JAMES RIVER INSURANCE	**James River Insurance Company and its Subsidiaries** 6641 West Broad Street, Suite 300 Richmond, VA 23230	**Ambulance/Non-Emergency Transport Supplemental Application (Submitted with AH General App)** **ALLIED HEALTHCARE Division** Email to AH@jamesriverins.com or, Fax to 804-420-1054

APPLICANT'S INSTRUCTIONS:

1. Answer all questions completely. Please attach extra sheets as required. Incomplete or illegible applications may be discarded.
2. Application must be signed and dated by the owner, partner, or officer not earlier than 45 days before the proposed effective date of coverage.
3. Please read the statements at the end of this application carefully. Thank you!

AMBULANCE/NON-EMERGENCY TRANSPORT SUPPLEMENTAL APPLICATION

PLEASE ATTACH THE FOLLOWING:

- **5 - year Currently valued loss runs**
- **Brochures**
- **Copy of standard incident reporting form**
- **Copy of guidelines and employee training protocols for patient loading and unloading**
- **Protocols for patient transfer**
- **Patient Refusal forms – used when patient refuses treatment**

Applicant Name: _____

GENERAL INFORMATION:

1. Number of volunteer members: _____ Number of paid members: _____

2. List all states of operation: _____

3. List all counties served: _____

4. Radius of operation:
   0-25 miles_____% 25-50 miles _____% Over 50 miles _____% Over 100 miles _____%

Services Provided (expected annual #)	**Number of Calls:**	**Number of Emergency Calls:**
Basic Life Support (BLS)		
Advanced Life Support (ALS)		
First Responder		
Non Emergency Transport (Ambulet/Wheelchair Service)		
Other Patient Transport – Describe:		
Air Ambulance / Air Medevac Transport		
Search & Rescue – Describe:		
Total Number of Calls		

5. Describe how emergency calls are received_____
   Does your company dispatch 911 calls? ☐ Yes ☐ No

   Does your company dispatch calls to others? ☐ Yes ☐ No
   How are these calls recorded? _____

6. Do you contract your services to others on an independent contractor basis? ☐ Yes ☐ No
   If "Yes", please advise to whom you contract your work: _____

7. Do you have a formal safety program ? ☐ Yes ☐ No
   If "No", please explain:_____

Staff:	**Full Time**	**Part Time**
EMT's		
Paramedics		
Nurses		
Drivers		
Other: Describe_____		

8. Do all professional employees meet state certification requirement? ☐ Yes ☐ No

9. How often are EMT's and Paramedics recertified?_____

10. Describe qualifications and training for drivers: _____
    _____

11. Are drivers trained on wheelchair patient restraint? ☐ Yes ☐ No

12. Do you administer any anesthesia? ☐ Yes ☐ No

Vehicles:	**Number:**
Ambulances	
Vans	
Other - Describe:	
Aircraft - Describe:	
Watercraft – Describe:	

13. Describe the maintenance of your vehicles:_____
    _____

14. **Automobile Liability Insurance Information:**

Current Carrier	
Limits of Liability	$
Deductible	$
Does the policy specifically exclude claims arising from loading and unloading of patients?	☐ No ☐ Yes
Does the policy remain silent on the applicability of coverage for claims arising from loading and unloading of patients?	☐ No ☐ Yes If "No", please explain:_____ _____

NOTICE TO APPLICANT: The coverage applied for is solely as stated in the policy. If policy is issued on a "CLAIMS MADE" or "CLAIMS MADE AND REPORTED" basis, it provides coverage only for those claims that are first made against the insured during the policy period unless the extended reporting period option is exercised in accordance with the terms of the policy. If issued on an "OCCURRENCE" basis, the policy provides coverage only for those occurrences that take place during the policy period.

The Insurer will rely upon this application and all such attachments in issuing the policy. If the information in this application or any attachment materially changes between the date this application is signed and the effective date of the policy, the Applicant will promptly notify the Insurer, who may modify or withdraw any outstanding quotation or agreement to bind coverage.

In New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

In all other states: It is a crime for any person to knowingly provide or facilitate in providing any false, incomplete, or misleading information to an insurance company. Penalties may include fines, imprisonment and denial of insurance benefits.

WARRANTY: I warrant to the Insurer, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy. I authorize the release of claim information from any prior insurer to James River Insurance Company and its Subsidiaries, 6641 West Broad Street, Richmond, VA 23230.

Applicant's Name:	Signature
Title:	Date:

