

**EMERGENCY MEDICAL SERVICES – SUPPLEMENTAL APPLICATION**

This is a Supplemental Application which attaches to and becomes part of the Lexington Miscellaneous Facilities Application. The Applicant represents that the statements and facts are true and no material facts have been suppressed or misstated. If a policy is issued, this Supplemental Application will become part of the policy as if physically attached. Therefore, it is mandatory that all questions be answered completely. Completion of this Supplemental Application does not bind coverage.

**Supplemental Questions**

Applicant’s Name: \_\_\_\_\_

1. Select the nature of the services offered.

Describe Other:

2. Describe the geographic area where the runs are made (in square miles and listing the counties serviced).

3. Describe ownership of the company.

4. Describe historical, current and future services provided:

	Number of Runs and Revenue By Year												# of Employees
											Projected		
	Runs	Rev	Runs	Rev	Runs	Rev	Runs	Rev	Runs	Rev	Runs	Rev	
ALS2 (Advanced Life Support – 2)													
ALS1 (Advanced Life Support – 1)													
BLS (Basic Life Support)													
Other													
Totals													

**Definitions:**

- ALS2 (Advanced Life Support – 2) is defined as Manual defibrillation/cardioversion, Endotracheal intubation, Central venous line, Cardiac pacing, Chest decompression, Surgical airway, Intraosseous line.
  - ALS1 (Advanced Life Support – 1) is defined as using the services of an EMT-Intermediate or Paramedic for a situation beyond the Basic Life Support level.
  - BLS (Basic Life Support) is defined as using the services of an EMT-Basic or including the establishment of a peripheral intravenous (IV) line.
5. Is the company/entity is certified by any state?  
If so, list the state(s) and provide certification copy.
  6. If any guidelines exist for procedures for redirecting patients to another hospital please explain, if not, enter, ‘N/A’.

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7. Does this entity also operate a separate dispatching service for incoming 911 calls?
8. What is the average response time to the initial 911 call?
9. Regarding the vehicle fleet:
  - (1) How many vehicles are in the fleet?
  - (2) Is each vehicle equipped with a satellite navigational system?
  - (3) What is the age of fleet?
  - (4) How often are inspections completed?
  - (5) Is vehicle maintenance history maintained?
10. Describe the formal training of the drivers.
11. Describe the turnover of staffing for the last 2 years.
12. EMS - Air Exposures – Is there is any aircraft/air rescue liability exposure?  
If so, please explain.

If yes, how many of the following (helicopters vs. fixed wing aircraft) are in the applicant’s fleet? (By Year)

<b>Categories - # of Vehicles</b> (if none or zero then indicate “none” or “0”)					<b>Current Year</b>	<b>Projected 12 Months</b>
Helicopter						
Fixed Wing Aircraft						

13. If there is any watercraft/water ambulance liability exposure, please explain.

If yes, is the facility Coast Guard Certified?                      If no, please explain.

14. If the entity offers medical evacuation flights or angel of mercy programs, please explain.
15. Is the EMS entity staff composed of volunteers?
16. Are background checks completed?
17. Is drug/alcohol screening conducted prior to hire?
18. If employee random drug/alcohol screening is conducted after hire, how is it conducted?

If yes, with what frequency?

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- 19. For drivers, are driving records checked with the motor vehicle department after hire?
- 20. Is a female staff member part of the transport team when transporting a female patient?
- 21. If the entity is operated by or as part of a hospital, please explain
  
- 22. **LOSS HISTORY** – Submit company produced 5 year loss history with clearly marked valuation date with breakdowns of incurred losses (including paid and reserves for indemnity and expenses), current status and an explanation for each loss (with detailed explanations for large losses).

THE UNDERSIGNED DECLARES THAT ALL STATEMENTS SET FORTH HEREIN ARE TRUE. ANY MATERIAL MISSTATEMENTS AND/OR OMISSIONS MAY RESULT IN RESCINDED COVERAGE. THE UNDERSIGNED AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, HE/SHE (UNDERSIGNED) WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS, AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY TO COMPLETE THE INSURANCE, BUT THE APPLICANT ACKNOWLEDGES THAT THE COMPANY IS RELYING ON THE INFORMATION CONTAINED IN THE APPLICATION, AND IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT AND SHALL BE INCORPORATED BY REFERENCE INTO THE POLICY SHOULD A POLICY BE ISSUED.

ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE COMPANY IN CONJUNCTION WITH THIS APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THE APPLICATION AND MADE A PART HEREOF.

**THIS APPLICATION MUST BE SIGNED BY AN OFFICER OR PRINCIPAL OF THE APPLICANT.**

Name of Applicant: \_\_\_\_\_

Title: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Brokerage Firm Name: \_\_\_\_\_

Producer Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_