



## 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 <i>Active</i> Accident-Avoidance Technology	Yes	No	
Driver's Seat Vibration or Audible Alarm, or Any other <i>Passive</i> 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
1. Does your service review drivers' motor vehicle reports?      Yes      No  
 If yes, how often?      Annually      Every 2-3 Years      More than 3 years      Other: \_\_\_\_\_
1. Do you have a driver training program?      Yes      No
1. 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
- Ï . 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*



## 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. 75<sup>th</sup> Ave., Ste. 100, Peoria, AZ 85381***  
***Phone: 602-942-3900 | Fax: 602-942-4300 | Email: [info@ambulanceinsurance.com](mailto:info@ambulanceinsurance.com)***