Hospital Fleet Complete Application
P.O. Box 440549, Kennesaw, GA 30160
Telephone: (678) 290-2100 Fax: (678) 290-2200
Email applications to: mscsubmissions@markelcorp.com
Website: markelinsurance.com

Markel Agent Number:_____ Agent Address: _____
Agent Name: _____ City:_____
Phone No:_____Fax No:_ State:_____Zip Code: _____
Submission #: _____

(Must be attached to Acord Application)

Today's Date:_____

BASIC INFORMATION:

1. Named Insured:_____2. DBA: _____
3. Mailing Address:_____
4. Physical Address: _____
5. Phone:_____ 6. Fax:_____
7. Website Address: _____
8. Safety Manager's Name, Cellphone Number & Email Address: _____
9. EMS Manager's Name, Cellphone Number & Email Address: _____
10. FEIN Number:_____
11. Date business started under current ownership:_____Is this a new venture? ☐ Yes ☐ No
12. Has your business had any change to key personnel (Medical Director, Safety/Operations Manager, Human Resource Manager) in the past year? ☐Yes ☐No
If yes, explain:_____

OPERATIONAL INFORMATION:

1. Does the hospital lease, hire or rent vehicles that are not listed on the vehicle schedule? ☐Yes ☐No
   If yes, please provide the following:
   Type of vehicles leased, hired or rented:_____
   Cost of hire for these vehicles for the previous 12 months: $ _____

2. Does the hospital operate a Home Health or Hospice program? ☐Yes ☐No
   If yes, please provide the following:
   Number of Home Health/Hospice Employees that use their own personal auto:_____
   Are certificates of insurance required for these employees? ☐Yes ☐No
   Annual number of visits: _____

3. Are motor vehicle reports (MVRs) checked prior to hiring drivers? ☐Yes ☐No

4. What is the established minimum age standard for drivers? _____

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

Type of Auto	As of Today	Renewal Date 1 year ago
Ambulances		
Patient Transport (non-ambulances)		
Mobile Clinics		
Fleet (all other autos)		
Wheelchair Vans		
Employee Transport Vehicles		
Hospital-Owned Home Health Vehicles		

6. Onboard Monitoring (OBM) ☐ black box ☐cameras ☐GPS ☐stickers
   a) Brand name of system(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:_____Phone Number:_____
   Email:_____

7. Patient Handling: Wheelchair
   a) Name the wheelchair tie-down occupant restraint system (WTORS) you use:_____
   b) Provide the product documentation that the WTORS meets SAE J2249 (WTORS) ISO 10542 standards.
   c) If you do not use a commercially develop WTORS, please provide a copy of the section of your SOP that outlines the manner in which you use the system to tie down a wheelchair and restrain its user.
   d) Please provide the section of your SOP that addresses the transportation of a scooter and its user:_____

VEHICLE MAINTENANCE

1. Is a condition report completed on each transport vehicle and its equipment on each shift? ☐ Yes ☐No
   If no, please explain: _____

2. Does the maintenance schedule for your fleet meet or exceed the manufacturer's recommendations? ☐Yes ☐ No
   If no please explain:_____

3. Who performs the maintenance on your fleet? _____
   Are they certified by the manufacturer? ☐Yes ☐ No

4. Do you keep maintenance repair records on file for each vehicle? ☐ Yes ☐ No
   If no, please explain: _____

5. Do you perform any after-market vehicle modifications? ☐ Yes ☐ No
   If no, please explain:_____

HUMAN RESOURCE

1. Please provide the following information for the person who is responsible for new employee orientation:
   Name:_____Title:_____
   Cell Phone:_____Email:_____

2. Check all that apply to your employee selection process:
   ☐ Written Application ☐ Job Specific Physical Examination ☐ Psychological Testing
   ☐ Criminal Background Check ☐ MVR Check ☐ Obtain evidence of Pertinent Certification Licensure
   ☐ Post Employment Drug Screening

3. Is previous ambulance driving experience required on new hires? ☐ Yes ☐ No
   If yes, how many years? _____

4. Please provide the name of the driver training program(s) that you provide or participate in:
   ☐ EVOC ☐CEVO ☐Arrive Alive Do No Harm ☐Other: _____
   # of Classroom Hours:_____ # of Behind the Wheel Hours:_____

5. How many drivers were added in the past 12 months? _____
   How many drivers left or were let go in the past 12 months?_____

SAFETY/RISK MANAGEMENT

1. Is a record kept of each request for service? ☐ Yes ☐ No

2. Is a trip ticket for billing purposes completed for each transport? ☐ Yes ☐ No

3. Is a patient care report (PCR) completed for each transport in which medical care, evaluation or observation has been performed? ☐ Yes ☐ No ☐ N/A

4. What % of your trip tickets and call reports are reviewed for completeness, legibility and when applicable, clinical content? _____
   How frequently are they reviewed? ☐Daily ☐Weekly ☐ Other:_____
   Who is responsible for the reviews?
   Name:_____Title: _____
   Phone #:_____ Email: _____

5. If operating ambulances:
   At what speed may your ambulances operate with the Emergency Warning Systems (EWS) activated?_____
   Who determines when the EWS is to be activated?_____

6. Are your vehicles always locked when unattended? ☐Yes ☐ No

7. Do you require third party riders (non patient/ non EMS personnel) to sit in the front passenger seat unless the patient's well being requires the rider to be in the back of the vehicle? ☐Yes ☐ No

8. Does your service maintain accident files? ☐ Yes ☐No If yes, for how long do your keep the files? _____

9. Are safety violations (i.e. auto crashes) part of your progressive discipline process? ☐ Yes☐ No

10. Does your service have a Medical Equipment Failure policy? ☐ Yes ☐ No
    If yes, does it address checking, charging and replacing batteries for medical equipment? ☐Yes ☐ No

11. Do you have a violent patient restraint policy? ☐Yes ☐No

LIMITS OPTIONS

Automobile Liability Limits (check one):
☐$1,000,000 Combined Single Limit Bodily Injury & Property Damage
☐$2,000,000 Combined Single Limit Bodily Injury & Property Damage

Auto Physical Damage Deductible Options (check one):
☐$500 ☐$1,000 ☐$2,000

Inland Marine (mobile ambulance equipment/supplies): Blanket limit: _____
Deductible: ☐$500 ☐$1,000

FRAUD WARNINGS

GENERAL FRAUD STATEMENT (not applicable in Colorado, Florida, Hawaii, Massachusetts, Nebraska, Ohio, Oklahoma, Oregon and Vermont) Any person who knowingly and with intent to defraud any insurance company or another 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, commits a fraudulent insurance act, which is a crime and subjects the person to criminal and (NY: substantial) civil penalties. In the District of Columbia, Louisiana, Maine, Tennessee and Virginia, and Washington insurance benefits may also be denied.

NOTICE TO COLORADO APPLICANTS: THIS NOTICE IS A PART OF YOUR APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

NOTICE TO HAWAII APPLICANTS: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment or both.

NOTICE TO OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: A person who knowingly and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO OREGON APPLICANTS: Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact, may be violating state law.

NOTICE TO VERMONT APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto, may be committing a crime, subjecting the person to criminal and civil penalties.

THE APPLICANT DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE APPLICANT AGREES THAT IF THE INFORMATION SUPPLIED ON THE APPLICATION BY THE APPLICANT CHANGES BETWEEN THE DATE OF THE APPLICATION AND THE EFFECTIVE DATE OF INSURANCE, APPLICANT WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS AND/OR AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

Applicant's Signature: _____ Date: _____
Producer's Signature: _____ Date: _____
(Only applicable if using a producer)
Producer's License Number: _____ Exp Date: _____

How did you hear about Markel: ☐Magazine Ad ☐Referral ☐Convention/Conference ☐Web Site ☐Other
Describe: _____

Thank you for choosing Markel!

Submit

TH APP HFC 08 14