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Non-Emergency Medical Transportation Application

NOT TO BE USED ON TAXI OR ACCOUNTS BEING UNDERWRITTEN VIA THE ONLINE NEMT POLICY MANAGEMENT SYSTEM

BROKER INFORMATION

Agency: _____ Producer's Name: _____ Incumbent (Y/N): _____

Phone: _____ E-Mail Address: _____ Date: _____

APPLICANT INFORMATION

Applicant Name: _____ Year Established: _____ Federal ID #: _____

Contact: _____ Years under current ownership: _____ Active Filings? _____

Phone: _____ Company Website: _____ DOT: _____

Email Address: _____ PUC: _____

Mailing Address
(Include Street, P.O. Box, City, ST, & Zip) _____

Primary Garaging Location: _____
*(If different from mailing address); *Attach schedule of locations if more than one*

Subsidiaries/Affiliated Companies*

Name: _____ Relationship: _____

Type of Business: _____ Included in Insurance? _____

Have you ever operated under a different entity name? _____ If so, identify prior entity names: _____

** If necessary, attach separate list of subsidiaries for which coverage is sought under this Application*

Key Management Personnel

President/CEO: _____ Yrs. in Position: _____ Ph./Ext.: _____ Email: _____

Safety Director: _____ Yrs. in Position: _____ Ph./Ext.: _____ Email: _____

Operations Manager: _____ Yrs. in Position: _____ Ph./Ext.: _____ Email: _____

Maintenance Director: _____ Yrs. in Position: _____ Ph./Ext.: _____ Email: _____

Claim Contact: _____ Email: _____ Ph./Ext.: _____

Historical Information

Historical Insurance Coverage	Current	1st Prior	2nd Prior	3rd Prior	4th Prior
Insurance Carrier / Broker					
Limits & Deductibles					
Auto Liability Premium					
Physical Damage Premium					

Projected & Historical	Projected	Current	1st Prior	2nd Prior	3rd Prior	4th Prior
Gross Revenues						
Total Fleet Mileage						
Projected & Historical Vehicle Count						
Paratransit						
Paratransit - Wheelchair						
Fixed Route Transit > 20 passengers						
Fixed Route Transit 9-19 passengers						
Fixed Route Transit 1-8 passengers						
Private Passenger/Service						
Other (describe)						
Total Units:	0	0	0	0	0	0

REQUESTED COVERAGES

Effective Date: _____ **Requested Quote Date:** _____

AUTO COVERAGE	Limits Requested	Deductible
Auto Liability (Up to $5M CSL) *		
Uninsured/Underinsured Motorist		
Medical Payments		
Personal Injury Protection (PIP)		
Property Protection Insurance (MI Only)		
Hired Auto Liability (Fleet Accounts Only)		
Non-Owned Auto Liability		
Excess Liability (For limits more than $5M)		

* SIRs and Alternative Risk Transfer products may also be available dependent on risk characteristics.

Physical Damage Coverage ($1M Per Occurrence Limit for All Vehicles)	Deductible
Specified Perils	
Comprehensive	
Collision	

Total Stated Values: 0

Excess APD Coverage (Only applies if total stated amount is greater than $1M)	
Catastrophic Physical Damage Coverage requested?	◯ Yes ◯ No
Total Coverage Limit Desired: (Provide locations & total garaged values at each)	

OPERATIONS

Provide a brief description of your operation:	

Does the insured subcontract FOR others? If yes, provide copies of contracts. _____ (Y/N)

Does the company enter into any written or verbal agreements to provide service? _____ (Y/N) If yes, Idenfiy: _____

Does the company borrow or lease agents, servants, or employees from others? _____ (Y/N)

Do operations include any case work, home nursing / healthcare, hospice care, or off-site community education services? _____ (Y/N)

Does the company have any contracts to provide transportation for railroad employees? _____ (Y/N)

Does the company generate revenue through means other than the transportation of people? _____ (Y/N)

If yes, please explain: _____

RISK SPECIFICS:

Use as a % of total trips.

Wheelchair:		Curb-to-Curb:		0-50 Miles:		Prescheduled:	
Stretcher:		Door-to-Door:		51-200 Miles:		On-Demand:	
Ambulatory:		Door-through-Door:		200+ Miles:		**TOTAL %:**	0
TOTAL %:	0	**TOTAL %:**	0	**TOTAL %:**	0		

Do you contract with the following organizations to provide transportation? (Y/N)

ModivCare: yes no MTM: yes no Hopelink: yes no National MedTrans: yes no

Access2Care: yes no Veyo: yes no Southeastrans: yes no Other (list): yes no

TYPES OF SERVICE: **Total:** 0

Use as a % of total trips.

Medical Appointments:		Deviated Fixed Route:		Social Service:	
Adult Day Care Programs:		Fixed Route Transit:		Airport Service:	
Shopping:		ADA Overflow:		Taxi or Ridesharing:	
Special Needs School:		Employee Shuttle:		Railroad Employee:	
Head Start / Day Care Transportation:		Van Pool:		Other:	

DESTINATIONS (Must equal 100%) **Total:** 0

List areas served and percent of trips.

City, State	%	City, State	%	City, State	%
Example: Richfield, OH	30%				

HIRED & NON-OWNED

Do you hire from others for your use? _____ If yes, Annual Cost of Hire: _____

Do you hire from others with a driver? _____ If yes, Annual Cost of Hire: _____

Do you lease to others for their use? _____ If yes, Annual Income Derived: _____

Do you lease to others without a driver? _____ If yes, Annual Income Derived: _____

Is there assumed liability by contract/agreement? If yes, provide a copy. _____

Do any employees use their own autos in the Applicant's business? _____ If yes, how many? _____

Do these employees transport clients with their own autos? _____ If yes, how often? _____

Does the Applicant require proof of insurance from these employees? _____ If yes, what minimum auto limits are required? _____

Does the Applicant use subcontractors for any operations? _____ If yes, describe: _____

Provide the annual "cost of hire" from subcontractors. _____

What limits are required from the subcontractor? _____

Is the Applicant added as an additional insured on its subcontractors' policy? _____

*** Please provide copies of contracts with subcontractors.**

SAFETY & MAINTENANCE

Do you have the following (Check all that apply):

Written maintenance program: yes no Written driver-training program: yes no Written safety program: yes no

Written Cell phone policy: yes no Written accident reporting procedures: yes no Written employee manual: yes no

Your vehicle maintenance program includes (Check all that apply):

A service record for each vehicle: yes no Vehicle daily condition reports: yes no Pre/Post trip inspections: yes no

In-Vehicle Technology:

Do you currently utilize AERs (Automated Event Recorders)? _____ Name of AER Vendor (if applicable): _____ % of fleet equipped? _____

Do you utilize a Telematics Service Provider (TSP)? _____ Name of TSP Vendor (if applicable): _____ % of fleet equipped? _____

Is there a formal process to consistently monitor and coach drivers? _____

Explain how in-vehicle technology is used to modify driver behavior? _____

Other Maintenance & Safety Questions:

How many certified mechanics do you employ? _____ Who is in charge of claims? _____

How often do you hold safety meetings? _____ Will claims be reported directly to NIIC? _____

Is attendance mandatory? _____ Is personal use of vehicles permitted? _____

Describe how personal use of vehicles is monitored: _____

Describe the Applicant's preventative maintenance policy: _____

Describe how and when drivers are evaluated: _____

Describe Driver Disciplinary plan: _____

Vehicles & Equipment

Number of vehicles equipped with:

Lifts: _____

Ramps: _____

Passenger restraint system: _____

Domes and/or Meters: _____

Lights/Sirens: _____

Types of Wheelchairs transported (check all that apply)

Motorized: ○ yes ○ no

Lightweight: ○ yes ○ no

Heavy Duty Industrial: ○ yes ○ no

Youth/child stroller: ○ yes ○ no

Scooter: ○ yes ○ no

Reclining/tilting: ○ yes ○ no

Tri-wheeler: ○ yes ○ no

Portable: ○ yes ○ no

Other (describe): _____

Are ALL persons involved in wheelchair transportation instructed in the proper use of securement equipment for all types of wheelchairs? _____

How often is wheelchair securement training performed? _____

Is all equipment factory-installed during vehicle construction? _____

Is the passenger restraint system a "4-point tie down and forward facing" design? _____

If yes, are shoulder belts retractable or non-retractable? _____

Is floor securement of wheels accomplished with fixed locations or moveable attachments, ie tracks? _____

Are wheelchair passengers ever permitted to ride in the vehicle in other than the designated securement location? _____

Are wheelchair passengers ever transported without a restraint? _____

Are passengers in tri-wheelers required to transfer to a wheelchair or a permanent seat after loading? _____

Describe procedures followed if wheelchair is not standard: _____

STRETCHER / NON-EMERGENCY AMBULANCE

Number of vehicles equipped with stretcher equipment: _____

What types of stretchers do you use in your vehicles? _____

Type of stretcher vehicle securing system? _____

Type of patient stretcher safety restraint system? _____

Who does the loading and unloading of the stretchers? _____

What training is provided for employees that load and unload? _____

Number of units that have life support equipment: _____

Do any vehicles respond to 911 calls directly or indirectly? _____

Does an attendant accompany stretcher clients? _____

If "Yes", is attendant an employee of the Applicant, employee of the facility requesting transportation or personal assistant of the passenger? _____

Driver Information

Driver Hiring criteria (check all that apply):

Full Medical: ○ yes ○ no

Drug Test: ○ yes ○ no

Current MVR: ○ yes ○ no

Min. Age: ○ yes ○ no

Max. Age: ○ yes ○ no

Written Application: ○ yes ○ no

Road Test: ○ yes ○ no

Written Test: ○ yes ○ no

Reference Checks: ○ yes ○ no

Background Checks: ○ yes ○ no

Do you agree to report all drivers to NIIC? ○ yes ○ no

Are all drivers properly licensed and DOT Compliant? ○ yes ○ no

Have all drivers been driving a similar vehicle for 2+ years? ○ yes ○ no

Do all drivers have at least 2 years U.S. driving experience? ○ yes ○ no

Is disciplinary plan documented for all drivers? ○ yes ○ no

Are criminal background checks performed on ALL drivers? ○ yes ○ no

Are MVRs pulled annually? ○ yes ○ no

Are their written MVR hiring guidelines? ○ yes ○ no

Is drug testing done annually, pre-hire, and post accident? ○ yes ○ no

Indicate the number of drivers that fall within the following categories:

Total Drivers: _____

Over 65: _____

Under 25: _____

Hired in the last 12 months: _____

Volunteers: _____

Independent Contractors: _____

** Provide copy of IC agreement if applicable*

Driver training (check all that apply)

Passenger Assistance Training: ○ yes ○ no

Non-Emergency Medical Training: ○ yes ○ no

Wheelchair / Stretcher Securement: ○ yes ○ no

Primary First Aid: ○ yes ○ no

Defensive Driving: ○ yes ○ no

Driver Orientation: ○ yes ○ no

GENERAL LIABILITY

(Complete only if requested); Fill-in limits requested below

Each Occurrence: _____ General Aggregate: _____ Personal & Advertising Injury: _____

Location Address (list each)	Square Footage / Class		Owned/Rented?	Fenced?	Night Watch?	Security Cameras?
	Office	parking				

Are sexual abuse & molestation limits higher than $50K required by contract? ○ yes ○ no

Are any of the above locations the primary residence of the Applicant? ○ yes ○ no

Do you allow parking by those other than employees or customers? ○ yes ○ no

Do operations involve storing, treating, discharging, applying, disposing of, or transporting of hazardous material (landfills, fuel tanks, waste)? ○ yes ○ no

Do you collect a fee for parking at any of the above locations? ○ yes ○ no

List any non-transportation operations at this location: ○ yes ○ no

Do you provide any CDL training to the general public? ○ yes ○ no

Do you provide training on non-discriminatory practices? ○ yes ○ no

Do you offer or sell any type of alcohol on the units? ○ yes ○ no

Does your business offer tour transportation? ○ yes ○ no

If Yes, please describe the tour activities offered: _____

List any non-transportation operations at this location: _____

If you answered "yes" to any of the questions to the left, please provide an explanation below.

Mandatory Underwriting Questions

If yes, please explain.

During the past 4 years, has your insurance ever been obtained through an Assigned Risk Plan? _____

Do you provide Worker's Compensation for all employees? _____

Have you ever filed for or contemplated filing for bankruptcy or had bankruptcy proceedings initiated against you by another party? _____

Has your operating authority ever been suspended or revoked, or have you received notice of intent to suspend? _____

Is all equipment operated under the applicant's authority scheduled on the applicant's driver and vehicle schedule? _____

Has any company provided notice of cancellation/non-renewal or otherwise canceled/refused to renew your insurance, including this term? _____

(If yes, please attach a copy of the cancellation/non-renewal notice.)(not applicable in MO)

Applicant and Producer: Please sign and date the Applicant's Statement Below.

APPLICANT'S STATEMENT

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

APPLICANT

Signature of Officer/Manager of Named Insured _____ Date _____

Print Full Name _____ Title _____

PRODUCER

Signature _____ Date _____

Print Full Name _____ Agency _____

IN ADDITION TO THIS APPLICATION, PLEASE SUBMIT THE FOLLOWING:

* Currently valued (within 3 months of policy incept), company issued loss runs for the current policy year and 4 prior years.
* Current driver's list and motor vehicle records for ALL drivers. Include dates of birth, dates of hire, years' experience, and drivers' license numbers.
* Current DOT medicals/authorization for all drivers.
* Current Vehicle list, including year, make, complete VIN, seating capacity, vehicle type, stated amount, deductible requested, and which units are wheelchair equipped.
* Pictures (inside and outside) and DOT inspections for units which are 15 years or older.
* Copy of cancellation or non-renewal notice issued in the current or 4 prior years.
* Applicable written agreements for all hired, leased or assumed liability arrangements.