BENCHMARK MANAGEMENT GROUP
SPECIALTY LINES UNDERWRITERS

ALLIED MEDICAL AMBULANCE/NON-EMERGENCY TRANSPORT SUPPLEMENTAL APPLICATION

SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION

GENERAL INFORMATION:

1. Number of volunteer members:_____ Number of Paid members:_____
   Population of area served:_____ Radius of operation (mi.):_____
2. Is your service involved in: Air Ambulance Operations ☐ No ☐ Yes
   Water Rescue Operations ☐ No ☐ Yes
   Off-shore EMS ☐ No ☐ Yes
   Activities or Operations other than EMS ☐ No ☐ Yes
   Special Event EMS ☐ No ☐ Yes

   If "Yes," to any of the above, provide details:_____

_____

Number of:		*Number of hours of annual training for each:*
EMTS – A		
EMTS – P		
Nurses		
Other		

Number of:		**Number of:**	
EMTS		Non-emergency Calls	
Paramedics		Ambulances	
Emergency Calls		Vans	
		Air Ambulance	

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

4. Any physician, nurse practitioner or CRNA exposure? ☐ No ☐ Yes
   Please provide number_____ and explain duties:_____

5. Do you contract your services to others on an independent contractor basis? ☐ No ☐ Yes

6. If "Yes," please advise to whom you contract your work:_____

7. Name of your Auto Liability Insurance Carrier for the upcoming policy year?_____

_____

a. Does your Auto Liability policy specifically exclude claims arising from loading and unloading of patients? ☐ No ☐ Yes
b. Does your Auto Liability policy remain silent on the applicability of coverage for claims arising from loading and unloading of patients? ☐ No ☐ Yes
c. If "No," please explain:_____

_____

* 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, may be committing a fraudulent insurance act, and may be subject to a civil penalty or fine.
* not applicable in all states

DECLARATION AND SIGNATURE:

The undersigned declares that to the best of his/her knowledge the statements in this application and its attachments are true. The company is hereby authorized to make any investigation and inquiry deemed necessary in regard to this application.

_____	_____
Applicant's Signature	Sub-Producer
_____	_____
Title/Date	Producer

SIGNING THIS FORM DOES NOT BIND THE APPLICANT OR THE COMPANY OR THE UNDERWRITING MANAGER TO COMPANY THE INSURANCE. Application MUST be currently signed, completed and dated to be considered for quotation.