



Hospital Fleet Supplemental Application

(Must be attached to Acord Application)

Today's Date: _____

BASIC INFORMATION:

- 1. Named Insured: _____ 2. DBA: _____
- 3. Mailing Address: _____
- 4. Physical Address: _____
- 5. Phone: _____ 6. Fax: _____
- 7. Website Address: _____
- 8. Safety Manager's Name, Cellphone Number & Email Address: _____
- 9. EMS Manager's Name, Cellphone Number & Email Address: _____
- 10. FEIN Number: _____
- 11. Date business started under current ownership: _____ Is this a new venture? Yes No
- 12. Has your business had any change to key personnel (Medical Director, Safety/Operations Manager, Human Resource Manager) in the past year? Yes No
If yes, explain: _____

OPERATIONAL INFORMATION:

- 1. Does the hospital lease, hire or rent vehicles that are not listed on the vehicle schedule? Yes No
If yes, please provide the following:
Type of vehicles leased, hired or rented: _____
Cost of hire for these vehicles for the previous 12 months: \$ _____
- 2. Does the hospital operate a Home Health or Hospice program? Yes No
If yes, please provide the following:
Number of Home Health/Hospice Employees that use their own personal auto: _____
Are certificates of insurance required for these employees? Yes No
Annual number of visits: _____
- 3. Are motor vehicle reports (MVRs) checked prior to hiring drivers? Yes No
- 4. What is the established minimum age standard for drivers? _____
- 5. What are the vehicle counts for the following classifications:

Type of Auto	As of Today	Renewal Date 1 year ago
Ambulances		
Patient Transport (non-ambulances)		
Mobile Clinics		
Fleet (all other autos)		
Wheelchair Vans		
Employee Transport Vehicles		
Hospital-Owned Home Health Vehicles		

6. Onboard Monitoring (OBM) black box cameras GPS stickers

a) Brand name of system(s): _____

b) Date the system was installed: _____

c) Number of vehicles currently installed with the system: _____

d) Employee responsible for the management of the OBM:

Name: _____ Phone Number: _____

Email: _____

7. Patient Handling: Wheelchair

a) Name the wheelchair tie-down occupant restraint system (WTORS) you use: _____

b) Provide the product documentation that the WTORS meets SAE J2249 (WTORS) ISO 10542 standards.

c) If you do not use a commercially develop WTORS, please provide a copy of the section of your SOP that outlines the manner in which you use the system to tie down a wheelchair and restrain its user.

d) Please provide the section of your SOP that addresses the transportation of a scooter and its user: _____

VEHICLE MAINTENANCE

1. Is a condition report completed on each transport vehicle and its equipment on each shift? Yes No

If no, please explain: _____

2. Does the maintenance schedule for your fleet meet or exceed the manufacturer's recommendations? Yes No

If no please explain: _____

3. Who performs the maintenance on your fleet? _____

Are they certified by the manufacturer? Yes No

4. Do you keep maintenance repair records on file for each vehicle? Yes No

If no, please explain: _____

5. Do you perform any after-market vehicle modifications? Yes No

If no, please explain: _____

HUMAN RESOURCE

1. Please provide the following information for the person who is responsible for new employee orientation:

Name: _____ Title: _____

Cell Phone: _____ Email: _____

2. Check all that apply to your employee selection process:

Written Application Job Specific Physical Examination Psychological Testing

Criminal Background Check MVR Check Obtain evidence of Pertinent Certification Licensure

Post Employment Drug Screening

3. Is previous ambulance driving experience required on new hires? Yes No

If yes, how many years? _____

4. Please provide the name of the driver training program(s) that you provide or participate in:

EVOC

CEVO

Arrive Alive Do No Harm

Other: _____

of Classroom Hours: _____

of Behind the Wheel Hours: _____

5. How many drivers were added in the past 12 months? _____

How many drivers left or were let go in the past 12 months? _____

SAFETY/RISK MANAGEMENT

1. Is a record kept of each request for service? Yes No
2. Is a trip ticket for billing purposes completed for each transport? Yes No
3. Is a patient care report (PCR) completed for each transport in which medical care, evaluation or observation has been performed? Yes No N/A
4. What % of your trip tickets and call reports are reviewed for completeness, legibility and when applicable, clinical content? _____
How frequently are they reviewed? Daily Weekly Other: _____
Who is responsible for the reviews?
Name: _____ Title: _____
Phone #: _____ Email: _____
5. If operating ambulances:
At what speed may your ambulances operate with the Emergency Warning Systems (EWS) activated? _____
Who determines when the EWS is to be activated? _____
6. Are your vehicles always locked when unattended? Yes No
7. Do you require third party riders (non patient/ non EMS personnel) to sit in the front passenger seat unless the patient's well being requires the rider to be in the back of the vehicle? Yes No
8. Does your service maintain accident files? Yes No If yes, for how long do you keep the files? _____
9. Are safety violations (i.e. auto crashes) part of your progressive discipline process? Yes No
10. Does your service have a Medical Equipment Failure policy? Yes No
If yes, does it address checking, charging and replacing batteries for medical equipment? Yes No
11. Do you have a violent patient restraint policy? Yes No

LIMITS OPTIONS

Automobile Liability Limits (check one):

- \$1,000,000 Combined Single Limit Bodily Injury & Property Damage
 \$2,000,000 Combined Single Limit Bodily Injury & Property Damage

Auto Physical Damage Deductible Options (check one):

- \$500 \$1,000 \$2,000

Inland Marine (mobile ambulance equipment/supplies): Blanket limit: _____

Deductible: \$500 \$1,000

FRAUD WARNINGS

GENERAL FRAUD STATEMENT (not applicable in Colorado, Florida, Hawaii, Massachusetts, Nebraska, Ohio, Oklahoma, Oregon and Vermont) Any person who knowingly and with intent to defraud any insurance company or another 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 subjects the person to criminal and (NY: substantial) civil penalties. In the District of Columbia, Louisiana, Maine, Tennessee and Virginia, and Washington insurance benefits may also be denied.

NOTICE TO COLORADO APPLICANTS: THIS NOTICE IS A PART OF YOUR APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

NOTICE TO HAWAII APPLICANTS: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment or both.

NOTICE TO OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: A person who knowingly and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO OREGON APPLICANTS: Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact, may be violating state law.

NOTICE TO VERMONT APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto, may be committing a crime, subjecting the person to criminal and civil penalties.

THE APPLICANT DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE APPLICANT AGREES THAT IF THE INFORMATION SUPPLIED ON THE APPLICATION BY THE APPLICANT CHANGES BETWEEN THE DATE OF THE APPLICATION AND THE EFFECTIVE DATE OF INSURANCE, APPLICANT WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS AND/OR AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

Applicant's Signature: _____
Producer's Signature: _____
Producer's License Number: _____

Date: _____
Date: _____
Exp Date: _____

Questions? 800 926-6771

SUBMIT

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