GREENHILL
INSURANCE SERVICES

Mailing Address:
1707 Post Oak, Suite 279
Houston, Texas 77056
WWW.GRNHLL.COM

Non-Emergency Medical Transportation Services Application

INSTRUCTIONS: ANSWER ALL QUESTIONS; APPLICANT'S NAME MUST INCLUDE THE NAMES OF ALL BUSINESSES AND LOCATIONS FOR WHICH COVERAGE IS DESIRED. If the answer is NONE, state NONE; If the answer is NOT APPLICABLE, state NOT APPLICABLE (N/A). If the space provided is insufficient to fully answer the question, PLEASE ATTACH A SEPARATE SHEET. NOTE: APPLICATION MUST BE DATED AND SIGNED BY OWNER, PARTNER, OFFICER OR ADMINISTRATOR. PLEASE TYPE OR PRINT IN INK.

***PLEASE PROVIDE VEHICLE ROSTER FOR REVIEW.**

PART I. GENERAL INFORMATION

1.1 Applicant Name (including dba's): _____

1.2 Mailing Address: _____

1.3 Location Address(es): _____

_____

1.4 County (parish) of each location: _____

1.5 Telephone Number: Office _____ Fax _____

Tax ID: _____

1.6 Risk Manager: Name: _____

Title: _____

Email Address: _____

1.7 Year entity established: _____

1.8 Entity is Association/Corporation

☐ Individual ☐ Corporation ☐ Partnership ☐ Professional

☐ Other (Describe) _____

1.9 Type of Service: (Check where applicable with percentages of services)

__ Non-Emergency Transportation __ City owned & operated

__ Wheelchair Transportation __ County owned & operated

__ Hospital Discharge Transport __ Fire Department

__ Public Transportation Service __ Other (Describe) _____

__ Emergency Response

1.10 Proposed effective date _____

1.11 Requested Limits of Liability (if available):

Professional Liability $ _____ /$ _____

General Liability $ _____ each occurrence

$ _____ general aggregate

1.12 Annual Gross Receipts or Budget: Estimated next twelve months: $ _____

Last twelve months: $_____

1.13 Annual Remuneration: Estimated next twelve months: $ _____

1.14 Total premises square footage occupied by applicant: _____

PART II. EXPOSURES

2.1 Total number of emergency runs: _____ last year, estimated _____ next year.

2.2 Total number of scheduled patient transport (non emergency) runs: _____ last year, estimated next year

2.3 Radius of operations: _____

2.4 Number patient encounters at special events (if any):_____ (please see question 2.11).

2.5 Total number of vehicles and type: _____

2.6 Are vehicles equipped with cardiac telemetry? __ Yes __ No

If yes, to what command center?_____

Who provides medical orders?_____

2.7 Does your service provide Air or Watercraft ambulance services? __ Yes __ No

If yes, please please describe_____

2.8 Does your service provide water rescue services? __ Yes __ No

If yes, please describe:_____

_____

2.9 Does your service provide mobile intensive care? __ Yes __ No

2.10 Does your service provide mobile neo-natal intensive care? __ Yes __ No

2.11 Does your service routinely provide first aid services to any sporting event, carnival, fair, etc? __ Yes __ No

If yes, state type, location, and number of patient encounters: _____

_____

_____

2.12 Qualifications and number of EMS Personnel:

Employed	Contract	Volunteer
____	____	____ Advanced First Aid and/or Red Cross
____	____	____ CPR Certificate only
____	____	____ EMT Basic
____	____	____ EMT Advanced or Intermediate (IV)
____	____	____ EMT Paramedic
____	____	____ Nurse (RN or LPN)
____	____	____ Physicians or Surgeons*
____	____	____ Other, describe _____

* Attach list and indicate specialty.

2.13 Does the applicant desire to provide coverage for independent contractor(s)? Including them as additional insured(s) on your policy while working on your behalf? Yes __ No __

2.14 Explain procedures for refusal or transfer by an adult:_____

_____

_____

For refusal for transport by a minor:_____

_____

2.15 Explain criteria for "No-Transport" by service:_____

_____

_____

2.16 Do you enter into contractual agreements? __ Yes __ No

If yes, please enclose copies or all such contracts.

PART III. HISTORY

3.1 List prior professional liability insurers for the past five years, starting with the most recent year.

If none, so state.

Insurer	Policy Number	Limits of Liability	Premium	Eff. Date	Claims-Made Yes	Claims-Made No
1._____						
2._____						
3._____						

4._____

5._____

If claims-made, what is the most recent retroactive date?_____

3.2 List prior general liability insurers for the past five years, starting with the most recent year. If none, so state.

Insurer	Policy Number	Limits of Liability	Premium	Eff. Date	Claims-Made Yes	Claims-Made No
1.						
2.						
3.						
4.						
5.						

If claims-made, what is the most recent retroactive date?_____

3.3 Have any claims been made or occurrences reported during the past six years against any of the proposed insureds or against any entity in which any proposed insured has or has had an interest? __ Yes __ No

If yes, please describe, indicate status of the claim or suit, and any amount(s) paid or reserved (attach an additional sheet if necessary)._____

3.4 Does any proposed insured have any knowledge of an event, circumstance or occurrence (other than any listed in 3.3

above) prior to the effective date of the proposed policy, or does any proposed insured foresee that a claim may be brought as a result of said event, circumstance or occurrence? __ Yes __ No

If yes, describe the event and indicate the reason for anticipation of a claim.

I understand and agree this Application and any and all supplements attached hereto may be made a part of any policy issued, and any such policy will be issued in reliance upon the representation made herein. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the Company, result in the voiding of insurance issued in reliance on this Application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, professional reputation and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release to the company providing insurance coverage and Greenhill Insurance Services, LLC. any documents, records or other information bearing upon the foregoing.

I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

Applicant and all owners, employees, and contractors are licensed or duly authorized in all states or jurisdictions where professional services are provided. Applicant warrants the truth of all answers to the above questions, and that applicant has not withheld any information which is calculated to influence the judgment of the insurance company in considering this application.

IMPORTANT: THIS APPLICATION MUST BE SIGNED BY THE APPLICANT. SIGNING THIS FORM <u>DOES NOT</u> <u>BIND</u> THE COMPANY TO COMPLETE THE INSURANCE.

Date	Applicant	Title