



Medical Transportation Professional Liability and General Liability Insurance Application

THIS IS AN APPLICATION FOR A CLAIMS MADE AND REPORTED POLICY. THIS APPLICATION IS NOT A BINDER.

This application for Professional Liability and General Liability Insurance is intended to be used for the preliminary evaluation of a submission. When completed in its entirety, this application will enable the Underwriter to decide whether or not to authorize the binding of insurance. Please type or print clearly and answer all questions. If space is insufficient to answer any question fully, attach a separate sheet. Complete all required supplemental forms/applications. "You" and "Your", as used in this application, means the Applicant.

PLEASE ATTACH THE FOLLOWING:

- A copy of the COI confirming current Commercial Auto Liability Coverage
- Currently valued loss runs for the last 5 years for Professional Liability, General Liability and Commercial Auto Liability
- A copy of the risk management company guidelines for patient loading and unloading, including wheelchair and stretcher patient transfers

1. GENERAL INFORMATION			
Name of Applicant			
Physical Address		Phone	
City, State, Zip Code		County	
Mailing Address			
Website		Contact e-mail	
2. OPERATIONS			
a. Date established			
b. Applicant is a:	<input type="checkbox"/> Sole Practitioner (unincorporated) <input type="checkbox"/> Sole Practitioner (incorporated) <input type="checkbox"/> Corporation (for profit) <input type="checkbox"/> Corporation (non-profit) <input type="checkbox"/> Partnership <input type="checkbox"/> Professional Association <input type="checkbox"/> Other (describe): _____		
c. Has the Applicant merged with any other entity in the past ten (10) years? If "YES", please provide details on a separate sheet of paper.			<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Is the Applicant contemplating a merger in the next eighteen (18) months? If "YES", please provide details on a separate sheet of paper.			<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Please check the category which best describes your organization. (Check all that apply if you offer multiple services.)			
Vehicle Type		Description	
<input type="checkbox"/>	Non-Medical Ambulette or Van Service	Services include transporting clients/patients from residential facilities/homes to physician offices; drivers are typically non-medical professionals with basic First Aid and/or CPR training.	
<input type="checkbox"/>	Non-Emergency Medical Transportation	Services include medical facility-to-facility transports by ambulance. EMT Basic or Intermediate personnel may accompany patients. This category encompasses Basic Life Support (BLS) and Advanced Life Support (ALS) services as defined by Medicare.	
<input type="checkbox"/>	Emergency Transportation	Services include response to 911 calls or the equivalent; EMT Basic, Intermediate and/or Paramedics may accompany patients.	
<input type="checkbox"/>	Other (Please provide a description of your organization if it does not readily reflect one of the above categories)		

3. COVERAGE DESIRED

a. Proposed Effective Date:	
b. Retroactive Date:	
c. Limit(s):	
d. Deductible(s):	
e. Does the company enter into any written or verbal service agreements that require this insurance? If "YES" , please provide the name of any party requiring the Applicant to have this insurance.	<input type="checkbox"/> Yes <input type="checkbox"/> No

4. SPECIALTY TRANSPORTS/SERVICES
(Additional Underwriting information will be needed for each service provided.)

a. Check all services that you provide:

<input type="checkbox"/> Air and/or Water transportation	<input type="checkbox"/> School Transportation
<input type="checkbox"/> Bariatric Transportation	<input type="checkbox"/> Escort/Travel Companion Services
<input type="checkbox"/> Organ Delivery/Donation Transportation	<input type="checkbox"/> Travel Arrangement Services or Agencies
<input type="checkbox"/> International Transportation	<input type="checkbox"/> Alarm Monitoring
<input type="checkbox"/> Involuntary (Psych) Transportation	<input type="checkbox"/> Dispatch Service for Others
<input type="checkbox"/> Ridesharing Transportation	<input type="checkbox"/> Other (specify): _____

b. Do you provide contracted or standby medical services for any of the following special events (check all that apply)?

<input type="checkbox"/> Car/Motorcross Races	<input type="checkbox"/> Horse Races
<input type="checkbox"/> Concerts	<input type="checkbox"/> High School/College Sports
<input type="checkbox"/> Professional Sports	<input type="checkbox"/> Night Clubs
<input type="checkbox"/> Other: _____	

c. Do you subcontract your services **FOR** others? Yes No
If **"YES"**, please provide copies of contracts.

5. TRANSPORTS AND GROSS REVENUES

a. Please enter the number of transports and gross revenue:

Type of Service	# of transports		Gross Revenue	
	Last 12 months	Projected next 12 months	Last 12 months	Projected next 12 months
Critical/Specialty Care Ambulance			\$	\$
Emergency (BLS) Ambulance			\$	\$
Emergency (ALS) Ambulance			\$	\$
Non-Emergency (BLS) Ambulance			\$	\$
Non-Emergency (ALS) Ambulance			\$	\$
Non-Medical/Paratransit/WC			\$	\$
Other (specify):			\$	\$
Total			\$	\$

b. Indicate the percentage of trips that fall into the following categories:

Pre-Scheduled	_____ %	Curb to Curb	_____ %
On-Demand	_____ %	Door to Door	_____ %
Emergency	_____ %	Door through Door	_____ %
Age range of passengers:	_____ % under 18	_____ % with Developmental or Intellectual Disabilities	

c. Radius of Operations
 Average Miles per trip: _____ Total Fleet Miles Annual: _____

d. Does the operating status cross any state lines? Yes No
 If **“YES”**, list states: _____

e. Are long-distance (more than 200 miles traveled in one leg of the trip) transport services provided? Yes No
 If **“YES”**, please provide detail on the risk management protocols as well as staff details per trip.

6. DISPATCH

a. How are calls dispatched? (Check all that apply)
 911 In-House Other (specify): _____

b. Is a record kept of each request for service? Yes No

c. Is a Patient Care Report (PCR) completed for each transport in which medical care, evaluation or observation has been performed? Yes No

d. Do you have protocols in place stating when Emergency Warning Systems (EWS) **must** be and **may** be activated? Yes No

e. What are your hours of operations? _____

f. What are the maximum hours allowed per shift, per driver? _____

7. VOCATIONAL TRAINING

a. Do you offer any CPR, First Aid or other medical training/certification for any persons other than employees? Yes No
 If **“YES”** to question **7.a.** above, please answer the following:

- (1) What is the total number of students per year? _____
- (2) What certifications or degrees are offered? _____
- (3) What are the annual receipts from this operation? _____
- (4) If classes are conducted on site, what is the capacity of the classroom in number of students? _____
- (5) How often are classes conducted? _____
 For what duration? _____

8. STAFF						
a. Please provide the number of:						
	Employees		Independent Contractors		Volunteers	
	Full-Time	Part-Time	Full-Time	Part-Time	Full-Time	Part-Time
Emergency Medical Responder						
Critical Care Paramedics						
Paramedics						
Nurse (LPN or RN)						
Physicians						
Advanced EMT						
Emergency Medical Tech						
Ambulatory/Wheelchair Operators						
Other (please describe:)						
b. Total Staff Count:						
c. Do you have a Medical Director on staff? If "YES", provide the name of the Medical Director: _____						<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Is your Medical Director board certified in emergency medicine?						<input type="checkbox"/> Yes <input type="checkbox"/> No
e. If your Medical Director is a Physician, do you require evidence of his/her own professional liability insurance? (A certificate of insurance evidencing the above information will be required to bind.)						<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Are all medical transports documented, with regular quality review by the Medical Director or other qualified person or group? If not reviewed by the Medical Director, who is responsible for the review? _____						<input type="checkbox"/> Yes <input type="checkbox"/> No
9. EMPLOYEE HIRING PRACTICES						
a. Are background checks performed on all employees, independent contractors and volunteers? If "YES", please check the level or type of criminal background checks you perform (check all that apply): <input type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/> Federal <input type="checkbox"/> Sexual Offender Registry						<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Are all employees, independent contractors and volunteers screened for drugs and alcohol? If "YES", how often? _____						<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Which of the following is a standard part of your pre-employment review? (Check all that apply) <input type="checkbox"/> Written Application <input type="checkbox"/> Motor Vehicle Record (MVR) review <input type="checkbox"/> Ride Along Driving Test <input type="checkbox"/> Job Specific Physical Examination <input type="checkbox"/> Employment background check <input type="checkbox"/> Pre-employment drug test <input type="checkbox"/> Other (specify): _____						

<p>d. Have you or any of your employees:</p> <p>(1) ever been the subject of a disciplinary proceeding, investigation or reprimand by a governmental or administrative agency, hospital or professional association?</p> <p>(2) ever been convicted for a violation of any law or ordinance other than traffic offenses?</p> <p>(3) ever been treated for alcoholism or drug addiction?</p> <p>(4) ever had any professional license or license to prescribe or dispense narcotics refused, suspended, revoked, non-renewed or accepted only on special terms, or ever voluntarily surrendered any such license?</p> <p>If “YES” to any of the above, please explain:</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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10. DRIVER TRAINING/SAFETY

<p>a. Do you have written driver criteria policies in place?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>b. Are there experience requirements for newly hired drivers? If “YES”, what are the requirements?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>c. Is there a minimum age requirement for drivers? If “YES”, what is the minimum age? _____</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>d. How many drivers are over age 65? _____</p>	<p>Under age 23? _____</p>	
<p>e. How often are Motor Vehicle Reports (MVRs) checked for all drivers?</p>		
<p>f. Do you have written criteria for acceptable MVRs?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>g. Please describe your drivers' training (Check all that apply):</p> <p><input type="checkbox"/> General Driving Orientation <input type="checkbox"/> Defensive Driving <input type="checkbox"/> CPR <input type="checkbox"/> Primary First Aid</p> <p><input type="checkbox"/> Advanced First Aid <input type="checkbox"/> Passenger Assistance <input type="checkbox"/> Non-Medical Emergency Training</p> <p><input type="checkbox"/> Emergency Vehicle Evacuation <input type="checkbox"/> Proper Wheelchair/Stretcher Securement Procedures</p>		
<p>h. Do you have a written safety program in place?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>i. Name and title of the person(s) responsible for safety & risk management:</p>		
<p>j. Name and title of person responsible for claims reporting:</p>		
<p>k. Are there formal accident investigation and review procedures in place?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>l. Is there a driver safety incentive plan in place? If “YES”, please describe:</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>m. How frequently are employees required to take a driver training course/refresher:</p>		
<p>n. Is there a progressive discipline policy for drivers involved in serious or multiple accidents/violations?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>o. Is there a maximum number of driving violations allowed? If “YES”, how many? _____</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>p. Is there a maximum number of accidents allowed? If “YES”, how many? _____</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>q. Is there a post-accident drug testing policy in place?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	

r. Do you have a violent patient restraint policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
s. Do you use global positioning systems (GPS) to monitor driver behavior?	<input type="checkbox"/> Yes <input type="checkbox"/> No
t. Are all vehicles equipped with cameras or accident event recorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No
u. Are there restrictions on the use of cell phones/hand-held while operating vehicles?	<input type="checkbox"/> Yes <input type="checkbox"/> No
v. Do you perform pre-trip vehicle inspections?	<input type="checkbox"/> Yes <input type="checkbox"/> No
w. Do you perform post-trip vehicle inspections?	<input type="checkbox"/> Yes <input type="checkbox"/> No
x. Are call reports completed on every call and/or run?	<input type="checkbox"/> Yes <input type="checkbox"/> No

11. VEHICLES

a. Please enter the number of units for each type of vehicle:

# of units	Type of Vehicle
_____	Advanced Life Support Ambulance
_____	Basic Life Support Ambulance
_____	Ambulette or Wheelchair Van
_____	Private Passenger Vehicles
_____	Total units

b. Are vehicles engaged with (check all that apply):

- | | | |
|---|--|---|
| <input type="checkbox"/> Cardiac Monitors | <input type="checkbox"/> Pacemakers | <input type="checkbox"/> Defibrillators |
| <input type="checkbox"/> Ventilators | <input type="checkbox"/> Intubation Kits | <input type="checkbox"/> Oxygen |
| <input type="checkbox"/> Pulses Oximeters | <input type="checkbox"/> Emergency Cardiac | <input type="checkbox"/> In-Vehicle Cameras |
| <input type="checkbox"/> GPS Tracking | <input type="checkbox"/> Lift-Out/Pull-Out Ramps | <input type="checkbox"/> Mechanical Lifts |

12. VEHICLE MAINTENANCE

- | | |
|---|--|
| a. Do you utilize a written vehicle preventive maintenance program? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. How often is maintenance performed? | |
| c. Do you maintain records listing vehicle defects and repairs? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. Are maintenance repair records on file for all vehicles? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e. Do all vehicles comply with ADA standards? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

13. PASSENGER ASSISTANCE

- | | |
|---|--|
| a. Are drivers instructed to request permission to assist ambulatory and/or walker passengers prior to the passengers entering and exiting the vehicle? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. How many vehicles are equipped with passenger restraint system? | |
| c. Do you have a mandatory lift assist policy? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. Do vehicles equipped with lifts or ramps exclusively transport non-ambulatory individuals? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e. Are all persons involved in wheelchair transportation instructed in the proper use of securement equipment for all types of wheelchairs? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| f. Are all restraint systems designed with a "4-point tie-down" and "forward facing" features? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| g. What types of wheelchairs are used to transport passengers?
<input type="checkbox"/> Portable <input type="checkbox"/> Motorized <input type="checkbox"/> Youth/Child Stroller <input type="checkbox"/> Tri-Wheeler/Scooter
<input type="checkbox"/> Lightweight <input type="checkbox"/> Heavy Duty Industrial <input type="checkbox"/> Reclining/Tilting | |
| h. How are wheelchairs secured to floor of vehicle?
<input type="checkbox"/> Fixed Access Locations <input type="checkbox"/> Moveable Attachments <input type="checkbox"/> Both | |
| i. Are wheelchair passengers ever transported without the use of a restraint system? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| j. Are passengers in scooter type chairs required to transfer to a wheelchair or a permanent seat after loading? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

k. Are wheelchair passengers ever permitted to ride in the vehicle in other than the designated securement locations? <input type="checkbox"/> Yes <input type="checkbox"/> No						
l. What types of stretchers do you use in your vans?						
m. What type of stretcher vehicle securing system do you provide in your stretcher vans?						
n. Do you use knee, hip, chest, and over the shoulder safety restraints on stretchers?						<input type="checkbox"/> Yes <input type="checkbox"/> No
o. Do employees load and unload stretchers? If "YES" , please provide a copy of the training procedures for loading and unloading clients.						<input type="checkbox"/> Yes <input type="checkbox"/> No
p. At what frequency are employees operating these vehicles trained in the use of these systems? <input type="checkbox"/> Time of Hire <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Annually <input type="checkbox"/> Post-Accident <input type="checkbox"/> Other (describe): _____						
14. NETWORK SECURITY AND PRIVACY CONTROLS						
a. Do you have a billing compliance program? If "YES" , when was it implemented: _____ If "NO" , do you outsource your billings to a third-party billing company?						<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
b. Is your practice using a current edition of the CPT manual?						<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Is software used to ensure billing compliance?						<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Who within your organization is responsible for billing compliance? Please include the person's name, title, qualifications and date of hire in this position and how often such person performs billing reviews?						
e. Are you HIPAA compliant?						<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Does your company use anti-virus software and firewall protection on all desktops, portable devices and mission critical servers, and is it updated in accordance with the software provider's recommendations?						<input type="checkbox"/> Yes <input type="checkbox"/> No
g. Do you enforce privacy and security policies that must be followed by all employees, contractors, or other individuals or organizations with access to your patients' information?						<input type="checkbox"/> Yes <input type="checkbox"/> No
h. Is all sensitive and confidential information stored on your organization's databases, servers and data file encrypted?						<input type="checkbox"/> Yes <input type="checkbox"/> No
i. Been placed on prepayment review by any local, state or federal government agency or by any private (commercial) payer?						<input type="checkbox"/> Yes <input type="checkbox"/> No
j. Been audited, investigated or sanctioned by any local, state or federal government agency or private (commercial) payer regarding Medicare/Medicaid billing practices, utilization of Medicare/Medicaid services or the delivery of health care services or reimbursement thereof?						<input type="checkbox"/> Yes <input type="checkbox"/> No
k. Been investigated for HIPAA, EMTALA or Stark/anti-kickback violations?						<input type="checkbox"/> Yes <input type="checkbox"/> No
15. COVERAGE HISTORY						
a. Please provide details of professional liability coverage purchased in the last five (5) years to date:						
Policy Period	Limits	SIR/ Deductible	Carrier	Annual Premium	Occurrence or Claims-Made	Retroactive Date

b. Please provide details of general liability coverage purchased in the last five (5) years to date:

Policy Period	Limits	SIR/ Deductible	Carrier	Annual Premium	Occurrence or Claims-Made	Retroactive Date

16. AUTOMOBILE LIABILITY INSURANCE INFORMATION

a. Current Carrier	
b. Limits of Liability	
c. Deductible	
d. Does the policy specifically exclude claims arising from loading and unloading of patients?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Does the policy remain silent on the applicability of coverage for claims arising from loading and unloading of patients?	<input type="checkbox"/> Yes <input type="checkbox"/> No

17. LOSS HISTORY

a. Has any insurer cancelled or refused to renew any similar insurance during the past five (5) years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Has any application for Professional Liability or General Liability Insurance made on behalf of the Applicant, any predecessors in business, or present partners ever been declined, or has such insurance ever been cancelled, non-renewed or accepted only on special terms? If "YES", please describe:	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. In the past five (5) years, has any claim been made, or legal action been brought, against you, any of your current or former officers, directors, owners, partners or employees, or any other person or entity proposed for this insurance? If "YES", please complete a Claim Supplemental Form for each claim.	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Are you or any other person or entity proposed for this insurance aware of any fact(s), incident(s), act(s), event(s), circumstance(s) or occurrence(s) that may result in any professional liability or general liability claim(s) being made against any person or entity proposed for this insurance? If "YES", please complete a Claim Supplemental Form for each allegation or incident.	<input type="checkbox"/> Yes <input type="checkbox"/> No

NOTICE TO APPLICANT

The insurance for which you are applying will not respond to incidents about which any person proposed for coverage had knowledge prior to the effective date of the policy, nor will coverage apply to any claim or circumstance identified or that should have been identified in question 17.c. and 17.d. of this application.

NOTICE TO NEW YORK APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO FRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

The Applicant hereby acknowledges that he/she/it is aware that the limit of liability shall be reduced, and may be completely exhausted, by claim expenses and, in such event, the Insurer shall not be liable for claim expenses or any judgment or settlement that exceed the limit of liability.

I HEREBY DECLARE that, after inquiry, the above statements and particulars are true and I have not suppressed or misstated any material fact, and that I agree that this application shall be the basis of the contract with the Underwriters.

CERTIFICATION AND SIGNATURE

The Applicant has read the foregoing and understands that completion of this application does not bind the Underwriter or the Broker to provide coverage. It is agreed, however, that this application is complete and correct to the best of the Applicant's knowledge and belief, and that all particulars which may have a bearing upon acceptability as a Professional Liability and General Liability Insurance risk have been revealed.

It is understood that this application shall form the basis of the contract should the Underwriter approve coverage and should the Applicant be satisfied with the Underwriter's quotation. It is further agreed that, if in the time between submission of this application and the requested date for coverage to be effective, the Applicant becomes aware of any information which would change the answers furnished in response to any question of this application, such information shall be revealed immediately in writing to the Underwriter.

This application shall be deemed attached to and form a part of the Policy should coverage be bound.

Must be signed by an officer of the company.

Print or Type Applicant's Name	Title of Applicant
Signature of Applicant	Date Signed by Applicant

California Fraud Warning

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.