183 Leader Heights Road
P.O. Box 2726, York, PA 17405
800.233.1957 | Fax: 717.747.7022
glatfeltercommercialambulance.com

Return completed application to:
submissions@glatfeltercommercialambulance.com

APPLICATION
GLATFELTER COMMERCIAL AMBULANCE

GENERAL INFORMATION

Date of Application: _____ Date Proposal Needed By: _____

Current Carrier and Agency: _____ Expiration Date: _____

Type of Organization: ☐ Individual ☐ Partnership ☐ Corporation ☐ Joint Venture
☐ Other (Describe: _____)

Legal Name of Organization: _____
(List all legal entities to be included as a Named Insured.)

_____

Federal Employer Identification Number (FEIN): _____

Organization's Mailing Address: _____
Street or PO Box

_____
City County State Zip Code

Organization's fax number: (____) _____ Organization's website: _____

Contact person's name: _____ Title: _____

Day phone: (____) _____ Evening phone: (____) _____ E-mail address: _____

Is this individual (check all that apply): ☐ the contact for inspection purposes?
If not, contact: _____ Phone: _____
☐ the contact for education and training purposes?
If not, contact: _____ Phone:_____
☐ the head of the organization?

Is the company a private for-profit ambulance service? ☐ Yes ☐ No
If no, please describe: _____

Is the company hospital owned? ☐ Yes ☐ No
In business for how long? _____ How long has the current ownership been in place? _____

Describe any name changes or acquisitions made in the last three years, or anticipated in the coming year:_____

_____

REAL & PERSONAL PROPERTY ☐ Yes ☐ No

Current Premium: _____

Coverage type desired: ☐ Scheduled Building ☐ Scheduled Contents ☐ Blanket Contents

Deductible desired: ☐ $500 (Standard) ☐ $1,000 ☐ $2,500 ☐ $5,000

Premises #	Item #	Building Occupied As:	Owner or Tenant?	Total Area of Building (including all floors)	Street Address City, State, Zip Code

Premises #	Item #	Amount of Insurance		Protection Class	Construction Code *	Sprinkler System Y / N	Mortgagee Name and Address
		Building	Contents ($5,000 minimum)				

* Construction codes:
1 – frame
2 – joisted masonry
3 – noncombustible
4 – masonry noncombustible
5 – modified fire resistive
6 – fire resistive
7 – heavy timber joisted masonry
8 – superior noncombustible
9 – superior masonry noncombustible

Premises #	Item #	Year Built	Age of electrical system if more than 35 years old	If more than one entity is insured, to which one is this property assigned?	Occupied 24 hours per day? Y / N	Are there any structures at this premises that you don't want to insure? If so, describe them below and make sure their values are not included in the "amount of insurance" requested above.

Premises #	Item #	# of Floors	Date of Last Inspection	Year of Mechanical System Updates	Year of Roof Updates	Roof Covering	Roof Geometry	Roof Anchors

Roof Covering:
(0 = Unknown)

1 – Metal sheathing with exposed fasteners

2 - Metal sheathing with CONCEALED fasteners

3 - Built-up roof or single-ply membrane WITH gutters

4 – Built up roof or single-ply membrane WITHOUT gutters

5 - Concrete/clay tiles

6 - Wood shakes

7 - Shingle - 55 mph wind rating

8 - Shingle - 55 mph wind rating/ Secondary Water Resistance (SWR)

9 - Shingle - 110 mph wind rating

10 - Shingle - 110 mph wind rating/ Secondary Water Resistance (SWR)

Roof Geometry:
(0 = Unknown)

1 – Flat roof WITH parapets

2 - Flat roof WITHOUT parapets

3 - Hip roof with slope <= 6:12 (26.5º)

4 – Hip roof with slope > 6:12 (26.5º)

5 - Gable roof with slope <= 6:12 (26.5º)

6 - Gable roof with slope > 6:12 (26.5º)

7 - Braced gable roof with slope <= 6:12 (26.5º)

8 - Braced gable rood with slope > 6:12 (26.5º)

Roof Anchors:
(0 = Unknown)

1 – Toe Nailing/No Anchorage

2 - Clips

3 – Single Wraps

4 - Double Wraps

5 - Structural

GENERAL LIABILITY / PROFESSIONAL HEALTH CARE LIABILITY ☐ Yes ☐ No

Current General Liability Carrier: _____ ☐ Occurrence ☐ Claims-Made Retroactive Date: _____

Professional Healthcare Liability ☐ Occurrence ☐ Claims-Made Retroactive Date: _____

Current Premium: $ _____

Limits Desired: ☐ $500,000 occ. / $1,000,000 agg. ☐ Occurrence ☐ Claims-made Retroactive Date: _____

☐ $1,000,000 occ. / $2,000,000 agg . ☐ Occurrence ☐ Claims-made Retroactive Date: _____

☐ $1,000,000 occ. / $3,000,000 agg. ☐ Occurrence ☐ Claims-made Retroactive Date: _____

Annual Revenue: This Year _____ Last Year _____

% from Medicaid /Medicare _____
% from Insurance Companies _____
% from Private Pay _____
% from Contract _____

What is your primary service area? County(s)_____

Does your organization service any major metropolitan areas? ☐ Yes ☐ No

If yes, please describe: _____

Do you operate in other states? ☐ Yes ☐ No

If so, what state(s): _____

Do you own any aircraft or watercraft in excess of 100 hp? ☐ Yes ☐ No

If yes, please describe: _____

Do you perform any aircraft or watercraft transportation? ☐ Yes ☐ No

If yes, please describe: _____

Are any medical clinical services offered? ☐ Yes ☐ No

If yes, please describe: _____

Do you operate a call/ dispatch center/ PSAP or secondary PSAP? ☐ Yes ☐ No

If yes, please describe: _____

Is there a written procedure for identification and handling of “true emergency” requests for service? ☐ Yes ☐ No

Are event standby services offered? ☐ Yes ☐ No

If yes, please describe: _____

Identify any medical facilities for which you have an exclusive transport service contract: _____

_____

TOTAL number of calls per year: _____

Medical Calls:

Emergency Medical Ambulance Calls (was dispatched as an emergency): _____

Non-Emergency Medical Ambulance Calls (was not dispatched as an emergency): _____

Non-Medical / Paratransit Calls:

Wheelchair Calls (wheelchair transportation): _____

Other Transportation Services Calls (buses, fly cars or unmodified vans): _____

Services Other Than Transport Calls (social services; community paramedicine): _____

CALL HISTORY / HISTORICAL COUNT

	1st Prior Year	2nd Prior Year	3rd Prior Year	4th Prior Year	5th Prior Year
Medical Calls					
Emergency Medical Ambulance Calls					
Non-Emergency Medical Ambulance Calls					
Non-Medical / Paratransit Calls					
Wheelchair Calls					
Other Transportation Services Calls					
Services Other Than Transport Calls					
Total Calls					

Describe the highest level of EMS service provided:

- ☐ Advanced Life Support
- ☐ Basic Life Support
- ☐ Intermediate Life Support
- ☐ No EMS

Indicate the highest level of medical training of the insured's personnel accounting for all employees that have medical duties (including your medical director) in the table below.

	Full-Time Employee	Part-Time Employee
Basic CPR	_____ #	_____ #
First Responder	_____ #	_____ #
EMT (Basic)	_____ #	_____ #
EMT (Intermediate/Advanced)	_____ #	_____ #
Paramedic	_____ #	_____ #
Nurse (LPN or RN)	_____ #	_____ #
Physician, Surgeon, Osteopath	_____ #	_____ #
Other, please describe:	_____ #	_____ #

Indicate the procedures used in the employee selection process:

- ☐ Written Application
- ☐ Physical Examination
- ☐ Written Test
- ☐ Road Test
- ☐ Pre-employment drug testing
- ☐ Criminal Background check
- ☐ Reference checks
- ☐ MVR check
- ☐ Other (describe: _____)

Do you utilize a Medical Director? ☐ Yes ☐ No

If yes, provide the following: Name: _____ Phone Number: _____

☐ Employee or ☐ Contracted Service
☐ Full-Time or ☐ Part-Time

If Medical Director is a Physician, Surgeon or Osteopath do they carry their own professional liability insurance? ☐ Yes ☐ No

If yes, please indicate insurance carrier and policy limits: _____
(A certificate of insurance evidencing the above information will be required to bind.)

Do you employ or contract physicians for critical care transport or other medical services? ☐ Yes ☐ No

If yes, are they required to carry their own professional liability insurance? ☐ Yes ☐ No
If yes, please indicate insurance carrier and policy limits: _____
(A certificate of insurance evidencing the above information will be required to bind.)

Is a standard call report completed on each call, and each time an ambulance is requested? ☐ Yes ☐ No

If no, please explain: _____

Who reviews the standard call reports for completeness, legibility and quality? _____

When are these reviews completed? ☐ Daily ☐ Weekly ☐ Monthly

What percentage of reports are reviewed? _____

Do you have formal medical protocols and procedures in place for patient care? ☐ Yes ☐ No
If yes, please indicate if protocols are in accordance with State EMS standards. ☐ Yes ☐ No

Do you have a formalized specialized training program for patient handling / lifting? ☐ Yes ☐ No

Annual in-house training? ☐ Yes ☐ No

Who performs the maintenance of the lifting equipment used? _____

Do you maintain and monitor records on an on-going basis to confirm that all employees and new hires meet appropriate state certification requirements? ☐ Yes ☐ No

Do you provide any specialized medical transport service, such as neo-natal transport or specialized cardiac transport? ☐ Yes ☐ No

If yes, please describe: _____

Have you entered into any written agreement with others to perform ambulance services for you?

☐ Yes ☐ No If Yes, please forward a copy of all such contracts.

Do you borrow or lease employees from others?

☐ Yes ☐ No If Yes, please forward a copy of all such contracts including hold harmless conditions.

Do you lend or lease employees to others?

☐ Yes ☐ No If Yes, please forward a copy of all such contracts including hold harmless conditions.

Has any claim been made or suit filed against the company and/or its employees in the past five years alleging negligence in the rendering, or failure to render, medical or professional health care services? ☐ Yes ☐ No

If yes, please describe: _____

_____

_____

Does the insured have any knowledge of any matter which would cause a reasonable person to believe that a claim or suit against the company is likely to arise alleging negligence in the rendering, or failure to render, medical or professional health care services? ☐ Yes ☐ No

If yes, please describe: _____

_____

_____

With respect to medical professional liability insurance for the insured, has any insurance policy been canceled or non-renewed, or an application for insurance been declined, or refused in the past five years? ☐ Yes ☐ No

If yes, please describe: _____

With respect to medical professional liability insurance, has the company received notice of any claims by a state regulatory agency in the past five years? ☐ Yes ☐ No

If yes, please describe: _____

_____

AUTO ☐ Yes ☐ No

Current Business Auto Carrier: _____ Current Premium: $_____

Limit Desired (Combined Single Limit): ☐ $500,000 ☐ $1,000,000

Medical Expenses : ☐ $5,000 per person, per accident

Uninsured Motorist / Underinsured Motorist: ☐ $35,000 UM / ☐ $35,000 UIM
☐ $100,000 UM / ☐ $100,000 UIM

Physical Damage Deductibles: Comprehensive ☐ $1,000 ☐ $3,000
Collision ☐ $1,000 ☐ $3,000

Radius of your operations: 0-50 miles _____% 50-150 miles _____% over 150 miles _____%

What is the largest city entered within your radius of operation? _____

How often is a maintenance report completed on each vehicle and the equipment? _____

Who maintains your vehicles? _____

If you have paratransit / wheelchair vans, who maintains the lifts? _____

How often? _____

Are there written procedures in place addressing:

Use of patient's wheelchair for transport	☐ Yes	☐ No
Securement of wheelchairs	☐ Yes	☐ No
Proper use of lifts	☐ Yes	☐ No

Are maintenance records kept on file? ☐ Yes ☐ No

Are vehicles locked when unattended? ☐ Yes ☐ No

Do you allow third parties (other than patient or personnel) to ride in the ambulance? ☐ Yes ☐ No

Do you maintain an accident review committee? ☐ Yes ☐ No

Do you maintain accident files? ☐ Yes ☐ No

If yes, for how long? _____

What is your minimum driver age? _____

Are drivers required to have at least 3 years driving experience? ☐ Yes ☐ No

Number of currently employed drivers: _____ Full Time _____ Part Time

What was the percentage of your driver turnover in the past 12 months? _____%

Do you review driver motor vehicle reports? ☐ Yes ☐ No

How often? ☐ Annually ☐ Every 2-3 years ☐ More than 3 years

Do you have written driver qualifications that include criteria for acceptable MVR's? ☐ Yes ☐ No

If yes, **PLEASE PROVIDE COPY**

Do you have a formal written driver training program? ☐ Yes ☐ No

Are your vehicles equipped with driver monitoring devices? ☐ Yes ☐ No
(ie. Drive Cam, Road Safe)

Do all drivers of vehicles with 16 or more passengers, including the driver, carry a CDL? ☐ Yes ☐ No

Do you own or lease any 15 passenger vans? ☐ Yes ☐ No

If yes, please answer the following questions:

- Are all vans equipped with ESC (Electronic Stability Control) ☐ Yes ☐ No
- Are all drivers at least 23 years of age and have adequate prior experience operating a 15 passenger van? ☐ Yes ☐ No
- Is care taken to prevent overloading of vans with passengers and luggage? ☐ Yes ☐ No
- Are passengers required to wear seatbelts or the appropriate child restraints? ☐ Yes ☐ No
- Are all van drivers thoroughly trained on the placement of passengers and cargo? ☐ Yes ☐ No
- Is there a requirement that no loads are placed on the roof of the vans? ☐ Yes ☐ No
- Are records retained on all activities regarding the vans, including but not limited to all of the above? ☐ Yes ☐ No

VEH #	YEAR	VEHICLE MAKE	DESCRIPTION (MODEL / TYPE)	VEHICLE CLASS (below)	SERIAL NUMBER (VIN)	SEATING CAPACITY	(ACV) COST NEW	AGREED VALUE	COMP. COVERAGE Y/N	COLLISION COVERAGE Y / N	TERR.
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											
15											

VEHICLE CLASSES: **ALS** (ADVANCED LIFE SUPPORT AMBULANCE) **BLS** (BASIC LIFE SUPPORT AMBULANCE) **LIV** (AMBULETTE OR WHEELCHAIR VAN)
PPT (PRIVATE PASSENGER VEHICLE) **OTH** (SERVICE VEHICLES AND ALL OTHER)

Do any of your vehicles require an Additional Insured or Loss Payee to be listed on the policy? ☐ Yes ☐ No

Name & Address: _____ Vehicle # _____ ☐ A.I ☐ L.P.

Name & Address: _____ Vehicle # _____ ☐ A.I ☐ L.P.

Name & Address: _____ Vehicle # _____ ☐ A.I ☐ L.P.

FLEET HISTORY / VEHICLE COUNT

	1st Prior Year	2nd Prior Year	3rd Prior Year	4th Prior Year	5th Prior Year
Ambulances (ALS and BLS)					
Ambullete and Wheelchair					
Private Passenger					
All Other					
Total					

PORTABLE EQUIPMENT ☐ Yes ☐ No

Indicate the type of coverage needed: ☐ Blanket ☐ Scheduled ☐ Blanket and Scheduled

Choose a deductible: ☐ $1,000 ☐ $2,500 ☐ $5,000

For blanket coverage, you must complete the "Vehicle Class" column on the vehicle schedule. Account for all vehicles owned by the organization or furnished to the organization for regular use. Use the codes defined on page 8.

For scheduled coverage, please provide the following for each item insured. Attach a separate sheet if necessary.

Item Number	Description	Serial Number	Unit Value	Quantity

CRIME ☐ Yes ☐ No

Do checks require at least two signatures?

☐ Yes, in excess of $ _____ ☐ No

Do purchases require the signed approval of two or more people?

☐ Yes, in excess of $ _____ ☐ No

Are bank accounts, credit card statements and vendor payments reconciled at least monthly? ☐ Yes ☐ No

Are bank accounts and credit card statements reconciled by someone not authorized to deposit, withdraw or use the card? ☐ Yes ☐ No

Are criminal background checks done on all employees as part of the hiring process? ☐ Yes ☐ No

If no, are criminal background checks completed on officers and/or management personnel? ☐ Yes ☐ No

Are you aware of, or do you have knowledge of, any dishonest or criminal act committed by any of your members prior to the date of this questionnaire, whether committed during the course of their membership with you or otherwise? ☐ Yes ☐ No

If yes, explain:_____

_____

_____

Are financial records audited by outside parties? ☐ Yes ☐ No

If yes, how often? _____

Please indicate the entity to be covered by the bond. _____

Employee Dishonesty Limit: $ _____

☐ Name or Position Schedule Bond

Name or Position	Covered Entity (if more than one)	Limit

Answer only if you've requested both Employee Dishonesty and a Name or Position Schedule bond. Is the Name or Position Schedule bond intended to be:

☐ Primary
☐ Specific excess over the Employee Dishonesty

Note: Forgery or Alteration, Computer Fraud and Identity Fraud Expense are coverage extensions that are only available if Employee Dishonesty was requested.

Forgery or Alteration Limit: ☐ $25,000 ☐ $50,000 ☐ $100,000 ☐ $250,000 ☐ $500,000

Computer and Funds Transfer Fraud: ☐ $25,000 ☐ $50,000

Identity Fraud Expense: ☐ $25,000 ☐ $50,000

MANAGEMENT LIABILITY ☐ Yes ☐ No

EMPLOYMENT RELATED PRACTICES AND EMPLOYEE BENEFITS LIABILITY

Choose limits:
- ☐ $300,000 each offense or wrongful act / $1,000,000 aggregate
- ☐ $500,000 each offense or wrongful act / $1,000,000 aggregate
- ☐ $1,000,000 each offense or wrongful act / $2,000,000 aggregate
- ☐ $1,000,000 each offense or wrongful act / $3,000,000 aggregate

☐ Claims made basis

Does the applicant have knowledge of any incidents which would cause a reasonable person to believe that a claim or suit might result? ☐ Yes ☐ No If Yes, please give complete details, including date:

_____

_____

☐ Occurrence basis

Please indicate whether the applicant:

- ☐ is currently insured on an occurrence basis for ML coverage, or
- ☐ does not currently carry ML coverage, or
- ☐ will purchase an extended reporting period from their current claims made carrier when they move their coverage to Glatfelter Commercial Ambulance

Does the organization have a personnel (human resources) administrator? ☐ Yes ☐ No

Does the organization have written policies and procedures covering the following areas?

Hiring or applying for membership	☐ Yes	☐ No	Discipline	☐ Yes	☐ No	
Dismissal	☐ Yes	☐ No	Promotions	☐ Yes	☐ No	
Discrimination	☐ Yes	☐ No	New employee / volunteer orientation	☐ Yes	☐ No	
Sexual Harassment	☐ Yes	☐ No	Performance evaluation	☐ Yes	☐ No	☐ N/A

<u>IMPORTANT NOTE</u>: When coverage is bound, a completed and signed Supplement C will be required if coverage is on a claims made basis. Consider getting the appropriate signature now.

CYBER LIABILITY AND PRIVACY CRISIS MANAGEMENT EXPENSE – COVERAGE C AND D OF MANAGEMENT LIABILITY

Cyber Liability protects you when claims are made against you for monetary damages arising out of an electronic information security event.

The limit for Each Electronic Information Security Event will be the same as the Management Liability each offense or wrongful act limit, subject to the Management Liability aggregate.

Privacy Crisis Management Expense reimburses for expenses you incur as a result of a privacy crisis management event first occurring during the policy period. This first party coverage is intended to provide professional expertise in the identification and mitigation of a privacy breach while satisfying Federal and State statutory requirements.

- ☐ $50,000 each privacy event / $50,000 aggregate automatically included
- ☐ $100,000 each privacy event / $100,000 aggregate
- ☐ $250,000 each privacy event / $250,000 aggregate
- ☐ $500,000 each privacy event / $500,000 aggregate

1. ☐ Yes ☐ No Is Firewall technology used at all internet points of presence to prevent unauthorized access to internal networks?
2. ☐ Yes ☐ No Do you use antivirus software on all desktops, portable computers and mission critical servers?
3. ☐ Yes ☐ No Are antivirus applications updated in accordance with the software provider's requirements? How often? _____

QUESTIONS 4 and 5 BELOW MUST BE ANSWERED FOR ANY COMMERCIAL AMBULANCE OPERATION WITH 50 OR MORE FULL TIME EMPLOYEES.

4. ☐ Yes ☐ No Do you have a written information security and privacy policy?
5. ☐ Yes ☐ No Do you backup your computer data and store it off site?

QUESTIONS 6 and 7 BELOW MUST BE ANSWERED IF $500,000 LIMIT IS REQUESTED.

6. ☐ Yes ☐ No Are your employee, customer, and other physical and electronic records maintained in a secure environment with limited access?
7. ☐ Yes ☐ No Has your organization suffered a computer attack, such as a hacking attack, breach of personal information, denial of service attack, virus or malware infection or ransomware attack, in the last 12 months? If Yes, please explain _____

Cyber Liability and Privacy Crisis Management Expense Comments: _____

_____

_____

EXCESS LIABILITY ☐ Yes ☐ No

Limits Desired: $ _____ occurrence / $ _____ aggregate

Note: Underlying limits of $1,000,000 are required.

Coverage desired over: General Liability Management Liability ☐ Automobile Liability
(Check all that apply)

WRAP-UP INFORMATION

Any special information the underwriter should know? **IMPORTANT: Be sure to include current premium information, loss runs for the past five years, and most current GAAP prepared financial statement**.

_____

_____

_____

Has the applicant's insurance program been cancelled or non-renewed by another carrier? ☐ Yes ☐ No
If Yes, please provide details: _____

_____

_____

Name of producing agency: _____

Agency's address: _____

Agency's phone: _____ Agency's fax: _____

Agency's e-mail address: _____

If you are not licensed as a broker, are you a property / casualty agent? ☐ Yes ☐ No

Name and email address of producer or CSR (for contact purposes): _____

_____

FRAUD WARNING NOTICE – PLEASE READ CAREFULLY

Any person who knowingly and with intent to defraud any insurance company or other 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 act, which is a crime, and may subject such person to criminal and civil penalties.

Alabama	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.
Arkansas	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
California	For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
Colorado	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.
District Of Columbia	WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
Florida	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.
Kansas	Any person who knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance that such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.
Kentucky	Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.
Louisiana	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
Maine	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.
Maryland	Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
Minnesota	A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
New Jersey	Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
New Mexico	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.
New York	Any person who knowingly and with intent to defraud any insurance company or other 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
Ohio	Any person who, with intent to defraud or knowing that he 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.
Oklahoma	WARNING: Any 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.
Oregon	Any person who knowingly and with intent to defraud any insurance company or other 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, may be guilty of a fraudulent act, which may be a crime, and may subject such person to criminal and civil penalties.
Pennsylvania	Any person who knowingly and with intent to defraud any insurance company or other 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 such person to criminal and civil penalties.
Rhode Island	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
Tennessee	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
Vermont	Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.
Virginia	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.
Washington	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.
West Virginia	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Your signature below acknowledges that you have read the General Fraud Warning Notice and the State Specific Fraud Warning Notice that applies to your state of domicile.

The undersigned is an authorized representative of the applicant and certifies the information provided to obtain this coverage is accurate to the best of their knowledge; this includes any applications, locations schedules, valuation statements, loss history in formation and engineering reports.

Applicant's signature: _____ **Title**: _____ **Date**: _____

Agent's signature: _____ **Date:** _____

GLATFELTER COMMERCIAL AMBULANCE
BUILDING VALUATION FORM
Photos of Building Must Accompany Completed Form
(Supplement A)

Submitted by: _____ **Date:** _____

General Information

Client Information		**Policy Information**	
Name:		Coverage Amount:	
Location Address:		Policy Number:	
		Location Number:	
City:			
State/Zip Code:			

Structure Information

(Answer only the applicable information for each structure. Some fields on the worksheet do not apply for every structure.)

Structure Type:

- ☐ Ambulance Station, Paid: _____%
- ☐ Ambulance Station, Volunteer: _____%
- ☐ Social Club: _____%
- ☐ Govt. Buildings: _____%
- ☐ Office: _____%
- ☐ Other: _____%

(Check all that apply)

- Year Built: _____
- Total Square Footage: _____
- Ground Floor Area: _____
- Number of Floors: _____
- Perimeter: _____
- Basement Square Footage: _____
- Type: ☐ Finished ☐ Unfinished
- Other Area Type *(mezzanine, balcony, etc.)* and Square Footage Amount: _____

Building Code Class

- ☐ 1 – Frame Combustible: _____%
- ☐ 2 – Joisted Masonry: _____%
- ☐ 3 – Noncombustible: _____%
- ☐ 4 – Noncombustible (Masonry): _____%
- ☐ 5 – Modified Fire Resistive: _____%
- ☐ 6 – Fire Resistive: _____%

(Check all that apply)

Construction Type

- ☐ Framing, Wood: _____%
- ☐ Metal Frame: _____%
- ☐ Masonry, Block: _____%
- ☐ Masonry, Brick: _____%
- ☐ Other: _____%

(Check all that apply)

Construction Quality

- ☐ Basic – *Plain, square/rectangular, no trim or decoration*
- ☐ Average – *Typical building style for occupancy, limited trim or decoration*
- ☐ Above Average – *More complex in shape or building style with more features, trim, decoration*
- ☐ Expensive – *Complex shape/roofline, specialized/costly materials or features*
- ☐ Very Expensive – *Involves well known architect/developer, expensive or vintage features*
- ☐ Exceptional – *Unique/vintage building, extensive use of artisans, finest materials/quality*

Building Exterior

☐ Brick veneer, standard	_____%	☐ Siding, vinyl	_____%
☐ Brick wall, reinforced w/ rebar	_____%	☐ Stone veneer, frame	_____%
☐ Concrete block	_____%	☐ Stone veneer, masonry	_____%
☐ Concrete block, split face	_____%	☐ Stucco	_____%
☐ Metal siding, corrugated aluminum	_____%	☐ Tilt up, concrete wall	_____%
☐ Siding, hardboard (wood)	_____%	☐ Other _____	_____%
☐ Panels, cement fiber siding	_____%	*(Check all that apply)*	

Foundation Type

☐ Concrete block	☐ Poured concrete walls
☐ Concrete slab	☐ Pier and beam
☐ Partial concrete slab	☐ Other _____

Slope of Site ☐ Flat ☐ Slight ☐ Moderate ☐ Steep ☐ Very steep

Roof Covering

☐ Corrugated Aluminum	_____%	☐ Shingles, architectural (30-40 year)	_____%
☐ Metal, other than standing seam	_____%	☐ Shingles, asphalt (Composition Shingle)	_____%
☐ Metal, standing seam	_____%	☐ Tiles, Slate	_____%
☐ Rubber/Membrane	_____%	☐ Other _____	_____%
☐ Built Up Tar & Gravel	_____%	*(Check all that apply)*	

Roof Pitch ☐ Flat ☐ Slight ☐ Moderate ☐ Steep

HVAC

☐ Complete HVAC	_____%	☐ Hot water, radiant (Floor, walls, etc.)	_____%
☐ Electric (Metal baseboards)	_____%	☐ Space heater (Overhead Heat Unit)	_____%
☐ Electric, wall	_____%	☐ Steam	_____%
☐ Evaporative cooling	_____%	☐ Steam boiler	_____%
☐ Floor Furnace	_____%	☐ Ventilation	_____%
☐ Forced air unit	_____%	☐ Warmed and chilled air (Chiller)	_____%
☐ Heat pump	_____%	☐ Warmed and cooled air (Condenser)	_____%
☐ Hot water	_____%	☐ None	_____%
		(Check all that apply)	

Equipment/Contents/Other Cost Items: (if any) i.e.: Generators, Radio Towers, Etc.	
Item:	
Item:	
Item:	
Risk Control Use Only: Equipment/Contents Percentage of Structure Value	_____%

Note: Attach Photos and Provide Diagram of Building

Left Front OR Right Front Angle (two sides)	Opposite Rear Angle (two sides)
	

At Least Two Interior Photos: (Bay, Office Space, and Kitchen)	
	

Photos of Building Must Accompany Completed Form