Return Application to:
Rockwood Programs, Inc
3001 Philadelphia Pike
Claymont, DE 19703
Tel:800-365-0816
Fax: 302-764-9125
medmal@rockwoodinsurance.com

NON-EMERGENCY MEDICAL TRANSPORT APPLICATION

FOR INDICATION ONLY – FULL APPLICATION WILL BE REQUIRED FOR FORMAL TERMS

BACKGROUND INFORMATION – PLEASE READ:

1. Please type or print clearly.
2. Answer ALL questions completely leaving no blanks. If any questions, or part thereof, do not apply, print N/A in the space.
3. If additional space is needed to answer any questions fully, please attach a separate page.

Requested Attachments:

1. Loss History for the last FIVE years
2. Copy of expiring declarations page if retroactive coverage is being requested

I. APPLICANT INFORMATION

a) Name of Applicant/Entity(s) _____

b) Date of Incorporation/Start of Operations: _____

c) Physical Address (City, State, Zip Code) _____

d) Is your service involved in any emergency transport operations, air ambulance operations, water rescue operations, off-shore EMS, or special event EMS?

☐ Yes ☐ No If "Yes", please explain: _____

II. COVERAGE HISTORY

i) Does your Auto Liability policy specifically exclude claims arising from loading and unloading patients?
☐ Yes ☐ No

ii) Does your Auto Liability policy remain silent on the applicability of coverage for claims arising from loading and unloading of patients? ☐ Yes ☐ No

iii) Date organization was established: _____

iv) Has the organization had prior insurance coverage? _____

a. If so, what is the retroactive date: _____

III. PROFESSIONAL SERVICE

a) Please provide a full description of services rendered: _____

	Full Time	Part Time	Projected Next Year	Current Year	Last Year
Non-emergency transports					
Wheelchair transports					
Other (please describe below):					
EMTS-A					
EMTS-B					
Paramedics					
Drivers					
Other (please describe):					

IV. INSURED HISTORY, CLAIMS, LOSSES AND INCIDENTS

a) Has any claim or suit for an error, omission or malpractice ever been made against you or your organization or any employees/staff working on your behalf?

☐ Yes ☐ No If yes, how many? _____ Complete a Supplemental Claim form for each.

b) Are you or any proposed insured for this insurance aware of any claim or suit, or any act, error, omission, fact, circumstance, or records request from any attorney which may result in a malpractice, general liability or products liability claim or suit? If yes, has each of these been reported to the current or any prior insurer?

☐ Yes ☐ No If yes, how many? _____ Complete a Supplemental Claim form for each.

c) Has the applicant or any staff:

1) Ever been the subject of disciplinary/investigative proceedings or reprimand by a governmental/administrative agency, hospital or professional association?

☐ Yes ☐ No

2) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?

☐ Yes ☐ No

3) Ever been treated for alcoholism or drug addiction?

☐ Yes ☐ No

Signed: _____

Date: _____

Print Name: _____

Title: _____
(Owner, Partner, Authorized Officer)