will not be included.

Insurer*: _____ Policy Number: _____

Policy Period: _____

Employers Liability (Coverage B) Limits: \$ _____ Bodily Injury by Accident (\$100,000 min)

\$ _____ Bodily Injury by Disease (\$100,000 min)

\$ _____ BI by Disease Policy Limit (\$500,000 min)

**Excess Employers Liability is subject to approval of the insurer providing the underlying coverage.*

RENEWAL INSTRUCTIONS

- Are there any building or BPP changes to be made to the renewal policy? Yes No
- Are there any vehicle additions or deletions to be made to the renewal policy? Yes No
- Are there any Agreed Value changes to be made to the renewal policy? Yes No
- Are there any interest changes to be made to the renewal policy? Yes No
- Are there any watercraft additions or deletions to be made to the renewal policy? Yes No
- Are there any aircraft/drone additions or deletions to be made to the renewal policy? Yes No

If yes to any of the above, please attach a change request.

- Is alcohol sold or served at any time throughout the year? Yes No (If yes, please complete and attach the liquor supplement.)
- Does the insured carry Workers Compensation coverage? Yes No
- Are all paid and volunteer staff covered by **Worker's Compensation** coverage? Yes No

If no, please explain: _____

If you would like to receive a quote for Accident & Sickness Insurance please complete the Accident & Sickness Application which can be downloaded from our website at: <http://www.mcneilandcompany.com/mcneil.aspx?page=forms#esip>

APPLICATION SIGNATURES & STATE FRAUD STATEMENTS

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.

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: _____