



NON-EMERGENCY PUBLIC TRANSPORT SUPPLEMENTAL APPLICATION

NOTE: Complete in addition to Commercial Automobile Application

NOTE: Provide copies of Driver Training Manual and Safety Procedures

SECTION A: Applicant Information

1. Applicant Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Website: _____ Phone Number: _____
2. Proposed Effective Date: From: _____ To: _____ 12:01 A.M., Standard Time at Address of Applicant

SECTION B: Business Information

1. Form of Insured's business:
☐ Corporation ☐ Partnership ☐ Individual ☐ LLC ☐ Other: _____
2. Number of years in business: _____ Number of years under current management: _____
3. Is the Insured's service a subsidiary or division of another company? ☐ Yes ☐ No
If yes, advise the name of the company, their address, and their relationship to Insured:

4. Has this service ever operated under another name? ☐ Yes ☐ No
If yes, what name? _____
5. Is the Insured's business for-profit or nonprofit? _____ Source of funding: _____
6. Does the Insured have a contract with a social service agency? ☐ Yes ☐ No
7. List the percentage of fares paid by the following:
Medicaid/Medicare: _____% VA Benefits: _____%
Other Government Benefits: _____% Passengers: _____%
Other (please specify): _____% → _____
8. Does the Insured carry Professional Liability coverage? ☐ Yes ☐ No
If yes, state the policy number, carrier, limits, term, and if loading and unloading are included:

9. Does the Insured carry General Liability coverage? ☐ Yes ☐ No
If yes, state the policy number, carrier, limits, and term:

SECTION C: Operations Information

1. Description of operations:

2. List the number of trips below:
Total Number of Trips: _____
Number of Emergency Trips: _____
Number of Non-Emergency Trips: _____
Percent of Wheelchair Transport: _____%
Percent of Stretcher Transport: _____%
3. List major cities entered: _____
4. What percentage of operations involves transportation in the above cities? _____%

5. Indicate, if applicable, the percentage of transportation provided to the following destinations:

Shopping Districts: _____%

Workplaces: _____%

Senior Centers: _____%

Schools: _____%

Daycare Centers: _____%

Psychiatric Centers: _____%

Heliport Or Airport: _____%

Other (please specify): _____% → _____

6. Are passengers assisted in or out of the autos? ☐ Yes ☐ No

If yes, provide the percentages of the following:

Curb to Curb: _____%

Door to Door: _____%

Door through Door: _____%

7. Who dispatches calls (911, outside source, in-house, etc.): _____

8. Does the Insured distribute any medical supplies or equipment? ☐ Yes ☐ No

If yes, provide details: _____

9. Indicate, in the table below, the level of training and number of individuals who drive and/or provide client care (full-time, part-time, or volunteer)

	EMT Basic	EMT Advanced	EMT Paramedic	No Certification	Other:
Number of Employees					
Number of Volunteers					

10. Identify the types of special driver training programs that drivers receive (check all that apply):

☐ General Driver Orientation ☐ Defensive Driving ☐ Non-Medical Emergency Training

☐ Emergency Vehicle Evacuation ☐ Primary First Aid ☐ Advanced First Aid

☐ Passenger Assistance Training ☐ CPR ☐ Human Relations Skills

☐ Emergency Vehicle Operators' Course (EVOC)

11. Does the Insured screen employees and drivers' histories for sexual abuse charges and convictions?..... ☐ Yes ☐ No

12. Does the Insured verify licenses/professional certificates? ☐ Yes ☐ No

13. Does the Insured screen employees for previous involvement as defendants in malpractice litigation? ... ☐ Yes ☐ No

14. What is the number of units equipped with lights and sirens? _____

15. How many vehicles are equipped with the 3-point tie-down wheelchair tie down mechanism? _____

How many vehicles are equipped with the 4-point tie-down wheelchair tie down mechanism? _____

16. Describe wheelchair and stretcher tie-down procedures:

17. Are any vehicles not equipped with both lap belts and shoulder harnesses for the passengers? ☐ Yes ☐ No

18. Is there an accident review procedure? ☐ Yes ☐ No

If yes, describe: _____

19. Describe vehicle maintenance program:

20. List any other pertinent information about business:

SECTION D: Vehicle/Auto Information

1. Are all vehicles owned by the Insured? ☐ Yes ☐ No
If no, explain (are they leased, rented, etc.): _____
2. Do employees use their own vehicles for business purposes? ☐ Yes ☐ No
If yes, explain: _____
3. Are any employee/volunteers' vehicles used for client transport? ☐ Yes ☐ No
4. Are all drivers covered by Worker's Compensation? ☐ Yes ☐ No
If yes, provide carrier name: _____

SECTION E: Notice and Signature

The undersigned is an authorized representative of the applicant and represents that reasonable inquiry has been made to obtain the answers to questions on any application, supplemental questionnaire or other written correspondence submitted in support of the submission made for purposes of obtaining insurance quotations and/or coverage for the applicant. They represent that the answers are true, correct and complete to the best of their knowledge.

Applicant Name: _____

Applicant Title: _____

Applicant Signature: _____

Date: _____