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An Amwins company

PARATRANSIT SUPPLEMENTAL APPLICATION

Named Insured: _____
Address: _____
City: _____ State: _____ Zip: _____
Years in Business: _____ Years in Paratransit Business: _____ Years Under Current Ownership: _____
Phone: _____ Website: _____
Insurance Contact: _____ E-Mail: _____

What is the primary purpose of your operation and how are services provided?

_____

_____

_____

General Information

How would you describe your operation?
☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Other_____

Do you have the following coverages in place?
☐ General Liability ☐ Professional Liability ☐ Workman's Compensation ☐ Umbrella/Excess

Are any filings required? ☐ Yes ☐ No
If yes, please provide filing entity and number: _____

Does the ownership/management of this company operate or have an interest in any other transportation businesses? Yes ☐ No ☐ (If yes, please describe):_____

_____

How long has this organization been operating under the present name? _____
Please list all subsidiary and/or prior names under which business was operated:

_____

_____

Please detail your insurance/premium history:

	Insurance Company	Auto Liability Premium	Physical Damage Premium	Physical Damage Total Insured Value	General Liability Premium	Annual Revenues	Total Trips
Proposed Year							
Expiring Year							
Expiring Year +1							
Expiring Year +2							
Expiring Year +3							
Expiring Year +4							

What is your target pricing per unit for the proposed year? _____

Have any of this organization's Auto Liability policies been canceled or non-renewed within the past 3 years? ☐ Yes ☐ No
If Yes, please explain: _____

_____

_____

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Operations

In what cities do you provide services?

City	% of Operations	City	% of Operations

PLEASE COMPLETE EACH COLUMN IN THE TABLE BELOW.
Please provide an amount, as a percentage of total trips for each.

Type of Transport		**Type of Service**		**Service Provided**		**Service Arrangements**		**Radius of Operations**	
Non-Emergency	_____ %	Wheelchair	_____ %	Curb to Curb	_____%	Pre-Scheduled	_____ %	0-50 miles	_____ %
Emergency	_____ %	Stretcher	_____ %	Door to Door	_____%	On-Demand	_____ %	50-200 miles	_____ %
OTHER	_____ %	Ambulatory	_____ %	Door thru Door	_____%	Fixed Route	_____ %	200+ miles	_____ %
TOTAL	100 %	TOTAL	100 %	TOTAL	100 %	TOTAL	100%	TOTAL	100%

Description of OTHER, if applicable: _____

Please provide the names of any entities that contract with you to provide transportation services: _____
_____

Are there any contractual arrangements / hold harmless agreements that have been entered into requiring the assumption of liability for another party? ☐ Yes ☐ No

(If Yes, please provide a copy of the contract.)

Is any work subcontracted to others? ☐ Yes ☐ No

If Yes, please describe the following:

- What services are subcontracted out? _____
- What percentage of trips are subcontracted out? _____
- Do you require subcontracted services to go through your MVR ordering requirements? ☐ Yes ☐ No
- Are certificates of insurance obtained? ☐ Yes ☐ No
- Are limits equal to or greater than your liability limits? ☐ Yes ☐ No

Age of Clients: 18 years old or less _____% 18 to 60 Years Old _____% Older than 60 _____%

Will you be transporting any pregnant women? ☐ Yes ☐ No

Do you administer any anesthesia? ☐ Yes ☐ No

Do you transport any patients against medical advice? ☐ Yes ☐ No

Do you transport passengers with oxygen tanks? ☐ Yes ☐ No

If Yes, how are tanks secured during transit? _____

Are any revenues generated from non-transportation activities? ☐ Yes ☐ No

If Yes, please explain: _____

Is any work dispatched by a TNC (Uber, Lyft etc.)? ☐ Yes ☐ No

Do you ever transport passengers using rented vehicles? ☐ Yes ☐ No

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Vehicle Information

Please detail the number of vehicles in your operation, by year:

	Vans (1-8 Passenger)	Mini-Van/Bus (9-20 Passenger)	Buses (20+ Passenger)	Private Passenger/Service
Proposed Year				
Expiring Year				
Expiring Year +1				
Expiring Year +2				
Expiring Year +3				
Expiring Year +4				

How many vehicles are equipped with: Lifts _____ Ramps _____

Are drivers allowed to take vehicles home? ☐ Yes ☐ No

If Yes, is any personal use allowed? ☐ Yes ☐ No

If Yes, is any family member usage permitted? ☐ Yes ☐ No

Are vehicles used for any purpose other than transporting passengers for hire? ☐ Yes ☐ No

If yes, please explain: _____

Are all vehicles titled and registered to the named insured? ☐ Yes ☐ No

If no, is there a lease agreement between the Named Insured and the vehicle owner? ☐ Yes ☐ No

Are all vehicles registered in the state in which they operate? ☐ Yes ☐ No

Do you have a written vehicle maintenance program? ☐ Yes ☐ No

How often are vehicles serviced? _____

Who provides maintenance on your vehicles? _____

How often are maintenance records reviewed by management? _____

Are all wheelchair vehicles equipped with forward facing, 4-point tie downs? ☐ Yes ☐ No

Are any vehicles equipped with lights and/or sirens? ☐ Yes ☐ No

If yes, please describe circumstances when they are used: _____

Employee Information

Are all drivers employees? ☐ Yes ☐ No

How many of the following do you have?

Full Time Drivers: _____ Regular Part Time Drivers: _____

Back Up Drivers: _____ Dispatchers: _____

Maintenance: _____ Administrative: _____

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

How often do you order MVRs? _____

What percentage of driver turnover do you have annually? _____

Do you have driver hiring criteria in place? ☐ Yes ☐ No

If yes, is the criteria in writing? ☐ Yes ☐ No

If yes, does it include the following:

- MVRs checked prior to hire ☐ Yes ☐ No
- Verification that license is appropriate for type of vehicle ☐ Yes ☐ No
- Drug/Alcohol testing at time of hire ☐ Yes ☐ No
- Reference checks at time of hire ☐ Yes ☐ No
- Defensive Driving Course prior to hire ☐ Yes ☐ No
- Road test given prior to hire ☐ Yes ☐ No
- Orientation in vehicle with experienced driver ☐ Yes ☐ No
  - If yes, how long? _____
- Criminal Records Check/CORI Check ☐ Yes ☐ No
  - If yes: ☐ State ☐ Federal

Please describe your standards for an acceptable MVR: (or attach a copy of your driver hiring criteria):_____

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Safety & Claims Management

Who is responsible for reporting claims?
Name/Title: _____ E-mail: _____ Phone: _____
Who is responsible for Safety Training?
Name/Title: _____ E-mail: _____ Phone: _____

Please describe your accident review procedures: _____
_____
How many vehicles are equipped with Accident Event Recorders or Cameras? _____
What is the name/brand of the AER Units / Cameras in place? _____
Where do cameras record? ☐ Interior ☐ Exterior ☐ Both (dual facing)
How is data reviewed? ☐ Third Party ☐ Internal (If internal, who is responsible?_____)
Are MVRs checked on all drivers at least annually? ☐ Yes ☐ No
What is the minimum number of years driving experience required? _____
Is there a driver incentive program in place? ☐ Yes ☐ No
If yes, please describe: _____
Please identify the types of special driver training that your drivers receive:

☐ General Driver Orientation
☐ Primary First Aid
☐ CPR
☐ Human Relations Skills
☐ Emergency Vehicle Evacuation
☐ Defensive Driving
☐ Advanced First Aid
☐ Passenger Assistance Training
☐ Non-Medical Emergency Training
☐ Proper Wheelchair/Stretcher Securement Procedures

Is there a post accident drug testing policy in place? ☐ Yes ☐ No
Do you have a "bus empty" procedure? ☐ Yes ☐ No
If yes, please describe: _____
How does your current Auto Liability policy address claims arising from loading and unloading patients? ☐ Silent ☐ Excluded ☐ Sublimit _____

Professional Liability

Has any claim or suit for an error, omission or malpractice ever been made against the applicant, the applicant's organization or any employees/staff working on the applicant's behalf? ☐ Yes ☐ No
If Yes, how many? _____ *(Please complete a supplemental form for each)*
Are you or any proposed insured for this insurance aware of any claim or suit, or any act, error, omission, fact, circumstance or records request from an attorney which may result in a malpractice, general liability or products liability claim or suit? ☐ Yes ☐ No
If Yes, has each of these been reported to the current or any prior insurer? ☐ Yes ☐ No
If Yes, how many? _____ *(Please complete a supplemental form for each)*
Has anyone on staff:
Ever been the subject of disciplinary /investigative proceedings or reprimand by a governmental/administrative agency, hospital or professional association? ☐ Yes ☐ No
Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? ☐ Yes ☐ No
Ever been treated for alcoholism or drug addiction? ☐ Yes ☐ No

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FRAUD STATEMENTS

Any person who knowingly and with intent to defraud any insurance company or another 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 the person to criminal and (NY; substantial) civil penalties. (Not applicable IN, CO, FL, HI, MA, NE, OH, OK, OR, VT, IN, DC, LA, ME, TN, VA, and WA insurance benefits may also be denied).

In Florida, any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claims or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

In Massachusetts, Nebraska, Oregon and Vermont, any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance or statement of claim containing any material 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 may subject the person to criminal and civil penalties.

In Ohio, any person who, with intent to defraud or knowing that he is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

In Pennsylvania, 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:_____