# Supplemental Questionnaire for Non-Emergency Medical Transportation

***(To be used in conjunction with a FULLY completed ACORD application and company provided loss information)***

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?

_____

Has insuread 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:_____

## Historical Vehicle Data (Must Be Provided)

| Vehicle by Seating Capacity | 1-8 Passengers | 9-20 Passengers | >20 Passengers |
|---|---|---|---|
| **Proposed Year** | | | |
| **Current Year** | | | |
| **Prior Year** | | | |
| **Second Prior Year** | | | |
| **Third Prior Year** | | | |
| **Fourth Prior Year** | | | |

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?_____
_____

**SAFETY & CLAIMS MANAGEMENT** *(provide copies of all policies and procedure 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*:_____
_____
_____
_____

Are passengers in tri-wheelers required to transfer to a wheelchair or a permanent seat after loading? Yes_____ No _____

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 _____
If "No", what is the training process?_____
_____

If "No", is there a supervisor who is able to speak the driver's native language? 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

**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.**

**Please provide a copy of any risk management procedures and manuals.**

**Please provide a copy of the Pre-Trip Vehicle Checklist (If one is not available, one will be provided to you)**

## 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 of Producer/Date_____

Print full name Agency_____

## Questions: 800-926-6771

RESET SUBMIT