



**Non-Emergency
Medical Transport™**

Specialized insurance
solutions for the medical
transportation industry.

1100 Virginia Drive | Suite 250 | Fort Washington, PA 19034

877.256.6215 | AffinityHCP.com

Email: nemt@affinityhcp.com
(submissions/endorsements)

Instructions:

The requested information is necessary before a quotation can be obtained.

Type or print clearly.

Answer ALL questions completely, leaving no blanks. If any questions, or part thereof, do not apply, print "N/A" in the appropriate space. Any spaces left blank will be interpreted to not apply.

Provide any supporting information on a separate sheet and reference the applicable question number.

Use for Yes or No answers and other selections.

This application must be completed, dated and signed by an authorized representative of the applicant. Underwriters will rely on all statements made in this application.

The information requested in this application is for underwriting purposes only and does not constitute notice to the Company under any Policy of a claim or potential claim. All such notices must be submitted to the Company pursuant to the terms of the Policy, if and when issued.

SECTION A. General Information

1. Legal name of the parent entity to be first named insured exactly as it shall be shown on the policy.

First Named Insured:

Mailing Address:

Street

City

State

Zip

County

Website:

Current Year and Projected Revenues:

Expiring: Past 12 Months

Projected 12 Months

2. What year did operations begin: _____

3. Number of years under current management: _____ Number of years under current insurance agency: _____

4. Have you ever operated under a different name? Yes No

5. Is your service a subsidiary of another company? Yes No

If yes, please explain. _____

6. Are any state and/or federal filings required? Yes No

If yes, please list permit numbers and states: _____

7. How many vehicles does the applicant operate:

Operational Ambulances _____

Vans/Mini Vans/Ambulettes _____

Standby Ambulances _____

Passenger Cars _____

Buses _____

Other (please specify) _____

8. What is the applicant's radius of operation (in miles)? _____

9. Does the operating radius cross any state lines? Yes No

If yes, into which states? _____

Are services provided in any of these major Metropolitan Areas? Check all that apply:

- Atlanta GA Boston MA Chicago IL Houston TX Los Angeles CA San Francisco CA Seattle WA
 Washington DC Miami FL New York City, NY incl the 5 boroughs Philadelphia PA

10. What was the fleet's total mileage last year: _____

11. Type of service: (check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Ambulance | <input type="checkbox"/> Non-Emergency Medical |
| <input type="checkbox"/> Paramedic | <input type="checkbox"/> Alarm Monitoring |
| <input type="checkbox"/> Adult Day Care | <input type="checkbox"/> School Transportation |
| <input type="checkbox"/> Social Service Organizations Transportation | <input type="checkbox"/> Special Needs Transportation |
| <input type="checkbox"/> Rescue Squad with Ambulance | <input type="checkbox"/> Rescue Squad without Ambulance |
| <input type="checkbox"/> Fire Department with Ambulance | <input type="checkbox"/> Fire Department without Ambulance |
| <input type="checkbox"/> Individual EMT | <input type="checkbox"/> Individual Paramedic |
| <input type="checkbox"/> Dispatch Service for Others | <input type="checkbox"/> Air Ambulance |
| <input type="checkbox"/> First Responder | <input type="checkbox"/> Off Shore EMT |
| <input type="checkbox"/> Psychiatric | <input type="checkbox"/> Incarcerated |
| <input type="checkbox"/> Taxi/Limo/General Transportation Service | <input type="checkbox"/> Other: _____ |

12. Indicate the number of annual calls:

Emergency (911) _____
Ambulatory Transports _____
Non-Emergency (Ambulance) _____
Wheelchair Transports _____

Non-911 Dispatch Services _____
School Transports _____
Child/Youth(under 18) _____
Other: _____

13. Please indicate the percentage of trips that fall into the following categories (columns should total to 100%):

Wheelchair: _____	Curb-to-Curb: _____	Prescheduled: _____
Stretcher: _____	Door-to-Door: _____	On-Demand: _____
Passenger: _____	Door-through-Door: _____	Emergency: _____
100%	100%	100%

14. What are the applicant's hours of operation? _____ Does the applicant provide weekend service? _____

15. Who dispatches calls for the applicant? _____

Do you utilize call screening measures to determine the use of lights and sirens by the dispatcher? _____

16. Has the applicant entered into any written contractual agreements to perform ambulance service for a government entity, hospital, or nursing home? Yes No

If yes, please explain: _____

17. Is the applicant aware of any circumstances which may result in a claim? Yes No

If yes, please provide full details: _____

18. Are there any losses in the prior five (5) years? Yes No

If yes, please provide full details: _____

SECTION B. Historical Information

Policy Term	Vehicle Count	Number of Transports
Expiring:		
First Prior:		
Second Prior:		
Third Prior:		
Fourth Prior:		

SECTION C. Drivers

19. Please indicate the number of drivers that fall into the following categories:

Total Number of Drivers: _____ Full-Time Drivers: _____ Volunteer Drivers: _____
Part-Time Drivers: _____ Backup Drivers: _____ Contracted Drivers: _____

20. Indicate the number of drivers by type:

EMT: _____ First Responder: _____ Paramedic: _____ Driver: _____ Other: _____

21. How many drivers are: Over 70? _____ Under 23? _____

22. If the applicant utilizes volunteer or contracted drivers, are they subject to all of the same qualifications as full-time and part-time drivers? Yes No

23. In the past twelve months, how many drivers were Added: _____ Replaced: _____

24. What is the basis for driver pay? Salary Hourly Trip Mileage Other

25. a. How often are MVRs checked for all drivers? _____

b. Does owner review MVRs for all drivers annually? Yes No
If yes, do you use pre-established criteria? Yes No

26. a. What percentage of drivers are trained in the following:

General Driver Orientation _____ Defensive Driving _____ CPR _____ Primary First Aid _____

Advanced First Aid _____ Passenger Assistance _____ Non-Medical Emergency Training _____

Emergency Vehicle Evacuation _____ Proper Wheelchair/Stretcher Securement Procedures _____

b: Is this training provided by a Medical Professional and/or Medical Director? Yes No

c: How frequently do you provide mandated driver training?

Annually: _____ Bi-Annually _____ Other _____ (please provide frequency)

SECTION D. Driver Hiring

27. Indicate the procedures used for pre-employment selection of drivers.

Written Application Physical Examination Motor Vehicle Record Check
 Criminal Background Check Written Driving Exam References Check
 Pre-employment Drug Testing Road Test Physical Abilities Test

28. Does the applicant have written driver criteria in place? Yes No

29. Is there an experience requirement for newly hired drivers? Yes No

If yes, what is the experience requirement? _____

30. Is there a minimum age requirement for drivers? Yes No

If yes, what is the minimum age? _____

31. If MVRs are ordered, what are the applicant's standards for an acceptable MVR? _____

SECTION E. Wheelchairs

32. How many vehicles are equipped with lifts? _____

33. How many vehicles are equipped with ramps? _____

34. Do vehicles equipped with lifts or ramps exclusively transport non-ambulatory individuals? Yes No

35. Is all equipment factory installed during vehicle construction? Yes No

36. What types of wheelchairs are accommodated within the vehicles:

Portable Motorized Youth/Child Stroller Tri-Wheeler/Scooter
 Lightweight Heavy Duty Industrial Reclining/Tilting

37. Are all persons involved in wheelchair transportation instructed in the proper use of securement equipment for all types of wheelchairs? Yes No

38. Are all restraint systems designed with a "4-point tie-down" and "forward facing" features? Yes No
39. How are wheelchairs secured to floor of vehicle? Fixed Access Locations Moveable Attachments Both
40. Are wheelchair passengers ever transported without the use of a restraint system? Yes No
41. Are passengers in scooter type chairs required to transfer to a wheelchair or a permanent seat after loading? Yes No

SECTION F. Stretchers

42. How many vehicles are equipped with stretcher equipment? _____
43. What types of stretchers are used in the vehicles? _____
44. Does the applicant use knee, hip, chest, and over the shoulder safety restraints on stretchers? Yes No
45. Do employees load and unload the stretchers? Yes No
If yes, what training on loading and unloading clients is provided? _____
46. Does an attendant accompany stretcher clients? Yes No
If yes, is the attendant: An employee of the applicant An employee of the organization requesting transport
 A personal assistant of the client

SECTION G. Safety Procedures

47. Does the applicant have a written safety program in place? Yes No
How long have these procedures been in place? _____
48. Does the insured employ a full-time Safety Director? Yes No
49. Does the insured have any salvaged vehicles in their fleet? Yes No
50. Is there a driver safety incentive plan in place? Yes No
If yes, please describe it: _____
51. Are drivers subject to random drug and alcohol testing? Yes No
52. Does the applicant maintain a drug and alcohol free workplace? Yes No
53. Is there a post-accident drug testing policy in place? Yes No
54. Are there formal accident investigation and review procedures in place? Yes No
55. Is there a progressive discipline policy for drivers involved in serious or multiple accidents/violations? Yes No
56. Does the applicant use global positioning systems (GPS) to monitor driver behavior? Yes No
(This question is **not** asking if GPS is used solely for navigation purposes.)
57. Are the vehicles equipped with cameras or accident event recorders? Yes No
58. Are there restrictions on the use of cell phones/hand-holds while operating vehicles? Yes No
59. Is there maximum number of driving violations allowed? Yes No
If yes, how many? _____
60. Is there maximum number of accidents allowed? Yes No
If yes, how many? _____
61. Does the applicant regularly perform pre-trip vehicle inspections? Yes No
62. Does the applicant regularly perform post-trip vehicle inspections? Yes No
63. Are call reports completed on every call and/or run? Yes No

SECTION H. Vehicle Maintenance

64. Does the applicant utilize a written vehicle maintenance program? Yes No
65. How often is maintenance performed? _____
66. Does the applicant maintain records listing vehicle defects and repairs? Yes No
67. Who performs maintenance on the fleet? In-house Outside Service
Are they certified by the manufacturer? Yes No
68. Does the applicant keep maintenance repair records on file for all vehicles? Yes No
69. Does the applicant perform any aftermarket vehicle modifications? Yes No
If yes, please explain: _____
70. Does the applicant lease, hire, or borrow vehicles from others? Yes No
71. Does the applicant lease, hire out, or loan vehicles to others? Yes No
72. Are all vehicles titled and licensed to the first named insured? Yes No
73. Is there any personal use of vehicles including owners/employees taking vehicles home? Yes No
If yes, please describe usage. _____
74. a. Where are vehicles stored after hours? _____
b. What provisions are made for vehicles when stored? _____
c. Are all vehicles garaged in the same location? Yes No
75. Do all vehicles comply with ADA standards? Yes No

SECTION I. Previous Insurance

76. **Professional Liability Insurance Coverage Information:** Provide the following information for each of the last three years starting with the current or expiring year.

Company	Policy Period	Limits of Liability	Retention/ Deductible	Premium	Claims-Made/ Occurrence
		\$ /	\$ /	\$	<input type="checkbox"/> Claims-Made Retro Date: <input type="checkbox"/> Occurrence
		\$	\$		<input type="checkbox"/> Claims-Made Retro Date: <input type="checkbox"/> Occurrence
		\$ /	\$ /	\$	<input type="checkbox"/> Claims-Made Retro Date: <input type="checkbox"/> Occurrence
		\$	\$		<input type="checkbox"/> Claims-Made Retro Date: <input type="checkbox"/> Occurrence
		\$ /	\$ /	\$	<input type="checkbox"/> Claims-Made Retro Date: <input type="checkbox"/> Occurrence
		\$	\$		<input type="checkbox"/> Claims-Made Retro Date: <input type="checkbox"/> Occurrence

77. **General Liability Insurance Coverage Information:** Provide the following information for each of the last three years starting with the current or expiring year.

Company	Policy Period	Limits of Liability	Retention/ Deductible	Premium	Claims-Made/ Occurrence
		\$ /	\$ /	\$	<input type="checkbox"/> Claims-Made Retro Date: <input type="checkbox"/> Occurrence
		\$	\$		<input type="checkbox"/> Claims-Made Retro Date: <input type="checkbox"/> Occurrence
		\$ /	\$ /	\$	<input type="checkbox"/> Claims-Made Retro Date: <input type="checkbox"/> Occurrence
		\$	\$		<input type="checkbox"/> Claims-Made Retro Date: <input type="checkbox"/> Occurrence
		\$ /	\$ /	\$	<input type="checkbox"/> Claims-Made Retro Date: <input type="checkbox"/> Occurrence
		\$	\$		<input type="checkbox"/> Claims-Made Retro Date: <input type="checkbox"/> Occurrence

78. Auto Liability Insurance Coverage Information: Provide the following information for each of the last three years starting with the current or expiring year.

Company	Policy Period	Limits of Liability	Retention/ Deductible	Premium	Claims-Made/ Occurrence
		\$ /	\$ /	\$	<input type="checkbox"/> Occurrence
		\$	\$		
		\$ /	\$ /	\$	<input type="checkbox"/> Occurrence
		\$	\$		
		\$ /	\$ /	\$	<input type="checkbox"/> Occurrence
		\$	\$		

SECTION J. Fraud Warning, Declaration & Certification and Signature

SECTION I. Fraud Warning, Declaration & Certification and Signature

Applicable in AL, AR, LA, MD, NM, RI and WV: Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. *Applies in MD Only

Applicable in CA: For your protection, California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Applicable in CO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Applicable in DC: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Applicable in FL and OK: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony (of the third degree)*. *Applies in FL Only.

Applicable in KS: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

Applicable in KY, OH and PA: 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.

Applicable in ME, TN, VA and WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties (may)* include imprisonment, fines and denial of insurance benefits. *Applies in ME Only.

Applicable in NJ: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Applicable in OR: Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

Applicable in PR: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for

each violation by a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Applicable in NY: Applicable to all claim forms for insurance and all applications for commercial insurance and accident and health insurance: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Applicable in NY: Applicable to all applications and claim forms for automobile insurance: Any person who knowingly and with intent to defraud any insurance company or other person files an application for commercial insurance or a statement of claim for any commercial or personal insurance benefits containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who, in connection with such application or claim, knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the value of the subject motor vehicle or stated claim for each violation.

NOTICE TO ALL OTHER APPLICANTS:

GENERAL: 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.

DECLARATION AND CERTIFICATION

BY SIGNING THIS APPLICATION, THE APPLICANT WARRANTS TO THE COMPANY THAT ALL STATEMENTS MADE IN THIS APPLICATION AND ANY SUPPLEMENTS ATTACHED HERETO ABOUT THE APPLICANT AND ITS OPERATIONS ARE TRUE AND COMPLETE, AND THAT NO MATERIAL FACTS HAVE BEEN MISSTATED OR MISREPRESENTED IN THIS APPLICATION OR HAVE BEEN SUPPRESSED OR CONCEALED.

THE APPLICANT AGREES THAT IF AFTER THE DATE OF THIS APPLICATION, ANY INCIDENT, OCCURRENCE, EVENT OR OTHER CIRCUMSTANCE SHOULD RENDER ANY OF THE INFORMATION CONTAINED IN THIS APPLICATION OR ANY OTHER DOCUMENTS SUBMITTED IN CONNECTION WITH THE UNDERWRITING OF THIS APPLICATION INACCURATE OR INCOMPLETE, THEN THE APPLICANT SHALL NOTIFY THE COMPANY OF SUCH INCIDENT, OCCURRENCE, EVENT OR CIRCUMSTANCE AND SHALL PROVIDE THE COMPANY WITH INFORMATION THAT WOULD COMPLETE, UPDATE OR CORRECT SUCH INFORMATION. ANY OUTSTANDING QUOTATIONS OR BINDERS MAY BE MODIFIED OR WITHDRAWN AT THE SOLE DISCRETION OF THE COMPANY.

COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. THE APPLICANT'S ACCEPTANCE OF THE COMPANY'S QUOTATION IS REQUIRED BEFORE THE APPLICANT MAY BE BOUND AND A POLICY ISSUED. THE APPLICANT AGREES THAT THIS APPLICATION, IF THE INSURANCE COVERAGE APPLIED FOR IS WRITTEN, SHALL BE THE BASIS OF THE CONTRACT WITH THE INSURANCE COMPANY, AND BE DEEMED TO BE A PART OF THE POLICY TO BE ISSUED AS IF PHYSICALLY ATTACHED THERETO. THE APPLICANT HEREBY AUTHORIZES THE RELEASE OF CLAIMS INFORMATION FROM ANY PRIOR INSURERS TO THE COMPANY.

THE APPLICANT AGREES TO COOPERATE WITH THE COMPANY IN IMPLEMENTING AN ONGOING PROGRAM OF LOSS-CONTROL AND WILL ALLOW THE COMPANY TO REVIEW AND MONITOR SUCH PROGRAMS THAT THE APPLICANT UNDERTAKES IN MANAGING ITS MEDICAL PROFESSIONAL EXPOSURES.

Applicant's Signature: _____ Date: _____

Title: _____



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Affinity Healthcare is a registered trade name of Affinity Insurance Services, Inc., a licensed producer in all states (TX 13695); (AR 100106022); in CA & MN, AIS Affinity Insurance Agency, Inc. (CA 0795465); in OK, AIS Affinity Insurance Services Inc.; in CA, Aon Affinity Insurance Services, Inc., (CA OG94493), Aon Direct Insurance Administrators and Berkely Insurance Agency and in NY, AIS Affinity Insurance Agency.