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Community & Medical Transportation (CMT) Application

-FOR USE WITH ALL CMT CLASSES EXCEPT TAXI

**This application forms a part of the insurance policy by endorsement*

BROKER INFORMATION

Date: _____

Agency: _____ Producer's Name: _____

Phone: _____ Fax: _____ E-Mail Address: _____

Are you the incumbent agency? If yes, how long has your agency written this applicant? _____

APPLICANT INFORMATION

Applicant's Name: _____ Business Type: _____

Insured DBA: _____ Federal ID #: _____

Year Established: _____

Mailing Address
(Include Street, P.O. Box, City, ST, & Zip) _____

Primary Garaging Location:
*(If different from mailing address) ; *Attach schedule of locations if more than one* _____

Phone: _____ Fax: _____ Company Website: _____

Person Completing Survey (Name): _____ Title: _____

Key Management Personnel:

Applicant Contact: _____ e-mail: _____ Ph./Ext.: _____
President/CEO: _____ Yrs. in Position: _____ Ph./Ext.: _____
Operations Manager: _____ Yrs. in Position: _____ Ph./Ext.: _____
Safety Director: _____ Yrs. in Position: _____ Ph./Ext.: _____
Maintenance Director: _____ Yrs. in Position: _____ Ph./Ext.: _____
Claim Contact: _____ e-mail: _____ Ph./Ext.: _____

Subsidiaries/Affiliated Companies:

Name: _____ Relationship: _____
Type of Business: _____ Included in Insurance? _____

Historical Insurance Coverage	Current	1st Prior	2nd Prior	3rd Prior	4th Prior
Insurance Carrier / Broker					
Limits & Deductibles					
Auto Liability Premium					
Physical Damage Premium					

REQUESTED COVERAGES

Effective Date: _____ **Requested Quote Date:** _____

AUTO COVERAGE	Limits Requested	Deductible
Auto Liability (Up to $5M CSL) *		
Uninsured/Underinsured Motorist		
Medical Payments		
Personal Injury Protection (PIP)		
Property Protection Insurance (MI Only)		
Hired Auto Liability (Fleet Accounts Only)		
Non-Owned Auto Liability		
Excess Liability (For limits more than $5M)		

Physical Damage Coverage ($1M Per Occurrence Limit)	Deductible
Specified Perils	
Comprehensive	
Collision	

Total Stated Values: _____

* SIR's, and Alternative Risk Transfer products also may be available dependent on risk characteristics.

EXCESS PHYSICAL DAMAGE COVERAGE

Are you interested in Catastrophic Physical Damage Coverage? ☐ Yes ☐ No

Total Coverage Limit Desired: _____ *Please provide a list of locations and total garaged values at each

Building type: _____

Fire protection type: _____

If a lot, is lot lighted? ☐ Yes ☐ No Is there a night guard? ☐ Yes ☐ No

Are any fuel tanks located on premises? ☐ Yes ☐ No

Total value of vehicles garaged outside: _____ Total value of vehicles garaged inside: _____

GENERAL LIABILITY *(Complete only if requested);* Fill-in limits requested below

Each Occurrence: _____ General Aggregate: _____

Personal & Advertising Injury: _____

Location Address (list each)	Class	Square Footage	Owned/Rented?	Fenced?	Night Watch?	Security Cameras?

Are any of the above locations the primary residence of the insured? _____

Do you allow parking by those other than employees or customers? _____

Do operations involve storing, treating, discharging, applying, disposing of, or transporting of hazardous material (landfills, fuel tanks, waste)? _____

Do you collect a fee for parking at any of the above locations? _____

If you answered "yes" to any of the questions to the left, please provide an explanation below.

List any non-transportation operations at this location: _____

FILING INFORMATION

Does applicant require a MC Docket filing? MC Docket #: _____

Does applicant allow others to operate under their authority? USDOT #: _____

Has the applicant previously allowed others to operate under their authority? PUC #: _____

Does applicant require intra-state filings? Other state filing # _____

If yes, please list states _____

Please list states where applicant has operating authority: _____

Please specify any Canadian Filings: _____

List name and address exactly as listed on filing: _____

_____

VEHICLES

Projections & Historical Figures	Projected	Current	1st Prior	2nd Prior	3rd Prior	4th Prior
Gross Revenues						
Total Fleet Mileage						
Transit > 20 passengers						
Transit 9-19 passengers						
Transit 1-8 passengers						
Private Passenger/Service						
Other (describe)						
Total units:						

Do you hire from others for your use? _____ If yes, Annual Cost of Hire: _____

Do you hire from others with a driver? _____ If yes, Annual Cost of Hire: _____

Do you lease to others for their use? _____ If yes, Annual Income Derived: _____

Do you lease to others without a driver? _____ If yes, Annual Income Derived: _____

Is there assumed liability by contract/agreement? _____

Do operations include any case work, home healthcare, hospice care, or off-site community education services? _____

Do any employees use their own autos in the insured's business? If yes, how many? _____

Do these employees transport clients? If yes, how often? _____

Does the insured require proof of insurance from these employees? If yes, what are the minimum auto limits required? _____

Does the insured use subcontractors fo any operations? If yes, describe: _____

Provide the annual "cost of hire" from subcontractors. _____

What limits are required from the subcontractor? _____

Is the insured added as an additional insured on the subcontractor's policy? _____

Please provide copies of contracts with subcontractors.

OPERATIONS

Provide a brief description of your operation:	

USE AS % OF TOTAL TRIPS

Wheelchair		Curb to Curb		Pre-Scheduled	
Stretcher Transportation		Door to Door		On-Demand	
Other (describe)		Door through Door			
TOTAL %:		**TOTAL %:**		**TOTAL %:**	

Does the insured subcontract FOR others? *If yes, provide copies of contracts.* _____
Does the company enter into any written or verbal agreements to provide service? _____
Does the company borrow or lease agents, servants, or employees from others? _____
Does the company have any home nursing or healthcare operations? _____
Does the company have any contracts to provide transportation for railroad employees? _____

DESTINATIONS (Must equal 100%)

TOTAL:

List areas served and percent of trips.

City, State	%	City, State	%	City, State	%
Example: Richfield, OH	30%				

RISK SPECIFICS

Hours of Service: _____ Days of Service: _____

Radius of Operation: 0-50 Miles: _____ 51-200 Miles: _____ 200+ Miles: _____

WHEELCHAIR INFORMATION

Number of vehicles equipped with:

Lifts: Buses _____ Mini-Van/Buses _____ Vans _____ Manufacturer _____

Ramps: Buses _____ Mini-Van/Buses _____ Vans _____ Manufacturer _____

Is all equpiment factory installed during vehicle construction? _____

Number of vehicles equipped with passenger restraint system:

Buses _____ Mini-Van/Buses _____ Vans _____ Manufacturer _____

Is the system a "4-point tie down and forward facing" design? _____

If yes, are shoulder belts retractable or non-retractable? _____

Is floor securement of wheels accomplished with fixed locations or moveable attachments, ie tracks? _____

Types of Wheelchairs transported (check all that apply)

Motorized		Youth/child stroller		Tri-wheeler	
Lightweight		Reclining/tilting		Scooter	
Portable		Heavy Duty Industrial		Other (describe)	

Are passengers in tri-wheelers required to transfer to a wheelchair or a permanent seat after loading? _____

Are wheelchair passengers ever permitted to ride in the vehicle in other than the designated securement locations? _____

Describe procedures followed if wheelchair is not standard: _____

STRETCHER / NON EMERGENCY AMBULANCE

Number of vehicles equipped with stretcher equipment: _____

What types of stretchers do you use in your vans? _____

What type of stretcher vehicle securing system do you provide? _____

What type of patient stretcher safety restraint system do you provide? _____

Who does the loading and unloading of the stretchers? _____

What training is provided if employees load and unload? _____

Does an attendant accompany stretcher clients? _____

If "Yes", is attendant an employee of the insured, employee of the facility requesting transportation or personal assistant of the passenger? _____

For non-emergency ambulance companies only:

Number of units that have lights and sirens: _____

Number of units that have life support equipment: _____

Total Number of calls per year: _____

Percentage of total trips:

Non-emergency ambulance:		Stretcher:	
Wheelchair:		Ambulatory:	

Are you dispatched by the police or fire departments? _____

Do any vehicles respond to 911 calls directly or indirecly? _____

Are lights/sirens used to facilitate movement through traffic? _____

Do all vehicles observe posted speed limits and obey all street signs and traffic control lights, without regard to urgency of transportation being provided? _____

If no, please explain. _____

How many vehicles are fly-cars used to reach an acutely ill patient quickly, and provide on scene care? _____

Describe your procedures if during a trip, a true emergency situation arises? _____

Does your service allow third parties, other than the patient, to ride along in the ambulance? _____

Do any of the crew member's duties preclude the use of their safety belt? _____

Is the company a private, for-profit, ambulance service? Is it hospital owned and/or operated? _____

If the company is not a private, for profit, company please describe the company. _____

DRIVER INFORMATION (*Please attach Driver Schedule with Dates of Birth, and Dates of Hire)*

Total # of Drivers: _____ # over 65 y.o.: _____ # under 25 y.o.: _____ # of Independent Contractors: _____

Dispatchers: _____ # Volunteer Drivers: _____ # Back-Up Drivers: _____

Total Non-medical Employees: _____ Medical employees (EMT's, paramedics, etc.) _____

In the past year, how many drivers were: Hired: _____ Terminated: _____

Are volunteer drivers subject to the same hiring guidelines and training as regular drivers? _____

Are back-up drivers subject to the same hiring guidelines and training as regular drivers? _____

Driver Hiring Criteria: (Check all that apply)			
Written Application		Full Med.	
Road Test		Drug Test	
Written Test		Current	
Reference Checks		MVR	
Min. Age:		Max. Age:	

Answer Yes or No to the following questions:	
Do you agree to report all drivers to NIIC?	
Are any family members under 21 primary drivers of a company auto?	
Are all drivers properly licensed and DOT Compliant?	
Have all drivers been driving a similar vehicle for 2+ years?	
Do all drivers have at least 5 years U.S. driving experience?	
Is disciplinary plan documented for all drivers?	

Are criminal background checks performed on ALL drivers? _____

Describe criteria for determining acceptability: _____

Is there an employee manual? _____

How often are current MVRs pulled? _____

Describe your drug testing program: _____

What percentages of drivers are trained in the following:

General Driver Orientation		Passenger Assistance Training		Advanced First Aid	
Defensive Driving Course		Emergency Vehicle Evacuation		Human Relations Skills	
Primary First Aid		Cardiopulmonary resuscitation		Non-Emergency Medical Training	
Wheelchair / Stretcher Securement					

Are ALL persons involved in wheelchair transportation instructed in the proper use of securement equipment for all types of wheelchairs? _____

MAINTENANCE & SAFETY

Do you have the following (Check all that apply):		
Written maintenance program	Written safety program	Accident Event Recorders (AER's) *
		# of units equipped with AER's
Written driver-training program	Written accident reporting procedures	Which AER system is used?

Your vehicle maintenance program includes (Check all that apply):		
A service record for each vehicle	Pre/Post trip inspections	Vehicle daily condition reports

Other Maintenance & Safety Questions:	
How many certified mechanics do you employ?	
How often do you hold safety meetings?	
Is attendance mandatory?	
Who is in charge of claims?	
Will claims be reported directly to NIIC?	

Describe the insured's preventative maintenance policy:	
Is personal use of vehicles permitted?	
Describe how personal use of vehicles is monitored:	
Describe how and when drivers are evaluated:	
Describe Driver Disciplinary plan:	

MANDATORY UNDERWRITING QUESTIONS

During the past 4 years, has your insurance ever been obtained through an Assigned Risk Plan? _____

If Yes, Please Explain: _____

Has any company provided notice of cancellation/non-renewal or otherwise canceled/refused to renew your insurance, including during the current term? *(If yes, please attach a copy of the cancellation/non-renewal notice.)(not applicable in MO)* _____

If Yes, Please Explain: _____

Do you provide Worker's Compensation for all employees? _____

If Yes, provide Worker's Comp.carrier: _____

If No, Provide Explanation: _____

Have you ever filed for or contemplated filing for bankruptcy or had bankruptcy proceedings initiated against you by another party? _____

If Yes, Please Explain: _____

Has your operating authority ever been suspended or revoked or have you received notice of intent to suspend? _____

If Yes, Please Explain: _____

Is all equipment operated under the applicant's authority scheduled on the applicant's driver and vehicle schedule? _____

If No, Please Explain: _____

Applicant and Producer: Please sign and date the Applicant's Statement Below.

APPLICANT'S STATEMENT

I hereby declare that the statements made in this application and the contents of the other documents supplied are true and correct and agree that any policy of insurance that may be issued now or in the future will be based on warranties and representations contained therein.

APPLICANT		PRODUCER	
Signature of Officer/Manager of Named Insured	Date	Signature	Date
Print Full Name	Title	Print Full Name	Agency

IN ADDITION TO THIS APPLICATION, PLEASE SUBMIT THE FOLLOWING:

* Currently valued (within last 3 months), company issued loss runs for the current policy year and 4 prior years.
* Current driver's list and motor vehicle records for ALL drivers. Include dates of birth, dates of hire, years experience and license numbers.
* Current DOT medical for all drivers age 70 or older and any driver with less than 2 year medical clearance.
* Current Vehicle list, including year, make, complete VIN, seating capacity, vehicle type, stated amount and deductible requested.
* Pictures (inside and outside) and DOT inspections for units which are 15 years or older.
* Current financials: Income statement and balance sheet
* Expiring declaration pages for all coverages.
* Copy of cancellation or non-renewal notice issued in the current or 4 prior years.
* Completed New Venture Supplemental if the operation has been in business for less than 2 years.
* Applicable written agreements for all hired, leased or assumed liability arrangements.
* Provide explanation as to independent contractor status of drivers, if applicable.