

**MEDICAL TRANSPORTATION PROGRAM
PROFESSIONAL LIABILITY APPLICATION
(CLAIMS-MADE FORM)**

NOTE: COMPLETION AND SUBMISSION OF THIS APPLICATION IS FOR THE PURPOSE OF SECURING A PREMIUM QUOTATION ONLY. NO COVERAGE WILL BE EFFECTED UNTIL RECEIPT OF WRITTEN INSTRUCTION AND PREMIUM PAYMENT. ANY SUBSEQUENT CONTRACT ISSUED WILL BE IN FULL RELIANCE UPON THE STATEMENTS AND REPRESENTATIONS MADE IN THIS APPLICATION (AND ATTACHMENTS HERETO) AND THIS APPLICATION WILL BE MADE A PART OF THE POLICY.

IF A POLICY IS ISSUED, IT WILL BE ON A CLAIMS-MADE BASIS. THE LIMITS OF LIABILITY AVAILABLE TO PAY JUDGMENTS OR SETTLEMENTS SHALL BE REDUCED BY AMOUNTS INCURRED FOR DEFENSE EXPENSES. AMOUNTS INCURRED FOR LEGAL DEFENSE SHALL BE APPLIED AGAINST THE APPLICABLE DEDUCTIBLE AMOUNT.

All Questions must be fully completed. If there is insufficient space to complete an answer, continue on a separate sheet of the Applicant's letterhead. If a Question is not applicable, state "N.A."..

SECTION I – GENERAL INFORMATION:

1. Full Name of Applicant (include ALL Firm names, trade names or dba's under which the Applicant operates, including subsidiaries):

2. Address of Principal Office:

3. Internet Address: _____

4. List all states in which Applicant operates:

5. Does the Applicant have any other office locations? YES NO
If YES, list complete addresses on a separate sheet.

6. Applicant is a: Individual LLC Corporation For profit Non-profit
 Partnership Joint Venture Other (specify): _____

Date Established: _____ (mm/dd/yy)

7. Has the name of the Applicant ever changed or has there been any acquisition, consolidation, dissolution, merger or any other change in business organization during the past five (5) years? YES NO
If YES, provide full particulars on a separate sheet, including all Firm names, in chronological order. Additionally, provide claims information (as per SECTION III) for all prior Firms.

8. During the coming twelve (12) months, does the Applicant contemplate offering any services not currently offered, or any mergers or acquisitions? YES NO
If YES, please explain: _____

9. Professional Activities and Specialties:

- Para Transit Operation** # trips annually: _____
Non-Medical stretcher and wheelchair van transportation services, patients do not require medical supervision during ground transit.
- Non- Emergency Transportation** # trips annually: _____
The transportation of patients who require medical supervision during ground transit.
- Emergency Transportation** # trips annually: _____
The insured is under 911 dispatch.
- Medical/Testing Laboratory** # tests annually: _____
- Out-Patient Medical Clinic** #outpatient visits annually: _____
- Out Patient Mental Health Clinic** #outpatient visits annually: _____
- Residential Healthcare Facility** #Beds: _____
- Residential Mental Health Facility** #Beds: _____
- other:** _____

10. State approximate % of gross income derived from the following (total should be 100%) :

- | | |
|--|--|
| _____ % Inpatient Detox | _____ % Physical/Occupational/Speech Therapy |
| _____ % Mental Health Counseling/Evaluations | _____ % Mental Health Group Home |
| _____ % Hospice | _____ % Blood/Urine Testing (Drug/Alcohol) |
| _____ % Supervised Living | _____ % Transportation Services |
| _____ % Training | _____ % Pre-Employment Testing |
| _____ % other: _____ | |

11. Does Applicant own (wholly or in part), operate, or administer any hospital, nursing home, assisted living facility or other institution where medical services are customarily rendered? [] Yes [] No
If Yes, please provide details by separate attachment.

12. State sources and amounts of TOTAL GROSS REVENUE:

SOURCE	<u>Present Year</u>	<u>Previous Year</u>
Charitable Contributions:	\$ _____	\$ _____
Government Funding:	\$ _____	\$ _____
Fee for Service:	\$ _____	\$ _____
_____	\$ _____	\$ _____
TOTAL GROSS REVENUE:	\$ _____	\$ _____

Estimate of Total Gross Revenue for next Year: \$ _____

13. Staff:		<i>Independent</i>
	<u>Employees</u>	<u>Contractors</u>
Principals, Partners, Officers, Directors:	_____	_____
Registered Nurse:	_____	_____
LPN:	_____	_____
Home Health Aide:	_____	_____
Speech Therapist:	_____	_____
Physical Therapist:	_____	_____
Psychotherapist/Psychologist:	_____	_____
Social Worker:	_____	_____
Physicians Assistant:	_____	_____
Paramedic:	_____	_____
Emergency Medical Technicians (EMT):	_____	_____
Drivers Not Medically Certified:	_____	_____
Clerical/Administrative:	_____	_____
Other (specify): _____		
TOTAL STAFF:	_____	_____

14. a) Are all above individuals licensed in accordance with all applicable state and federal regulations?
 Yes No If No, please attach explanation.
- b) Do you required any of the above individuals to maintain their own professional liability coverage?
 Yes No If Yes please list individuals and required limits:

If No, is coverage requested for above individuals? Yes No

15. Please attach explanation for any of the questions below answered "YES":

Has the applicant or have any of the above employees ever:

- a) Been the subject of disciplinary or investigative proceedings or reprimanded by a governmental or administrative agency, hospital or professional association? Yes No
- b) Been convicted for an act committed in violation of any law or ordinance other than a traffic offense? Yes No
- c) Had any state professional license or license to prescribe or dispense narcotics, refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? Yes No
- d) Been treated for alcoholism or drug addiction? Yes No

16. Does applicant have a location where additional services or business exposures exist?
 Yes No If Yes, please attach detailed explanation.
Applicant has no additional services or business exposures that have not been disclosed on this application.

17. Does the applicant perform hospital emergency room care:
- for its own regular patients? Yes No
- for patients not its own? Yes No
- if answer to b) is Yes, please specify the percent of time devoted to this work? _____% and the number of hours devoted to this work _____ hrs.

18. Does the applicant prescribe drugs? Yes No
Please list drugs prescribed on a separate attachment.
19. Does the applicant administer drugs incase of emergency? Yes No
Please list drugs prescribed on a separate attachment.
20. Do applicant or others administer anesthesia (other than topical or by means of local infiltration)?
 Yes No If Yes, please attach detailed explanation.
21. Does applicant maintain any beds for overnight occupancy? Yes No
If Yes, please include # beds licensed and type of care provided on separate attachment.
22. Does applicant have a formal safety-driving program established? Yes No
If Yes, please include a copy of the driver standards and hiring practices.
23. Are all drivers certified and licensed in First Aid and CPR (Cardio Pulmonary Resuscitation)? Yes No
What is the minimum medical licensed experience requirement for employees: _____
24. Does the applicant have a training program for EMT's or Drivers? Yes No
25. Do you sell products? If so, what kind, please include brochures. If so, do any of them require a physician's prescription?
- _____
- _____

SECTION II - Current Insurance

26. Provide a copy of the insured's current General Liability Declarations page showing the limits and coverage terms. Is coverage occurrence? Yes No Retroactive Date: _____
27. Professional Liability: (provide coverage for last 5 years), also provide a copy of the insured's current Professional Liability Declarations page showing the limits and coverage terms.

Carrier	Limit	Deductible	Premium	Expiration Date
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If expiring coverage is claims made please provide Retroactive Date: _____

SECTION III - Claims History

28. Has any application for Professional Liability Insurance made on behalf of the applicant or any predecessor in business or present Partner, Officer of Principal ever been declined or has the insurance been cancelled or renewal refused? Yes No If Yes, please provide details by attachment.

29. Has any claim ever been made against the applicant or any of its employees? Yes No
If Yes, please complete the Supplemental Claims Application for each situation and include currently values loss runs for last 5 years.
30. Is the applicant aware of any circumstance, which may result in any claim against the applicant, or any predecessor in business or present Partner, Officer or Principal? Yes No If Yes, please provide details by separate attachment.

The applicant declares that the above statements and representations are true and correct and that no facts have been suppressed or misstated. The completion of this application does not bind the Company to sell nor the applicant to purchase this insurance, but any subsequent contract issued will be in full reliance upon the statements and representations made in this application and this application will be made a part of the policy.

The applicant understands that any subsequent contract issued by the Company will be issued on a CLAIMS MADE FORM.

Signature of Applicant (Principal, Partner or Officer) _____

Title: _____ Date: _____

Submission Checklist (please include the following with your submission):

- Accord 125 & 127 Business Automobile Section
- Prior (3 to 5) Years Loss History for Professional Liability
- Prior (3 to 5) Years Loss History for General Liability
- Prior (3 to 5) Years Loss History for Commercial Automobile Liability
- Current General Liability Declarations Page
- Current Professional Liability Declarations Page



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Medical Ground Transportation Program

Professional Liability

Supplemental Claims Application

Please complete this form in its entirety for all prior and pending E&O claims.

1. Name of claimant: _____
2. Date claim occurred: _____
3. Date claim reported to E&O Carrier: _____
4. Name(s) of employees involved in claim: _____

5. Alleged act resulting in claim: _____
6. Description of loss: _____
7. What is the status of the claim? _____
8. Defense costs paid to date: _____
9. Settlement amount or offer for settlement: _____
10. If claim is still open, what is the reserve amount? _____
11. What remedial measures have been taken to prevent a recurrence of a similar claim?

Signature: _____ Date _____
(Principal, Partner or Officer of the Firm)

The information on this supplemental application is material to the Company underwriting this risk and shall be deemed attached a part of this Policy as if physically attached hereto.