



Hospital Fleet Complete

**Hospital Fleet Complete Auto Application
(Must be attached to Acord Application)**

PO Box 440549 Kennesaw, GA 30160
Phone: (678) 290-2100
www.thomcoins.com

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: _____

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)		

AMBULANCE INFORMATION:

If the hospital operates ambulances, please answer the following:

- 1. The number of ambulance calls in the past 12 months:
Emergency _____ Non Emergency _____
- 2. At what speed may your ambulances operate with the Emergency Warning Systems activated? _____
- 3. 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: _____

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: _____
(Only applicable if using a producer)

Date: _____

Producer's License Number: _____

Exp Date: _____