APPLICATION FOR PARATRANSIT PROVIDERS

GENERAL INFORMATION

1. Expiration Date or Effective Date (if new venture): ________________
2. Named Insured: ________________
3. DBA: ________________
4. Mailing Address: ________________
5. Physical Address: ________________
6. Phone: ________________ Fax: ________________
7. Website: ________________
8. Owner's Name: ________________ Email: ________________
9. Type of Entity: Corporation Individual Partnership Joint Venture LLC
10. FEIN: ________________
11. Date business started under current ownership: ____________ *Is this a new venture? Yes No

***If less than 3 years, we will need resume on all managers/owners.**

12. Are PUC, Form E/F, or MC-90 filings required? Yes No (If yes, provide copies.)
13. Is your business a subsidiary or division of a parent company? Yes No

    If yes, name of company: ________________
14. Has your business had a change of ownership in the past 3 years? Yes No If yes, please explain:

    ____
15. Have you ever been cancelled or non-renewed? Yes No If yes, please explain:

    ____
16. Have you ever filed for bankruptcy? Yes No If yes, please explain:

    ____
17. Estimated Annual Revenue: $ ____________
18. Hours of Service: ____________ Days of Service: ____________
19. Radius of operation (total to 100%): ______% 0-50 Miles ______% 51-200 Miles ______% 200+ Miles

OPERATIONAL INFORMATION

1. What major cities do you transport in? ________________
2. Do you provide public livery other than specialized transportation services for the elderly, physically challenged or mentally challenged? Yes No If yes, please describe:

   ____
3. Is your business affiliated or associated with any transit authority? Yes No

   If yes, please list which authorities: ________________

4. Does your service operate any of the following? Taxi Cab service Limousine Service Valet/Shuttle Service
Other (please describe):______________________________

5. Do any of your vehicles have lights and sirens? Yes No

If yes, please specify which vehicle and the use: ____

6. Total estimated number of annual transports:_________

Percentage of Total Transports (Total MUST equal 100%):

Wheelchair Van	%	Curb to Curb	%	Pre-scheduled	%
Gurney/Stretcher Vans	%	Door to Door	%	On-Demand	%
Ambulatory Vans/Sedans	%	Door through Door	%		
Private Passenger/Service	%				

7. **Special Equipment –** ***Please attach vehicle schedule listing all vehicles, and indicating those with special equipment***

Are any vehicles equipped with the following?		**If Yes, indicate the number of vehicles with this type of equipment below:**
Lift-Out/Pull-Out Ramp	Yes No	
Mechanical Lift	Yes No	
Wheelchair Passenger/Patient Safety Restraint System	Yes No	
Automatic Braking Sensor, or Any other *Active* Accident-Avoidance Technology	Yes No	
Driver's Seat Vibration or Audible Alarm, or Any other *Passive* Accident-Avoidance Technology	Yes No	
GPS	Yes No	
In-Vehicle Camera	Yes No	

8. Do you subcontract work to others? Yes No Are certificate of insurance obtained? Yes No

9. Are all vehicles both titled and registered to the named insured? Yes No**
*****If no, there must be a lease agreement between the named insured and the vehicle owner*****

10. Are all vehicles titled/licensed in the state in which they operate? Yes No

DRIVER INFORMATION

1. In the past year, how many drivers were hired?_______ How many were terminated?_______
2. What is your minimum driver age? _______
3. Number of currently employed drivers: ______Full-Time ______Part-Time

I . Does your service review drivers' motor vehicle reports? Yes No
If yes, how often? Annually Every 2-3 Years More than 3 years Other: ____________

Í . Do you have a driver training program? Yes No

Î . Are your drivers employees of your company or independent operators? Employees Independent Operators

VEHICLE MAINTENANCE

1. Do you have a written vehicle maintenance program? Yes No
2. Do you keep maintenance repair records on file for each vehicle? Yes No
3. How often are your vehicles serviced? 3,000 Miles Monthly Semi-Annually Other: ____________

SAFETY & RISK MANAGEMENT

1. Safety Manager's Name: ________________________ Phone Number: ________________________

   Email: ____
2. Check all that apply to your employee selection process:

   Written Application Job Specific Physical Examination Psychological Testing

   Criminal Background Check MVR Check Pre-Hire Drug Screening

   Obtain Evidence of Pertinent Certification Licensure
3. Do you conduct post-employment drug testing? Yes No
4. Is a post-accident drug testing policy in place? Yes No

Í . Do any of your employees take the company vehicle home at night? Yes No
If yes, please describe your company policy regarding personal use of the vehicle:

____

Î . Are safety violations (i.e. auto crashes, patient handling events) part of your progressive discipline process? Yes No

Ï . Are drivers trained to assist elderly and/or handicapped passengers? Yes No

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

J. Are accident investigation and review procedures, including records, maintained? Yes No
Do the review procedures include driver disciplinary procedures? Yes No

1€. How often do you hold safety meetings? ______________________

COVERAGE & LIMITS OPTIONS

1. **Auto Liability Coverage:** Yes No
   Desired Auto Liability Limit: $_______________
   Uninsured/Underinsured Motorist: $_______________

2. **Automobile Physical Damage:** Yes No
   Desired Collision Deductible: $_______________
   Desired Comprehensive Deductible: $_______________

3. **Medical Professional Liability:** Yes No
   If Yes: Occurrence Claims Made (Retroactive Date:__________)
   Desired Limits: $1,000,000 each incident / $2,000,000 aggregate
   $1,000,000 each incident / $3,000,000 aggregate

4. **General Liability:** Yes No
   If Yes: Occurrence Claims Made (Retroactive Date:__________)
   Desired Limits: $1,000,000 each incident / $2,000,000 aggregate
   $1,000,000 each incident / $3,000,000 aggregate
   Stop Gap Employers Liability:* Yes No
   Only available if you have employees in one or more of the following states: North Dakota, Ohio, Washington, and Wyoming

5. **Abuse Liability:** Yes No
   If Yes: Occurrence Claims Made (Retroactive Date:__________)
   Desired Limits: $ _________________________

6. **Employee Benefits Liability:** Yes No Retroactive Date: __________

7. **Employment Practices Liability:** Yes No Retroactive Date: __________

8. **Cyber Liability:** Yes No Retroactive Date: __________

9. **Real and Personal Property:** Yes No ***If yes, please fill out the Supplemental Property application***
   Building Coverage: Yes No
   Contents Coverage: Yes No

10. **Portable Equipment:** Yes No
    Desired Limit: $_____________
    Desired Deductible: $_____________

11. **Workers' Comp Coverage:** Yes No ***If yes, please fill out the Workers' Comp application***
    Effective Dates: _________ to _________
    Desired Limits: Each Accident / Policy Limit / Each Employee
    $1,000,000 / $1,000,000 / $1,000,000
    $500,000 / $500,000 / $500,000
    $100,000 / $500,000 / $100,000

12. **Umbrella:** Yes No
    Desired Limit: $_____________ in excess of scheduled primary limits

SUPPLEMENTAL PROPERTY APPLICATION

1. Business Name: ____

2. Effective date of coverage desired: __________ Building occupied as: ______________________

3. **Property and Location Information**: Location #:_______ Building #:_______

4. Location Street Address: ______________________________________

City: ______________________ State:_______ Zip: __________ Building Age:_______

5. Do you: Own Rent Lease

6. Total square footage of building: _________

7. Total square footage you occupy: _________

8. Number of stories: _________

9. Is the building sprinklered? Yes No

10. Building Construction: Frame Joisted Masonry Non-Combustible Mason Non-Combustible Modified Fire Resistive Fire Resistive

11. Any other businesses in the building? Yes No If yes, what kind?______________________

12. Do you have a burglar alarm? Yes No If yes: Central Station Local Gong

13. Do you have fire extinguishers and smoke detectors? Yes No

AMOUNT OF INSURANCE:

1. Building value: $_______________ (Complete value if you own the building)

2. Contents, Furniture, Fixtures & Equipment (inside) Value: $_______________

3. Computer Hardware Value: $________________ Computer Software Value: $________________

4. Deductible: $250 $500 $1,000

5. Do you have a mortgagee and/or loss payee? Yes No If yes, please fill out the following:

Name of Interest	Address	Attn	Interest*	Coverage**

****Interests:*** ***M*** *= Mortgagee* ***LP*** *= Loss Payee*

*****Coverages:*** ***B*** *= Building* ***C*** *= Contents*

VEHICLE SCHEDULE

	Year	Make	Model/Unit #	VIN	Garaging Location	Use of Vehicle*	Original Cost New	Today's Value
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

***Use of vehicle:** **PWCV** = Paratransit Wheelchair Van **PAML** = Paratransit Ambulatory
GV = Gurney Van **PPS** = Private Passenger/Service (non-patient transport)

DRIVER SCHEDULE

***Please list all drivers, this would include full time, part time, volunteer, infrequent or incidental who are authorized to operate any of the company vehicles.**

Name (as it appears on license)	Date of Birth	Driver's License #	State Licensed	Date of Hire

SCHEDULE OF LOCATIONS

	Street Address	City, State	Zip Code	Square Footage	Building Occupied As
1.					
2.					
3.					
4.					
5.					

LIST OF CERTIFICATE HOLDERS

Certificate Holder Name:	Address:	Attn:	Interest*	Coverage**

****Interests:*** ***V*** *= Verification of Insurance* ***A*** *= Additional Insured* ***L*** *= Loss Payee*

****Coverages:*** ***GL*** *= General Liability* ***AL*** *= Auto Liability* ***APD*** *= Auto Physical Damage*
PC *= Property Contents* ***PB*** *= Property Building* ***IM****= Portable Equipment*

FRAUD WARNINGS

GENERAL FRAUD STATEMENT (not applicable in Colorado, Florida, Hawaii, Massachusetts, Nebraska, Ohio, Oklahoma, 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 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. In the District of Columbia, Louisiana, Maine, Tennessee and Virginia, and Washington insurance benefits may also be denied.

NOTICE TO COLORADO APPLICANTS: THIS NOTICE IS A PART OF YOUR APPLICATION FOR PROFESSIONAL

LIABILITY INSURANCE: 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.

NOTICE TO FLORIDA APPLICANTS: 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.

NOTICE TO HAWAII APPLICANTS: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment or both.

NOTICE TO OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: A person who knowingly and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO OREGON APPLICANTS: 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.

NOTICE TO VERMONT APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto, may be committing a crime, subjecting the person to criminal and civil penalties.

THE APPLICANT DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE.
THE APPLICANT AGREES THAT IF THE INFORMATION SUPPLIED ON THE APPLICATION BY THE APPLICANT CHANGES BETWEEN THE DATE OF THE APPLICATION AND THE EFFECTIVE DATE OF INSURANCE, APPLICANT WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS AND/OR AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

Please forward the completed application to us now. Request the following and once you have received them please send to us:

- *Currently valued loss runs for the past 5 years*
- *Copies of your current insurance policies*

Applicant's Signature: ____ Date: _________

Producer's Signature: ____ Date: _________

Please return signed and completed application to:

Cindy Elbert Insurance Services, Inc.
15182 N. 75th Ave., Ste. 100, Peoria, AZ 85381
Phone: 602-942-3900 | Fax: 602-942-4300 | Email: info@ambulanceinsurance.com