Property/Casualty Renewal Survey
Indiana

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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	☐ Ferno ☐ Stryker Other:	
Power Cot	☐ Ferno ☐ Stryker Other:	
Bariatric Cot	☐ Ferno ☐ Stryker Other:	
Other	☐ Ferno ☐ 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: ☐ 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

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: 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.

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:** ______________

(To be signed by someone who does not have access to funds)