



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 [X] 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: [input field]

Mailing Address: [input fields for Street, City, State, Zip, County]

Website: [input field]

Current Year and Projected Revenues:

Expiring; Past 12 Months [input field] Projected 12 Months [input field]

2. What year did operations begin: [input field]

3. Number of years under current management: [input field] Number of years under current insurance agency: [input field]

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

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

If yes, please explain. [input field]

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

If yes, please list permit numbers and states: [input field]

7. How many vehicles does the applicant operate:

Operational Ambulances [input field] Vans/Mini Vans/Ambulettes [input field]
Standby Ambulances [input field] Passenger Cars [input field]
Buses [input field] Other (please specify) [input field]

8. What is the applicant's radius of operation (in miles)? [input field]

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

If yes, into which states? [input field]

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

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

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

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

- Ambulance
- Paramedic
- Adult Day Care
- Social Service Organizations Transportation
- Rescue Squad with Ambulance
- Fire Department with Ambulance
- Individual EMT
- Dispatch Service for Others
- First Responder
- Psychiatric
- Taxi/Limo/General Transportation Service
- Non-Emergency Medical
- Alarm Monitoring
- School Transportation
- Special Needs Transportation
- Rescue Squad without Ambulance
- Fire Department without Ambulance
- Individual Paramedic
- Air Ambulance
- Off Shore EMT
- Incarcerated
- Other: \_\_\_\_\_

12. Indicate the number of annual calls:

Emergency (911)	_____	Non-911 Dispatch Services	_____
Ambulatory Transports	_____	School Transports	_____
Non-Emergency (Ambulance)	_____	Child/Youth(under 18 )	_____
Wheelchair Transports	_____	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:	_____
	<b>100%</b>		<b>100%</b>		<b>100%</b>

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-helds 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

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

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: \_\_\_\_\_

