

NON-EMERGENCY MEDICAL TRANSPORTATION

Information Needed for Insurance Quote

- 1** **Copy of Current Policies**
- 2** **Loss Runs**
5 Year currently valued loss runs. If you do not have loss runs available, please [fill out attached](#).
- 3** **Submit a Current Vehicle List**
Submit a current vehicle list, preferably in [attached Excel format](#).
- 4** **Submit Driver List**
Submit a copy of Driver List preferably in [attached Excel format](#).
- 5** **Supplemental Application**
Application attached.
- 6** **Submit Copy of Safety Manual**

CONTACT US TODAY

1-800-847-0544 • nemt@clginsurance.com



Paratransit and Patient Transport Submission Application

- A. The Application must be completed, signed and dated by a principal of the business.
- B. If a question does not apply, it should be noted as N/A.
- C. Target effective date.

1. General Information	
Name of Applicant/Entity	
DBA Name, if applicable	
Federal Employer Identification Number (FEIN)	
List States You Operate In	
USDOT Number(s)	
Name and Title of Corporate Contact	
Phone Number	
E-Mail Address	
Corporate Address	
Mailing Address (if different than above)	
Number of Locations (including garaging locations)	
Website URL	
Years in Business	
Does the Applicant provide services other than passenger-mobility transport or patient transport? If YES, describe.	
Does the Insured have any other businesses? Yes No	
Are state and federal filings required? Yes No If yes, which filings?	
Do you cross state lines? Yes No	
Do you do any Uber/Lyft work? Yes No	
Do you have any R-titled vehicles in your fleet? Yes No	

2. Emergency/Emergent Services	YES	NO	NA
Is the applicant licensed by the state(s) to respond to EMS/911 emergency calls			
Is the applicant licensed by the state(s) to run lights/sirens?			
Has the applicant run lights/sirens within the past three years? If YES, how many times?			

3. Transport Services

Please provide an amount as a percentage of total trips for each. Each column should total 100%

General Public Transportation	Wheelchair	Curb to Curb	Pre-Scheduled	Radius 0-50 miles
Non-Emergency Transportation	Stretcher	Door to Door	On-Demand	Radius 51-200 miles
Charter/Livery	Ambulatory	Door Through Door	Fixed Route	Radius 200+ miles
BLS				
ALS				
EMS/911				
Rideshare				
Air Transport				
Other, Please Describe Below				
TOTAL	TOTAL	TOTAL	TOTAL	TOTAL
100%	100%	100%	100%	100%

4. Gross Revenue

Projected	Current Year	1 Year Prior	2 Years Prior	3 Years Prior
\$	\$	\$	\$	\$

5. Vehicle Count History

Projected	Current Year	1 Year Prior	2 Years Prior	3 Years Prior

6. Extended Reporting Period Coverage

YES NO NA

Did the Applicant purchase Extended Reporting Period coverage for previously owned entities?

If "NO", provide detail.

Within the past five years, has the Applicant acquired, sold, or discontinued any operations?

If YES, provide detail.

If YES, does the Applicant require insurance coverage for previously owned entities?

7. Current Coverages

Coverages	Insurer Limits of Liability	Deductible	Claims Made or Occurrence	Retroactive Date if Claims Made
Professional Liability				
Commercial General Liability				
Employee Practices Liability				
Cyber Liability				
Auto Liability				
Umbrella				

8. Employee Data				
Staff Numbers/ Employees & Independent Contractors	# of Full Time Employees	# of Part Time Employees	Annual Payroll	# of 1099s
Driver				
EMT				
Paramedic/ Critical Care				
Mechanics				
Clerical				

9. Vehicle Exposure		
Construction Building Type	Owned	Leased
Parking Lot	Owned	Leased
Lights	YES	NO
Guarded	YES	NO
Are more than 25% of vehicles parked in same location?	YES	NO
Can vehicles be garaged/parked at employees' home?	YES	NO
If YES, does the applicant have additional Comprehensive coverage sufficient to cover physical loss of vehicles?	YES	NO
If YES, can the vehicle be used for noncompany business?	YES	NO
Are all vehicles titled and registered to the named insured?	YES	NO
If your patient is transported with an oxygen tank, are the tanks secured?	YES	NO
Permanently installed medical equipment	Total Value \$	
Number of vehicles with lift		

10. Contracts/ Service Agreements	YES	NO	NA
If the Applicant provides services to another entity (e.g. nursing homes, assisted living, other aging services organizations, day care centers and governmental agencies) does the Applicant have a written contract or agreement in place with said entity?			
Does an attorney review all contracts and agreements prior to signing?			
Does the Applicant contract with or receive reimbursement from:			
Adult Day Care Facility			
Assisted Living Facility			
Health Plan/Health Insurer			
Hospital			
Independent living Facility			
Medicare			
Rideshare			
Skilled Nursing Facility			
State Medicaid Program			
Veteran Program			
Other (Describe)			

11. Hiring/ Screening & Employment Procedures	YES	NO
References are contacted before hiring or placement.		
Motor Vehicle Records (MVRs) are checked before hiring and annually.		
Drivers are not permitted to drive if the MVR indicates serious/major moving violations or serious preventable accidents within past three years.		
Drivers are not permitted to drive if drug or alcohol related offenses in the past three years.		
Do you have a drug and alcohol screening program		
Verification of professional license (EMT, Paramedic, Physician, Nurse Practitioner, Physician Assistant, Nurse, Respiratory Therapist, etc.) and professional license suspensions/revocations/pending disciplinary actions before hiring and annually		
Background checks		
Pre-placement evaluations and testing		
Do you require all drivers to have a physical examination every 2 years? If NO, all drivers to have a physical examination upon 60 days of binding insurance.		
All drivers are at least 22 years old.		
All drivers are licensed and have driven for at least three years.		
All drivers have a U.S. state-issued driver's license.		
Employees are offered Workers Compensation coverage.		

12. Safety Program Elements	YES	NO
Documented Driver and Passenger Safety program in place		
Drivers are trained in the use of specialized vehicle equipment prior to transporting passengers.		
Passenger trip reports are maintained for every transport.		
Transports are preplanned to ensure that pickup/delivery locations are accessible for the vehicles and staff.		
Staff receives training in safe assist of passengers.		
Passenger mobility requirements are known pre-transport by the driver.		
Passengers are required to wear seatbelts/restraints at all times.		
Patients transported in wheelchairs are secured.		
Vehicles have special securing systems for motorized wheelchairs, if applicable.		
All drivers are trained with handling pediatric passengers		
Bariatric special accommodations include bariatric power-lift stretchers, bariatric wheelchairs, and additional transport staff.		
Documented procedures are followed after an accident.		
All accidents are reviewed.		

13. Driver Safety & Driver Telematics			
Automatic Braking Sensor, or Any Other Type of Active Accident Avoidance Technology			
Driver's Seat Vibration or Audible Alarm, or Other Type of Passive Accident - Avoidance Technology			
GPS			
Dual Facing Cameras			
Name of vendor, if applicable.			
Please select camera system: Samsara Azuga Other			
If telematics are used, does the system include:			
Acceleration Events			
Alert/ notify supervisor			
Braking Events			
Cornering Events			
Distraction Alerts			
High Risk Warnings			
Real-Time Prevention			
Tailgating Alerts			
Driver Scoring			
Do you require passengers to wear seatbelts, including in wheelchairs?			
Do you have a non-compliant passenger policy?			

14. Litigation/Claims History/ Sanctions/Fines/Driving Violations:	YES	NO
<i>Additional information must be provided to the Application on the Applicant's letterhead if the response is "YES" to any of the questions below.</i>		
Is the Applicant or any of its employees aware of any incident (including requests for medical records), circumstance or occurrence which may result in a claim and which has not been reported to another insurer?		
Has the entity's license ever been suspended, revoked or voluntary surrendered?		
Has any company with which the Applicant has been affiliated become insolvent?		
Has any federal/state civil/criminal investigation or action been initiated or filed that directly or indirectly involves the Applicant's organization?		
Has the organization, its employees, medical staff, or officers been sanctioned or experienced disciplinary actions or limitations on licensure brought against them by federal or state authorities, professional medical societies accreditation agencies or other governmental or non-governmental oversight entities?		

AUTHORIZATION

I have answered the questions in the Application to the best of my ability and declare that, to the best of my knowledge, the statements set forth herein are true and correct. My signing of the Application does not bind the Insurance Company to complete the insurance, but it is agreed that this Application shall be the basis of the contract if a policy is issued. It is agreed that the Application shall be on file with Company. I further understand that an incorrect or incomplete statement or answer in the Application could void my insurance coverage, if issued. I further understand that an incorrect or incomplete statement or answer could void my insurance coverage.

FRAUD NOTICE - WHERE APPLICABLE UNDER THE LAW OF YOUR STATE

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 or incomplete 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 be subject to civil fines and criminal penalties (for New York residents only: 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.) (For Pennsylvania Residents only: Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and payment of a fine of up to \$15,000.) (For Tennessee Residents only: Penalties include imprisonment, fines and denial of insurance benefits.)

A signature from the Applicant can be obtained electronically or as a “wet” signature prior to quote or binding.

If the Applicant decides to submit its signature electronically, the Applicant must check the “Accept” button below. By doing so the Applicant hereby consents and agrees that its use of a key pad, mouse or other device to check the “Accept” button constitutes its “signature”, acceptance and agreement as if actually signed by the Applicant in writing and has the same force and effect as a signature affixed by hand. Further, the Applicant agrees the lack of a certification authority or other third party verification will not in any way affect the validity or enforceability of its signature of any resulting contract. After checking the “Accept” button the Applicant must type in the name of the person completing this application, including the Applicant’s title and the date signed.

If the Applicant decides to submit a “wet” signature, the Applicant must sign, and add the title and date to the Application prior to quoting or binding.

ELECTRONIC SIGNATURE

Accept

Name

Title

Date

WET SIGNATURE

Name

Title

Date

Signature in full