Paratransit, Community and Medical Transportation

Supplemental Application

A. GENERAL INFORMATION

Named Insured: _____ FEIN#: _____

Primary Address: _____ County: _____

City: _____ State: _____ Zip: _____

Email: _____ Phone: _____ Fax: _____

**** IMPORTANT ****** Complete Description of ALL operation(s):

_____

_____

_____

_____

_____

1. Operating as: [ ] Individual [ ] Partnership [ ] Corporation [ ] Other: _____
2. Applicant is: [ ] For Profit [ ] Not for Profit [ ] Gov't Facility [ ] Other: _____
3. Number of Years: In Business: _____ Current Ownership: _____
4. Current Operating Budget: $_____
5. Annual Budget for each of the past (two) years: $_____ $_____
6. Insured's annual transportation revenue: $_____ Insured's annual mileage: _____
7. Does insured have filings [ ] Yes [ ] No DOT#: _____ MC#: _____ PUC#: _____
8. Exact Name of Filing: _____

MANDATORY INFORMATION

Name of current GL carrier for this insured: _____

Policy Limit: _____ **Policy Dates:** _____ **Policy Number:** _____

Name of current Professional Liability carrier for this insured: _____

Policy Limit: _____ **Policy Dates:** _____ **Policy Number:** _____

B. HISTORICAL VEHICLE DATA

Type of Vehicle	Vans (1-8 Passenger)	Mini-Van/Bus (9-20 Passenger)	Bus (>20 Passenger)	PPT/ Service	Class B Ambulance
Proposed Year					
Current Year					
Prior Year					
First Prior Year					
Second Prior Year					
Third Prior Year					

C. PREMIUM HISTORY

Period Term	Insurance Company	Auto Liability	Physical Damage	
Current Year				
Prior Year				
First Prior Year				
Second Prior Year				
Third Prior Year				

SCHEDULE OF HAZARDS

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LOC #	HAZ #	CLASSIFICATION	CLASS CODE	PREMIUM BASIS	EXPOSURE	TERR	RATE		PREMIUM	
							PREM/OPS	PRODUCTS	PREM/OPS	PRODUCTS

RATING AND PREMIUM BASIS
(S) GROSS SALES - PER $1,000/SALES
(P) PAYROLL - PER $1,000/PAY
(A) AREA - PER 1,000/SQ FT
(C) TOTAL COST - PER $1,000/COST
(M) ADMISSIONS - PER 1,000/ADM
(U) UNIT - PER UNIT
(T) OTHER

D. OPERATIONS

1. Any 911 calls? [ ] Yes [ ] No
2. Total estimated number of annual paratransit calls: _____

_____% of total calls are Wheelchair/Scooter
_____% of total calls are Gurney/Stretcher
_____% of total calls are Passenger Vehicle
_____% of total calls are Ambulatory Passenger – Please Describe: _____

3. For Wheelchair, Ambulette, and Other Transportation, please list your primary source of requests for services:

[ ] Medicaid _____%
[ ] HMO's _____%
[ ] Private Pay _____%
[ ] Other _____%
[ ] Regional Contracts _____%
[ ] Workers Comp _____%
[ ] Private Insurance _____%
Describe: _____

4. Pick Ups are: [ ] Pre Scheduled _____ % [ ] On Demand _____ %
5. Services Provided: [ ] Door to Door ___ % [ ] Door thru Door __% [ ] Curb to Curb ___%
6. Does the insured subcontract FOR others? [ ]Yes [ ]No If yes, provided copies of contracts.
7. In what county does insured provide transportation?

County	%	County	%

E. SAFETY & CLAIMS MANAGEMENT

1. Name and title of the person(s) responsible for safety & risk management: _____
2. Describe his/her duties: _____

_____

_____

3. Name and title of person responsible for claims reporting: _____
4. Describe the insured's accident review program: _____

_____

_____

5. Does the insured hold safety meetings: [ ] Yes [ ] No
6. How often are they held: _____

7. Is attendance mandatory: [ ] Yes [ ] No

F. VEHICLE MAINTENANCE

1. Describe the insured's preventive maintenance program: _____

_____

_____

2. Does the insured have the following:

Documentation of Repairs: [ ] Yes [ ] No Pre-Trip Inspections: [ ] Yes [ ] No
Post-Trip Inspection: [ ] Yes [ ] No Driver Trouble Reports: [ ] Yes [ ] No
Periodic In-depth Inspections: [ ] Yes [ ] No

3. What is the insured's vehicle replacement policy? _____
4. Where are vehicles stored after hours? What security is provided? _____
5. If vehicles are stored at driver's homes, what provisions are made for vehicle security? _____
6. What is the maximum value of vehicles stored at each location?

	Location #1	Location #2	Location #3
Inside			
Outside			

G. WHEELCHAIR INFORMATION

1. Number of vehicles equipped with:

Lifts: Buses: _____ Mini-Van/Buses: _____ Vans: _____ Manufacturer: ____
Ramps: Buses: _____ Mini-Van/Buses: _____ Vans: _____ Manufacturer: ____

2. Is all equipment factory installed during vehicle construction? [ ] Yes [ ] No
3. Number of vehicles equipped with passenger restraint system:

Buses: _____ Mini-Van/Buses: _____ Vans: _____ Manufacturer: _____

4. Is the system a "4-point tie down and forward facing" design? [ ] Yes [ ] No
5. If yes, are shoulder belts retractable of non-retractable? _____
6. Is floor securement of wheels accomplished with fixed locations or moveable attachments, i.e. tracks?_____
7. Do all lifts/ramps/securement areas comply with ADA accessibility requirements?
   [ ] Yes [ ] No
8. What types of wheelchairs can be accommodated by your vehicles (check all that apply):

heavy duty industrial [ ] reclining/tilting [ ]
lightweight [ ] motorized [ ]
portable [ ] tri-wheeler/scooter [ ]
youth/child stroller [ ] other _____

9. Are all passengers in tri-wheelers required to transfer to a wheelchair or a permanent seat after loading? [ ] Yes [ ] No

10. Are wheelchair passengers ever permitted to ride in the vehicle in other than the designated securement locations? [ ] Yes [ ] No
11. Are ALL persons involved in wheelchair transportation instructed in the proper use of securement equipment for all types of wheelchairs? [ ] Yes [ ] No
12. Describe procedures followed if wheelchair is not standard: _____

H. STRETCHER INFORMATION

1. Number of vehicles equipped with stretcher equipment: _____
2. What types of stretchers do you use in your vans? _____
3. What type of stretcher vehicle securing system do you provide in your stretcher vans? _____

   _____
4. What type of patient stretcher safety restraint system do you provide on your stretchers? _____

   _____
5. Who does the loading and unloading of the stretchers? _____
6. What training is provided if employees load and unload? _____
7. Does an attendant accompany stretcher clients? [ ] Yes [ ] No
8. If "Yes", is attendant an employee of the insured, employee of the facility requesting transportation or personal assistant of the passenger: _____

I. EMPLOYEES

1. Number of Employees:

   Full time drivers: _____ Vehicle maintenance: _____

   Regular part time drivers: _____ Dispatchers: _____

   Back-up drivers: _____ Administrative: _____

   Volunteer drivers: _____

   Other (Number & Description of Duties): _____
2. Average annual driver turnover (%): _____
3. Describe driving hiring procedures: _____

   _____

   _____
4. Are MVR's ordered prior to hiring: [ ] Yes [ ] No What criteria is used for acceptability:

   _____
5. How often does the insured review MVR's: _____
6. Are MVR's ordered and reviewed on ALL drivers annually: [ ] Yes [ ] No
7. Describe driver orientation program: _____

   _____

8. What **percentages** of drivers are trained in the following?

General Driver Orientation:	_____	Cardiopulmonary resuscitation:	_____
Defensive Driving Course:	_____	Passenger Assistance Training:	_____
Primary First Aid:	_____	Human Relations Skills:	_____
Advanced first Aid:	_____	Non-Medical Emergency Training:	_____
Emergency Vehicle Evacuation:	_____	Other (specify):	_____

9. If volunteer drivers are used, are they subject to the same hiring guidelines and training as the regular drivers? [ ] Yes [ ] No
   Comments: _____
10. Are employment applications required: [ ] Yes [ ] No
11. Are previous employment references checked: [ ] Yes [ ] No Comments: _____
    _____
12. Are pre-employment physicals performed: [ ] Yes [ ] No Comments: _____
    _____
13. Are drug tests performed: [ ] Yes [ ] No If yes, frequency: _____
14. Are criminal background checks performed on <u>all</u> drivers? [ ] Yes [ ] No If yes, describe criteria used to determine acceptability: _____
    _____
15. Are back-up drivers required to follow the same hiring, MVR and training criteria used to determine acceptability: _____
16. Are drivers files kept: [ ] Yes [ ] No
17. Is there an employee manual: [ ] Yes [ ] No
18. Are drivers permitted to use their cell phones when driving: : [ ] Yes [ ] No
19. If policy is to provide coverage for Private Passenger Type autos, please describe insured's policy as to personal use of these vehicles. **If written, provide a copy.**
    _____
    _____
20. Is there any personal use of insured vehicles?: [ ] Yes [ ] No If yes, describe: ____
    _____
21. If No, how is it monitored? _____
    _____

Medical certificates should be provided on all drivers over the age of 70 who have a CDL, if not, provide any medial qualification report currently in use. Please attach any policies, procedures or programs used specifically for these drivers that serve to insure their fitness for duty and ability to operate assigned vehicles safely.

J. HIRED & NON-OWNED ** IMPORTANT **

1. Do any employees use their own autos in the insured's business: [ ] Yes [ ] No
   If yes, how many: _____
2. Do these employees transport clients: [ ] Yes [ ] No If yes, how often: _____
   _____
3. Does the insured require proof of insurance from these employees: [ ] Yes [ ] No

If yes, what are the minimum auto limits required: _____
_____

4. Does the insured use subcontractors for any of his operations: [ ] Yes [ ] No
   If yes, describe: _____
   _____
   _____
5. Provide the "cost of hire" of these subcontractors: _____
6. Does the insured require minimum limits from the subcontractor? : [ ] Yes [ ] No
   If yes, what limits: _____
7. Is the insured added as an additional insured on the subcontractor's policy: [ ] Yes [ ] No
8. Provide copies of contracts with subcontractors. Attached: [ ] Yes [ ] No If no, explain:
   _____
   _____

FRAUD STATEMENTS

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.

Agents'/Broker's Signature: _____ Date: ___/___/_____

Applicant's Signature: _____ Date: ___/___/_____