TDC SPECIALTY UNDERWRITERS
The Doctors Company Group

TDC Specialty Insurance Company
TDC National Assurance Company
(Stock companies owned by The Doctors Company)
(hereafter, the "Underwriter")
Servicing Address: 29 Mill Street
Unionville, CT 06085

MEDICAL FACILITIES AMBULANCE/EMT TRANSPORT SUPPLEMENTAL APPLICATION

THIS SUPPLEMENT IS PART OF THE APPLICATION, INCLUDING A RENEWAL APPLICATION, SUBMITTED BY OR ON BEHALF OF THE APPLICANT FOR THE PROPOSED INSURANCE. THE NOTICES, CONDITIONS, REPRESENTATIONS AND AUTHORIZATIONS CONTAINED IN SUCH APPLICATION ARE INCORPORATED INTO AND APPLY TO THIS SUPPLEMENT.

1. Applicant Name (as identified in the Liability Insurance Application for proposed insurance):	

OPERATIONS

2. Please list:
   a. All states where Applicant is licensed to practice:

   b. All Counties you provide services:

3. Please provide:
   a. The maximum number of miles for any one trip _____
   b. The average radius of operations _____

4. Please indicate the number of:

EMT:	Basic/EMT:	Intermediate / Paramedics:
_____	_____	_____
Non-Medical Drivers:	**Other(describe):**	
_____	_____	

5. **Ground Services:**

	Actual past 12 months	Projected 12 Months
Emergency Transports		
Non-Emergency Transports		
Paratransit/Wheelchair Transports		
Stand-by/Special Events		

Describe the type of special events, e.g. high school football games, fairs, fun runs, etc:

Air Services

6. Do you provide any air services? ☐Yes ☐No

If "Yes," to the above, please provide:

	Actual past 12 months	Projected 12 Months
Number of Aircraft		
Number of Emergency Air Transports		
Number of Non-Emergency Air Transports		

   a. the type of Aircraft: _____
   b. the owner of the Aircraft: _____
   c. the Aviation/Aircraft liability Carrier: _____

7.	Please indicate the number of:	Ambulances: _____	Ambulettes: _____	Wheelchair Vans: _____
		Non Wheelchair Vans: _____	Other (describe): _____	
8.	Please indicate the name of the Applicant's auto carrier for the upcoming year:			
9.	Does the auto carrier provide liability coverage for claims arising out of loading and unloading patients?			☐Yes ☐No
10.	Are motor vehicle records checked and reviewd for all drivers at time of hiring?			☐Yes ☐No
11.	Are motor vehicle records checked and reviewd for all drivers on an annual basis?			☐Yes ☐No
12.	Does the Applicant offer EMT/Paramedic/First Aid training courses or certifications? If "Yes," please provide the number of students annually? _____ Please describe the courses/certifications:			☐Yes ☐No
13.	Does the Applicant have any accreditations - Joint Commission, Commission on Accreditation of Medical Transport Systems, other? If "Yes," please describe:			☐Yes ☐No

SIGNATURE AND AUTHORIZATION

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, represents that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Supplement are true and complete.

The notices, conditions, representations and authorizations contained in the Application submitted by or on behalf of the Applicant for the proposed insurance, are incorporated into and apply to this Supplement.

Applicant Name	
By (Authorized Signature)	
Name/Title	
Date	