

**Emergency Service Organization
Property/Casualty
Insurance Survey**



McNeil & Company, Inc.
C/O Bernard Insurance Agency, LLC
P.O. Box 5010
Shreveport, La. 71135
Phone (800) 256-9124 Phone (318) 797-5651
Fax (318) 797-5688

General Information

Date of survey: _____ Insurance Renewal Date: _____

Legal Name of Organization: _____
(please include all organizations that are to be included as insureds)

FEIN: _____

Mailing Address: _____

County: _____

Telephone: _____ Fax: _____

Contact Name: _____ Contact Title: _____

Website Address: _____ E-Mail Address: _____

Business Information

Which best describes the organization (please check one):

- Fire Suppression only (no EMS) Fire and Rescue/EMS
 Rescue/EMS Squad or Ambulance Squad Other (please describe): _____

The organization is a (please check one):

- Tax District Independent Non-Profit Organization
 Municipal, Village or Town Department Other (please describe): _____

If a municipal, village or town department, is the organization a separate legal entity? Yes No

Population served on a first-call basis: _____ Years in operation: _____

Insurance Agent Information

Agent's Name: _____

Name of Agency: _____

Address: _____

Agency telephone: _____ Agency fax: _____

Date proposal is needed: _____ Agency e-mail address: _____

Do you currently write this account? Yes No

If so, for how long? _____ With what Carrier? _____

Is the account Sub-Brokered? Yes No

If Yes, please indicate Agency Name: _____



Property and Casualty
Insurance Survey
for
Ambulance Service Companies



McNeil & Company, Inc.
C/O Bernard Insurance Agency, LLC
P.O. Box 5010 - Shreveport, La. 71135
Phone (800) 256-9124 - Fax (318) 797-5688

Insurance Agent Information

Name of Agency: _____

Agent's Name: _____

Address: _____

Agency telephone: _____ Agency fax: _____

Agency e-mail address: _____ Date proposal is needed: ____/____/____

Do you currently write this account? Yes No

If so, for how long? _____ With what Carrier? _____

General Information

Date of survey: ____/____/____ Insurance Renewal Date: ____/____/____

Legal Name of Organization: _____ FEIN: _____

_____ In business for how long? _____

Type of Organization: Individual Partnership Corporation Joint Venture Other _____

Mailing Address: _____

_____ County: _____

E-mail Address: _____

Non-emergency Phone #: _____ Contact for inspection: _____

Contact telephone #: _____

Is the company a private for-profit ambulance service? Yes No

If no, please describe: _____

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

Annual Revenue: \$ _____
% from Medicaid / Medicare: _____
% from Insurance Companies: _____
% from Private Pay: _____
% from Contract: _____

