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

SCHEDULE OF HAZARDS

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: ___/___/_______

SMM New Business Application

Sexual Misconduct & Molestation Liability Application Form

Instructions

Please answer all questions. If the answer to any question is NONE, please print NONE. Attach separate sheets of paper as necessary. The application must be signed and dated by the highest ranking clergy or executive. PLEASE CAREFULLY READ STATEMENT AT THE END OF THE APPLICATION BEFORE SIGNING.

General Information

1 Name of Applicant: ______________________________

2 Mailing Address: ______________________________
City: ______________________ State: __________ Zip Code: __________
Phone: ______________ Fax:______________ Website:______________

3 Person to Contact: ______________________ Phone number:______________________
E-mail: ______________________

4 Years in Operation: ______________

5 Description of Service: ______________________________
____

6 Industry:
☐ Education ☐ Transportation ☐ Non-profit ☐ Healthcare ☐Religious ☐Other
Please complete Industry supplement if any industry except "Other."

7 Please complete financial data below:

Current assets: $	Total assets: $	Net income/loss: $
Current liabilities: $	Cash flow: $	Annual Revenues: $

8 Has the applicant merged with any other entity in the past 10 years or planning to do so in the future or has there been any significant change in the operations or scale of the organization? ☐ Yes ☐ No

If **Yes**, please provide full details ______________________________
____
(Please use a separate sheet of paper if necessary)

9 Reason coverage is requested:______________________________

Past coverage

10 Prior Sexual Misconduct Liability Coverage for the last five years, please list most recent first.

Period	Claims Made or Occurrence	Insurer	Premium	Limit	SIR
From ___/___ to ___/___	____________	____________	________	________	________
From ___/___ to ___/___	____________	____________	________	________	________

From ___/___ to ___/___ _______________ ____________________ __________ __________ __________

From ___/___ to ___/___ _______________ ____________________ __________ __________ __________

From ___/___ to ___/___ _______________ ____________________ __________ __________ __________

11 Retroactive date:__________________________

12 Has any applicant ever canceled or non-renewed this type of coverage: ☐ Yes ☐ No
(If **Yes**, please identify the provider and explain on a separate sheet of paper.)

Staff details

13 Please complete employee grid below:

	Number employed	Number contracted	Number volunteer	% Male
All employees with client contact				
All employees without client contact				
Totals				

14 Annual Turnover Rate: _____________

15 Historical headcount for the past 5 years (all staff from question 13)
20__: _______ 20__: _______ 20__: _______ 20__: _______ 20__: _______

16 Top 5 states where employees are located (list state and number of employees):

Client details

17 Total number of individual clients/patients/students/members served annually:_______________________

18 Percentage of the above that are disabled/handicapped/at risk :_____________________________________

19 Please breakdown clients served annually (%):

0-10:	11-18:	19-65:	65+:

Loss Prevention Efforts

19 Check which of the following methods are used in the screening and hiring process for all listed in question 9 above.

Loss Prevention Methods Type in "Y" for Yes and "N" for No	Number employed	Number contracted	Number volunteer
a. Standard Application			
b. Code of Conduct			
c. Interview			
-Face to face interview			
-Standard list of interview questions			
-Use behavioural interviewing techniques			
-Interview by more than one person			
d. Standard questions for references			
e. Criminal background check			
f. Abuse registry check			
g. Organizational abuse prevention prior to			

working/volunteering			
h. Annual abuse training			
i. Checklist of indicators that may indicate increased risk to abuse			
j. Other *(please describe)*:			

20 Are one-on-one encounters permitted with clients? ☐ Yes ☐ No

If **Yes**, please explain when these situations occur and how the interactions are monitored ________________

____

(Please use a separate sheet of paper if necessary)

21 Do any of those listed in question 13 above ever have children at their home or ever spend time at the home of children? ☐ Yes ☐ No

If **Yes**, please explain when these situations occur and how such situation is monitored__________________

____

(Please use a separate sheet of paper if necessary)

22 Does the Organization ever sponsor 'events' (including overnight events)? ☐ Yes ☐ No

If **Yes**, please provide details of events that are sponsored including the normal ratio of children to 'safe' adult on such sponsored events________________________________

____

(Please use a separate sheet of paper if necessary)

23 Does central administration establish, monitor, and enforce policies and ☐ Yes ☐ No

If **No**, please explain ________________________________

____

24 Are items below included in the written policies for all those listed in question 13 above?

Yes	No	
☐	☐	A zero tolerance statement for sexual abuse perpetrated on children or other vulnerable persons in the applicant's care.
☐	☐	A written policy that defines appropriate and inappropriate displays of affections.
☐	☐	A written procedure for governing the interactions between those listed in question 6 above and children or other vulnerable persons in your care outside of regular program activities.
☐	☐	A written procedure for managing the risk when those listed in question 6 above is alone with a lone child or other vulnerable person.

Loss History

25 Please furnish the past ten years' first dollar loss history for all sexual misconduct claims.

☐None ☐See attached

Period	# Claims Paid	# of Claims Loss	Total Paid Expenses	Total Paid Losses	Total Reserved Expenses	Total Reserved Reserved
From ___/___ to ___/___	________	________	________	________	________	________
From ___/___ to ___/___	________	________	________	________	________	________
From ___/___ to ___/___	________	________	________	________	________	________
From ___/___ to ___/___	________	________	________	________	________	________

From ___/___ to ___/___ ____________ ____________ __________ __________ _____________ _____________

From ___/___ to ___/___ ____________ ____________ __________ __________ _____________ _____________

From ___/___ to ___/___ ____________ ____________ __________ __________ _____________ _____________

From ___/___ to ___/___ ____________ ____________ __________ __________ _____________ _____________

From ___/___ to ___/___ ____________ ____________ __________ __________ _____________ _____________

From ___/___ to ___/___ ____________ ____________ __________ __________ _____________ _____________

Please complete the claims supplement for any sexual misconduct claim.

26 Is the applicant aware of any facts, incidents, circumstances, or allegations that may result in claims being made against you? ☐ Yes ☐ No
(If **Yes**, please provide details on a separate sheet of paper)

27 Has the applicant or any person listed in question 13 above currently seeking coverage been involved in an allegation or claim relating to sexual abuse or been transferred in or out of your school, parish/diocese, branch or corporate location because they were involved, suspected, or a complaint was made regarding an allegation of sexual misconduct? ☐ Yes ☐ No
(If **Yes**, please provide details on a separate sheet of paper)

28 In the past 10 years, have any person listed in question 13 above or officers been terminated for cause related to sexually abusive behavior? ☐ Yes ☐ No
(If **Yes**, please provide details on a separate sheet of paper)

Claims Handling

29 How do you handle allegations of sexual abuse or molestation?

____

____

THE APPLICANT WARRANTS TO THE BEST OF ITS KNOWLEDGE AND BELIEF THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE AND INCLUDE ALL MATERIAL INFORMATION.

THE APPLICANT FURTHER WARRANTS THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE INCEPTION DATE OF THE POLICY PERIOD, IT WILL IMMEDIATELY NOTIFY US OF SUCH CHANGE. SIGNING OF THIS APPLICATION DOES NOT BIND THE COMPANY TO OFFER NOR THE APPLICANT TO ACCEPT INSURANCE, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE INSURANCE AND WILL BE ATTACHED AND MADE PART OF THE POLICY SHOULD A POLICY BE ISSUED. IF AN EXCESS POLICY IS ISSUED THE APPLICATION WILL BECOME A PART OF THE EXCESS POLICY.

______________	____	______________
date	applicant's authorized signature of a principal, partner or officer	title

______________	____	______________
date	applicant's authorized signature of the individual in charge of the human resources or personnel department	title

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.

Transportation Supplement

Instructions

Please answer all questions. If the answer to any question is NONE, please print NONE. Attach separate sheets of paper as necessary. The application must be signed and dated by the highest ranking executive. PLEASE CAREFULLY READ STATEMENT AT THE END OF THE APPLICATION BEFORE SIGNING.

General Information

1 Name of Applicant: ______________________________

Applicant details

2 Please complete employee grid below:

	Number employed	Number contracted	Number volunteer	% Male
Number of corporate staff				
Number of drivers				
Totals				

Organization details

3 Number of vehicles ______________________________

4 Age range of passengers______________________________

5 Please check yes or no in the grid below:

Services	Yes	No
Cabs		
School buses		
Charter buses		
Small group transfer		
Ambulatory		
Paratransit		
Non-emergency medical		
Other (please describe)		

Loss Prevention Efforts

5 Please check yes or no in the grid below:

Method	Yes	No
Matron on board		
Cameras		
GPS tracking		

6 Detail any other methods of risk management______________________________
____

7 What procedures are in place for first client in and last client out?______________________________
____

8 What is the protocol for drivers in the event of an incident?______________________________

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______________	____	______________
date	applicant's authorized signature of a principal, partner or officer	title

______________	____	______________
date	applicant's authorized signature of the individual in charge of the human resources or personnel department	title

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