

# APPLICATION FOR PARATRANSIT PROVIDERS

- 1. Expiration Date or Effective Date (if new Business): \_\_\_\_\_
- 2. Full Name of Service: \_\_\_\_\_
- 3. Street Address: \_\_\_\_\_
- 4. City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
- 5. Mailing Address (if different): \_\_\_\_\_
- 6. Phone #: \_\_\_\_\_ FAX #: \_\_\_\_\_
- 7. Email address: \_\_\_\_\_ Web address www. \_\_\_\_\_
- 8. Name of contact person: \_\_\_\_\_ Title: \_\_\_\_\_  
Phone # for contact: \_\_\_\_\_
- 9. Type of Organization:  
 Individual     Partnership     LLC     Corporation- FEIN# \_\_\_\_\_
- 10. Date your service was legally established? \_\_\_\_\_ \*  
**\* if less than 3 years we will need resume on all managers/owners.**  
  
Number of years in this type of business: \_\_\_\_\_  
Number of year's current ownership: \_\_\_\_\_  
Number of year's current management in place: \_\_\_\_\_
- 11. Have you ever operated under a different name?     Yes     No  
If yes, what name: \_\_\_\_\_
- 12. Is your service a subsidiary of another company?     Yes     No  
If yes, please explain: \_\_\_\_\_
- 13. Do you provide transportation for non-emergency medical appointments?     Yes     No
- 14. Do you provide public livery other than specialized transportation services for the elderly, physically challenged or mentally challenged?     Yes     No  
If yes, please describe: \_\_\_\_\_
- 15. Is your business affiliated or associated with any transit authority?     Yes     No  
If yes, please list which authorities: \_\_\_\_\_

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16. Does your service operate any of the following?  
 Taxi Cab service       Limousine Service       Valet/Shuttle Service  
 Other (please describe): \_\_\_\_\_
17. Which service(s) does your company provide?  
 Curb to Curb       Door to Door       Door through Door
18. Do any of your vehicles respond to emergency calls?  Yes  No  
If yes, please explain: \_\_\_\_\_
19. Do any of your vehicles have sirens or emergency lights?  Yes  No  
If yes, please specify which vehicle and the use: \_\_\_\_\_
20. Total estimated number of annual paratransit calls: \_\_\_\_\_  
\_\_\_\_\_ % of total paratransit calls are Wheelchair  
\_\_\_\_\_ % of total paratransit calls are Gurney/Stretcher  
\_\_\_\_\_ % of total paratransit calls are Passenger Van
21. What is your average mileage per transport? \_\_\_\_\_ miles
22. What major cities do you provide transportation in? \_\_\_\_\_  
\_\_\_\_\_
23. Describe your driver dispatching and/or scheduling procedures: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
24. Describe your accident review program: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
25. 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:  
\_\_\_\_\_  
\_\_\_\_\_
26. Describe your vehicle maintenance procedures: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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**SUPPLEMENTAL PROPERTY APPLICATION**

Business Name: \_\_\_\_\_

Effective date of coverage desired: \_\_\_\_\_ Building occupied as \_\_\_\_\_

**Property and Location Information:** Location# \_\_\_\_\_ Building # \_\_\_\_\_

Location Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Building Age \_\_\_\_\_

Are you a ( ) owner, ( ) tenant or ( ) lessee? Total square footage of building: \_\_\_\_\_

Total square ft you occupy: \_\_\_\_\_ # of stories: \_\_\_\_\_ Sprinklered? ( ) yes ( ) no

Building Construction: ( ) frame ( ) stucco ( ) brick ( ) block ( ) steel ( ) other: \_\_\_\_\_

Any other businesses in the building?: ( ) yes ( ) no What Kind? \_\_\_\_\_

Do you have a burglar alarm?: ( ) yes ( ) no What Kind?: \_\_\_\_\_

Do you have a safe?: ( ) yes ( ) no What Kind?: \_\_\_\_\_

Do you have fire extinguishers and smoke detectors? ( ) yes ( ) no

**AMOUNT OF INSURANCE REPLACEMENT COST**

Building value: \$ \_\_\_\_\_ (Complete value if you own the building)

Contents, Furniture, Fixtures & Equipment (inside) Value: \$ \_\_\_\_\_

Computer Hardware Value: \$ \_\_\_\_\_ Computer Software Value: \$ \_\_\_\_\_

Deductible: ( ) \$250 ( ) \$500 ( ) \$1,000

Certificate Holder: \_\_\_\_\_

Address: \_\_\_\_\_

Attn: \_\_\_\_\_ Phone#: \_\_\_\_\_ FAX#: \_\_\_\_\_

- Additional Insured       Mortgagee       Loss Payee





