TDC Specialty Underwriters
TDCGROUP

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 where you provide services:

3. Please check the type of services you provide (check all that apply):

- ☐ GroundAmbulance
- ☐ Non-Emergency
- ☐ Taxi/Limo/General Transportation
- ☐ OTHER: _____
- ☐ Alarm Monitoring
- ☐ Dispatch Service for Others
- ☐ Air Transport

4. **Ground Services:**

	Actual past 12 months	Projected 12 Months
Emergency Ground Transports		
Non-Emergency Ground Transports		
*Emergency Air Transports		
*Non-Emergency Air Transports		
Paratransit/Wheelchair Transports		
School Transports		
**Stand-by / *Special Events		
Other: _____		

*If providing any Air Transport services, please provide:
   a. Number and type of aircraft :

   b. Name of Aviation/Aircraft Liability Carrier& limit of insurance carried on the aircraft policy (please provide a copy of the current Aircraft Dec page)

**If providing any stand-by or special event services:

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

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

6. Who dispatches calls for the Applicant?

7. If dispatch is provided in-house, check the functions performed by internal dispatchers:
   ☐ Dispatch non-emergency requests for your service
   ☐ Schedule wheelchair/paratransit transfers
   ☐ Schedule routine ambulance transfers
   ☐ Dispatch emergency requests for your service

8. Are all dispatchers Emergency Medical Dispatch (EMD) Certified? ☐Yes ☐No

9. Do you transport vent/trach dependent pediatric patients? ☐Yes ☐No
   If 'Yes' how many transports annually? _____

10. Do you provide prisoner transport services that are unrelated to 911 dispatch? ☐Yes ☐No
    If 'Yes', please provide percentage of correctional transports and list of correctional facilities you contract with. _____

11. Please indicate the number of:

EMT - Advanced:	EMT – Basic:	Intermediate / Paramedics:
_____	_____	_____
Non-Medical Drivers:	**Other(describe):**	*Physicians:_____
_____	_____	*[☐] Providing Patient care
		*[☐] No Direct Patient care

12. Please indicate the number of:

Ambulances:	Ambulettes:	Wheelchair Vans:
_____	_____	_____
Non Wheelchair Vans:	**Other (describe):**	
_____	_____	

13. Indicate Name and Limit of Insurance carried for Applicants Auto carrier or provide copy of current Auto Dec Page

14. How does your Auto policy address liability coverage for claims arising out of loading and unloading patients?
    ☐ Covered in full ☐ Excluded ☐ Covered with a Sublimit (list the sublimit) _____
    ☐ Other (describe):_____

15. Are motor vehicle records checked and reviewed for all drivers at time of hiring? ☐Yes ☐No
    If "No," please explain:

16. Are motor vehicle records checked and reviewed for all drivers on an annual basis? ☐Yes ☐No
    If "No," please explain:

17. Does Applicant have written driver protocols in place? ☐Yes ☐No
    If "No," please explain:

18. Please identify driver training you require for all drivers:

☐ General driver orientation	☐ Defensive Driving	☐ Emergency vehicle evacuation
☐ Primary first aid	☐ Advanced First Aid	☐ Passenger Assistance
☐ CPR		☐ Non-Medical Emergency

	☐ Proper wheelchair/stretcher Securement procedures ☐ Offer continuing education	
19.	Do you require a consent form to be signed in the event a transport is refused? If "No," please explain:	☐Yes ☐No
20.	Are all wheelchair vehicles designed with "4-point tie-down" and "forward facing" features? If "No," please explain:	☐Yes ☐No
21.	Are wheelchair passengers ever transported without the use of a restraint system? If "Yes," please explain:	☐Yes ☐No
22.	Does the Applicant offer EMT/Paramedic/First Aid training courses or certifications? If "Yes," a. Please provide the number of students annually? _____ b. Do you have written protocols and procedures in place for students to be always supervised? c. Please describe the courses/certifications:	☐Yes ☐No ☐Yes ☐No
23.	Is the Applicant currently accredited? If "Yes," please lis the name of the accrediting organization(s):	☐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	