



SUPPLEMENTAL APPLICATION FOR
AMBULANCE SERVICES

MISCELLANEOUS HEALTHCARE FACILITIES
PROGRAM

NOTE – Coverage is not afforded by this policy to any resident, intern, physician, surgeon, dentist, psychiatrist, licensed or certified registered nurse anesthetist, nurse midwife, podiatrist or chiropractor for rendering or failure to render professional services.

Instructions to the Applicant.

- A. Please answer all the questions on this supplemental application(s). The information is required to make an underwriting and pricing evaluation. Your answers hereunder are considered legally material to that evaluation.
- B. If a question is not applicable, state "N/A". If more space is required to answer a question, continue on your letterhead.
- C. The application must be signed and dated by an owner, partner, officer or director of your facility.

I. GENERAL INFORMATION

Applicant's / Entity Name: _____

II. OPERATIONS

- 1. Hours of operation _____
- # of Shifts Maintained _____
- # of Shifts per 24 hours _____

- 2. a. Do you dispatch 911 calls? Yes No
- b. Do you dispatch calls to other firms? Yes No
- c. Are all incoming calls taped/recorded? Yes No

- 5. Radius of operation:
 - 0-25 Miles _____ %
 - 26-50 Miles _____ %
 - 51 or more Miles _____ %

Must total 100%

- 4. Are any transports provided to non-medical facilities or destinations? Yes No

If yes, please explain. _____

5. Total Number of:

	<u>Projected</u>	<u>Current</u>
<u>Ground Ambulance Services</u>		
<input type="checkbox"/> Emergency Transports	_____	_____
<input type="checkbox"/> Non-Emergency Transports (Ambulance)	_____	_____
<input type="checkbox"/> Non-Emergency Transports (Ambulette)	_____	_____
<input type="checkbox"/> Ground Ambulances – owned	_____	_____
<input type="checkbox"/> Ground Ambulances – leased	_____	_____
<input type="checkbox"/> Chair cars/vans – owned	_____	_____
<input type="checkbox"/> Chair cars/vans – leased	_____	_____
<u>Air Ambulance Services</u>		
<input type="checkbox"/> Emergency Transports	_____	_____
<input type="checkbox"/> Non-Emergency Transports	_____	_____
<input type="checkbox"/> Aircraft – owned	_____	_____
<input type="checkbox"/> Aircraft – leased	_____	_____

6. Number of crew providing "professional services" per ambulance / aircraft: _____
7. a. What aviation insurance limits do you carry? \$ _____ N/A
b. What commercial auto liability limits do you carry? \$ _____ N/A
8. Is there a formal maintenance program routinely followed for your vehicles/aircraft? Yes No

I understand the information submitted herein becomes a part of my General Star Insurance Application and is subject to the same warranty and conditions.

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 fact material thereto, commits a fraudulent insurance act.

Signature of Owner, Officer or Partner

Print or Type Name and Title

Date (month-day-year)