Supplemental Questionnaire for Non-Emergency Medical Transportation

(To be used in conjunction with a FULLY completed ACORD application and company provided loss information. Please be sure to complete all questions on Page 8. A SIGNED copy will be required to bind.)

Name of Insured:

GENERAL INFORMATION

Number of Years:

• In Business: _________
• Current Ownership: _________
• Current Management in Place: _________

Does the insured have a website [ ] Yes [ ] No. If Yes, what is the address?

______________________________________________________________________________

Have you ever operated under a different name: [ ] Yes [ ] No If "Yes", what name:

______________________________________________________________________________

Insured's annual NEMT revenue:__________ Insured’s annual mileage:__________

Names and descriptions of ALL operations and entities under common ownership (whether or not to be insured under the above named insured):

______________________________________________________________________________

______________________________________________________________________________

Limit of Liability Requested:__________________________________________

EDITION 11-9-15
### Historical Vehicle Data (Must Be Provided)

<table>
<thead>
<tr>
<th>Vehicle by Seating Capacity</th>
<th>1-8 Passengers</th>
<th>9-20 Passengers</th>
<th>&gt;20 Passengers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proposed Year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current Year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prior Year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Second Prior Year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Third Prior Year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fourth Prior Year</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Expiring Liability Premium:__________    # Units:__________

### OPERATIONS

Does the insured respond to any 9-1-1 or emergency calls? [ ] Yes [ ] No

Does the insured have any vehicles that are equipped with lights/sirens? [ ] Yes [ ] No

As a percentage (%) of total trips:

- Wheelchair: _____%
- Stretcher transportation: _____%
- Curb to Curb:_____%
- Door to Door:_____%
- Door through Door:_____%
- Pre-Scheduled:_____%
- On-Demand:_____%

*Radius, as a % of total trips:*

- 0-50 miles:_____%
- 51-200 miles:_____%
- 200+ miles:_____%
Does the insured subcontract **FOR** others? [ ] Yes [ ] No. *If yes, provide copies of contracts.*
Does the company enter into any written or verbal agreements to provide service? [ ] Yes [ ] No.

In what areas does the insured provide transportation?

Please check all that apply:

[ ] I will be transporting patients to the hospital/clinic/medical appointments
[ ] I will be transporting elderly passengers to the senior center
[ ] I will be transporting children under the age of 21  
   If yes, please describe the age range of the children:____________________
   If yes, do these children have physical/mental/or emotional handicaps? _____

If yes, will they be accompanied by a parent or guardian? ________________

*If yes, confirmation will be needed that all drivers are properly trained to assist a child with a physical/mental/emotional handicap (Please describe in detail the training process, certifications, and any special procedures that are taken):*

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
SAFETY & CLAIMS MANAGEMENT (IF APPLICABLE, PLEASE PROVIDE COPIES OF ALL POLICY AND PROCEDURE MANUALS, TRAINING MANUALS, AND HIRING MANUALS)

Name and title of the person responsible for safety & claims management:
________________________________________________________________________

Email & Contact Number of safety & claims contact person:
________________________________________________________________________

Describe his/her duties:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Describe the insured's accident review & safety program:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

How often are reviews held and is attendance mandatory?
________________________________________________________________________

Are cameras or other recorders installed in all vehicles? Since when? Name and model of camera or other equipment?
________________________________________________________________________
________________________________________________________________________

Is there a set protocol to follow if drivers are involved in an incident/accident?
[ ] Yes [ ] No: If yes, please describe it:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
VEHICLE MAINTENANCE:

Describe the insured's preventive maintenance program:
________________________________________________________________
________________________________________________________________
________________________________________________________________

How often are preventative measures taken? (ex. every 1000 miles):
________________________________________________________________
________________________________________________________________

How often will the cameras be maintained/inspected?________________________

Does the insured require:
• Pre-Trip Inspections? [ ] Yes [ ] No
• Post-Trip Inspections? [ ] Yes [ ] No
• Regular In-Depth Inspections? [ ] Yes [ ] No
• Driver Problem Reports? [ ] Yes [ ] No
• Documentation of Repairs? [ ] Yes [ ] No

Do Drivers take vehicles home with them? [ ] Yes [ ] No

Please provide details on all special equipment in vehicles (such as Lifts, Ramps, Passenger Restraint Systems, Floor Securement Systems, Stretcher Securing Systems, etc. Indicate which vehicles have which equipment):
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Brand of Wheelchair Locks:______________________________________________

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

EDITION 11-9-15
Are wheelchair or stretcher passengers ever permitted to ride in the vehicle in other than the designated securement locations? [ ] Yes [ ] No

Are ALL persons involved in wheelchair or stretcher transportation instructed in the proper use of securement equipment for all types of wheelchairs?[ ] Yes [ ] No
Describe procedures followed if wheelchair is not standard:

_____________________________________________________________________________________

Who does the loading and unloading of the stretchers? __________________________
Who does the loading and unloading of wheelchairs? __________________________
What training is provided if employees load and unload? __________________________

_____________________________________________________________________________________

Does an attendant accompany stretcher clients? [ ] Yes [ ] No.
If “Yes”, is attendant an employee of the insured, employee of the facility requesting transportation or personal assistant of the passenger?

_____________________________________________________________________________________

TRAINING
What training procedures are in place (please mark those that apply):

[ ] Training Manuals
[ ] Company Guideline Pamphlets
[ ] Observation Period
  How long? __________________________________________
[ ] Certification Process
[ ] Wheelchair Loading
[ ] Wheelchair Securing

Is there re-training held? [ ] Yes [ ] No
If yes, how often is it held? __________________________________________
EMPLOYEES
• Full time drivers:_____
• Regular part time drivers:_____
• Back-up drivers:_____
• Volunteers:_____

Describe driver hiring procedures (such as background checks, MVR acceptability, etc.):
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Are MVR’s ordered and reviewed on ALL drivers at least annually? [ ] Yes [ ] No

Are all drivers able to speak English? [ ] Yes [ ] No

Describe driver orientation program:
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Check all that apply:
[ ] Employment applications are required
[ ] Employment references are checked
[ ] All new drivers are required to have previous NEMT driving experience
   What experience?________________________________________________________
[ ] Pre-employment physicals are performed
[ ] Drug tests are performed
[ ] Criminal background checks are performed on all drivers
   If checked, what criteria is used to determine acceptability?_________________
[ ] Back-up drivers are required to follow the same hiring, MVR, and training
   criteria as regular drivers
[ ] Driver files are kept
[ ] There is an employee manual or handbook
[ ] All vehicles are equipped with a cell phone or radio
NEMT Certification Form

Please have either the Owner or Operations Manager Initial Below & BOTH OWNER AND ALL SCHEDULED DRIVERS must sign below.

_____ All drivers are both knowledgeable and certified in operating an NEMT
If there are any EXCEPTIONS, please initial here: ______

_____ All drivers have received training and are certified in the loading and unloading of wheelchairs.
If there are any EXCEPTIONS, please initial here: ______

_____ Knowledgeable and certified in the proper securing wheelchair lockdown on 4 point lockdowns including not loading a passenger unless all four points are properly working.
If there are any EXCEPTIONS, please initial here: ______

_____ Trained in the use of and proper procedures of wheelchair ramps or lifts (if applicable).
If there are any EXCEPTIONS, please initial here: ______

_____ Confirm with passengers understanding that the seatbelt must always be fastened and physical impairments and pre-existing injuries must be taken into account when assisting passengers.
If there are any EXCEPTIONS, please initial here: ______

_____ Complete familiarity with the required procedures in the event of an emergency with a passenger and/or accident regardless of degree of seriousness to either notify Dispatch or call 911
If there are any EXCEPTIONS, please initial here: ______

It is hereby agreed and understood that all scheduled drivers are both certified and knowledgeable in all those signed above. It is understood that if not both certified or knowledgeable those individuals will not be assisting in the loading or unloading of passengers or driving the NEMT.

If there are any exceptions, please provide details below.

If you agree to the terms and conditions, please sign and date below:

Owner’s Signature ___________________________ Print Name ___________________________ Date ______________

Driver Signature ___________________________ Print Name ___________________________ Date ______________

Driver Signature ___________________________ Print Name ___________________________ Date ______________

Driver Signature ___________________________ Print Name ___________________________ Date ______________

Driver Signature ___________________________ Print Name ___________________________ Date ______________

Driver Signature ___________________________ Print Name ___________________________ Date ______________

Edition 11-9-15
Driver Signature | Print Name | Date
--- | --- | ---
Driver Signature | Print Name | Date
Driver Signature | Print Name | Date
Driver Signature | Print Name | Date
Driver Signature | Print Name | Date
Driver Signature | Print Name | Date
Driver Signature | Print Name | Date
Driver Signature | Print Name | Date

**Exceptions** (please provide detailed explanations with full driver names and the particular exception, if necessary include an additional page):
Medical certificates should be provided on all drivers over the age of 70 who have a CDL. If not, provide any medical 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.

APPLICANT’S STATEMENT

I hereby declare that the statements made in this application and the contents of the other documents are true and correct and agree that any policy of insurance that may be issued now or in the future will be based on the warranties and representations contained therein.

Applicant:

______________________________  Signature of Officer/Manager Date

______________________________  Print full name Title

Producer:

______________________________  Signature Date

______________________________  Print full name Agency

Questions?
800-926-6771

Submit Completed Application to:
quotes@cluettinsurance.com