Ambulance Renewal Supplemental Questionnaire

ZURICH

Today's Date: _____

BASIC INFORMATION:

1. Named Insured _____

2. DBA: _____

3. Has your business, its owner(s), officers, directors or employees ever been party to any civil, criminal or regulatory proceedings resulting in an administrative sanction or license suspension or revocation? ☐ Yes ☐ No

If Yes, please explain on separate sheet.

4. Has your business had a change of ownership in the past 3 years? ☐ Yes ☐ No

If Yes, please explain: _____

5. Has your business been involved in consolidations of separate entities? ☐ Yes ☐ No

If Yes, please explain: _____

6. Is your service involved in activities or operations other than EMS? ☐ Yes ☐ No

If Yes, please explain: _____

OPERATIONAL INFORMATION:

1. List the major metropolitan area(s) served:

a. _____ **b.** _____

2. The number of ambulance calls in the past 12 months? Emergency _____ Non Emergency _____

The estimated ambulance calls in the next 12 months? Emergency _____ Non Emergency _____

3. The number of paratransit/wheelchair calls in the past 12 months? _____

The estimate of paratransit/wheelchair calls in the next 12 months? _____

4. Does your service perform the following?

☐ Advanced Life Support	☐ Basic Life Support	☐ Capnography or Capnometry
☐ Conscious Sedation	☐ Endotracheal Intubation	☐ IV Therapy or Monitoring
☐ Manual Defibrillation	☐ Mechanical Ventilation	☐ Pulse Oximetry
☐ Telemetry	☐ Thrombolytic Therapy	☐ 12-Lead EKG Monitoring

5. Number of full and part time employees/volunteers that drive or provide patient care:

Paramedics	_____	Critical Care Paramedics	_____
Registered Nurses	_____	Emergency Medical Tech (EMT-B)	_____
Advanced EMT (EMT-A or EMT-I)	_____	Emergency Medical Responder	
Advanced EMT (EMT-A or EMT-I)	_____	(First Responder, EMR)	_____
Non-Emergency Medical Tech	_____	Other	_____

TOTAL _____

6. What are the vehicle counts for the following classifications:

Type of Auto	As of Today	Renewal Date 1 year ago	Renewal Date 2 years ago
Ambulances			
Paratransit/Wheelchair			
First Responder			
Service (all other autos)			
Wheelchair Vans			
Stretcher Vans			
Ambulatory Vehicles			

7. Number of Ambulance by type: Type I _____ Type II _____ Type III _____

8. Onboard Monitoring (OBM) (black box, cameras, GPS, stickers)

a. Brand name of systems(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: _____

9. Mark all your business is involved in and complete the total annual percentage for each operation.

☐ Air Ambulance % ☐ Water Rescue % ☐ Tactical Medic Services %

☐ Aerial Rescue % ☐ Off-shore EMS % ☐ Confined Space Rescue %

Special Events: ☐ Car/Motocross Races ☐ Horse Races ☐ Concerts

☐ High School Sports ☐ Professional Sports ☐ Night Clubs ☐ Rave Events

WORKERS' COMPENSATION

Name of Carrier: _____

Policy #: _____ Eff. Dates: _____ to _____

Employers Liability Limit: $_____

Bodily Injury by Accident: $_____ Each Accident

Bodily Injury by Disease: $_____ Policy Limit

Bodily Injury by Disease: $_____ Each Employee

Does your Workers Compensation policy include volunteers as insured's by endorsement? _____

Any changes in operations not mentioned above? _____