KEYSTONE INSURERS GROUP®

MEDICAL TRANSPORTATION APPLICATION

SECTION I – GENERAL INFORMATION ***PLEASE COMPLETE EVERY ITEM OR INDICATE N/A***

1. Name of Applicant: _____ Requested Effective Date: _____

   DBA: _____

   (If applicable, include DBA or Trade Name)

   Do you conduct operations under any other Name(s)? ☐ Yes ☐ No If yes, please list Name(s) on a separate page.

2. Mailing Address: _____

   (Street)

   _____

   (City) *(County)* *(State)* *(Zip Code)*

   Physical Address: _____

   (Street)

   _____

   (City) *(County)* *(State)* *(Zip Code)*

   Do you have any other Location(s)? ☐ Yes ☐ No If yes, please list Location Address(es) on a separate page.

3. Contact Name: _____

4. Phone: _____ Email: _____

   Fax: _____ Website: _____

5. Business Type: ☐ Individual ☐ Partnership ☐ Corporation/Organization ☐ LLC ☐ Other **(Describe)**: _____

6. Entity Type: ☐ For Profit ☐ Non-profit ☐ Other **(Describe)**: _____

7. Federal ID#: _____

8. Number of years in business under the above name: _____

9. How many years of Emergency Medical Transportation Experience does the Owner, Medical Director and/or Manager have?

   Owner: _____ Years Medical Director: _____ Years Manager: _____ Years

   A. If applicable, describe the Owner's prior Emergency Medical Transportation experience: _____

   _____

   B. If applicable, describe Medical Director's prior Emergency Medical Transportation experience: _____

   _____

   C. What is the Medical Director's name? _____

   D. What type of Medical Degree does the Medical Director have? _____

   E. If applicable, describe Manager's prior Emergency Medical Transportation experience: _____

   _____

10. Within the last 10 years has the Applicant/Business Owner operated under any other name? ☐ Yes ☐ No

    Does the Applicant/Business Owner currently own any other Entities or operate any other Businesses? ☐ Yes ☐ No

    If yes has been answered for either question, answer A-C.

    A. Provide name and describe operations: _____

    _____

    B. Is the Entity/Business still active? ☐ Yes ☐ No

    C. If still active, is there separate General Liability Insurance in place for such operations? ☐ N/A ☐ Yes ☐ No

SECTION II – LIABILITY LIMITS ***PLEASE COMPLETE EVERY ITEM OR INDICATE N/A***

1. Desired Each Occurrence Limit/Each Professional Incident Limit/General Aggregate Limit:

   ☐ $300,000/$300,000/$600,000 ☐ $500,000/$500,000/$500,000 ☐ $500,000/$500,000/$1,000,000

   ☐ $1,000,000/$1,000,000/$1,000,000 ☐ $1,000,000/$1,000,000/$2,000,000 ☐ $1,000,000/$1,000,000/$3,000,000

SECTION III – OPERATIONS ***PLEASE COMPLETE EVERY ITEM OR INDICATE N/A***

1. Total Number of Employees: _____ Full-Time: _____ Part-Time: _____
2. Total Number of Volunteers: _____ Full-Time: _____ Part-Time: _____
3. Provide your Employee breakdown by type of Certification:

Number of Employees	Type of Certification	Number of Employees	Type of Certification

4. Annual Driver turnover percentage: _____ %
5. What is your projected total Annual Gross Sales for the current Policy Term? $ _____
6. Provide a percentage breakdown of your projected total Annual Gross Sales **(must total 100%)**:
   From Medicare/Medicaid: _____ % From Insurance Companies: _____ %
   From Private Payers: _____ % From Contracts: _____ %
7. In which States do you operate? _____
8. Do you travel into Michigan? ☐ Yes ☐ No
   A. If yes, how many days per month? _____
9. Do you travel into Ontario, Canada? ☐ Yes ☐ No
10. Which major metropolitan areas do you service? _____
11. Total number of calls last year: _____
12. Provide a breakdown of your total annual calls:
    Number of 911 Calls: _____
    Number of Emergency Calls (i.e. the assignment was dispatched as a true emergency): _____
    Number of Non-emergency Calls (i.e. the assignment was not dispatched as a true emergency): _____
    Number of Non-medical Calls (i.e. van, ambulette and/or wheelchair transportation): _____
13. Provide the total number of vehicles used for each type of Medical Transportation:
    Ambulance/Emergency Care Services – Non-profit: _____ Non-emergency Transportation – Non-profit: _____
    Ambulance/Emergency Care Services – For Profit: _____ Non-emergency Transportation – For Profit: _____
14. Do you lease, hire, rent or borrow any vehicles? ☐ Yes ☐ No
    If yes, please answer A-B.
    A. What is your annual cost for leased, hired or rented vehicles? $ _____
    B. What is the maximum value of any vehicle you lease, hire or rent? $ _____

SECTION IV – RISK MANAGEMENT ***PLEASE COMPLETE EVERY ITEM OR INDICATE N/A***

1. Do you meet all County, State and/or Federal Licensing requirements? ☐ Yes ☐ No
2. Describe the Owner's duties or involvement in the daily operations: _____
3. Describe the Executive or Medical Director's duties or involvement in the daily operations: _____
4. Describe the Manager's duties or involvement in the daily operations: _____
5. Are all potential Employees subject to a Pre-employment Screening process? ☐ Yes ☐ No
   A. If yes, your Pre-employment Screening process includes (please check all that apply):
   ☐ Criminal Background Check ☐ Prior Employment Checks ☐ Reference Checks
   ☐ Other **(Describe)**: _____
6. Do you obtain Motor Vehicle Reports for all Drivers? ☐ Yes ☐ No
   If yes, please answer A-B.
   A. How often do you obtain Motor Vehicle Reports? _____
   B. Who reviews the Motor Vehicle Reports? _____

7. Do you have an Orientation Program in place for all new Employees? ☐ Yes ☐ No

A. If yes, your Orientation Program includes a comprehensive review of the following (please check all that apply):

- ☐ Accident Reporting Procedures
- ☐ Assigned Routes
- ☐ Commercial Vehicle Rules and Regulations
- ☐ General Company Rules and Policies
- ☐ HIPAA Regulations and Policies
- ☐ Lift Equipment Operation
- ☐ Passenger Loading and Unloading Procedures
- ☐ Vehicle Inspection Procedures
- ☐ Wheelchair Locking and Tie-down Procedures
- ☐ Other **(Describe Below)**: _____

8. Are all Employees subject to Pre-employment and Random Drug Testing? ☐ Yes ☐ No

9. Do you have a written Progressive Disciplinary Plan in place for all Employees? ☐ Yes ☐ No

A. If yes, is it reviewed annually with all Employees? ☐ Yes ☐ No

10. Are all Employees covered by Workers' Compensation? ☐ Yes ☐ No

11. Do your Managers and/or Supervisors perform periodic Ride Checks with all Drivers? ☐ Yes ☐ No

12. Do all applicable Employees know how to handle Passengers with highly contagious illnesses and Passengers that carry blood borne pathogens? ☐ Yes ☐ No

13. Are Passenger Assistants used whenever a Non-emergency vehicle is used to transport medically fragile and/or severely disabled Passengers? ☐ N/A ☐ Yes ☐ No

14. Are all Non-emergency vehicles equipped with a First Aid Kit and a Vehicle Roadside Emergency Kit? ☐ N/A ☐ Yes ☐ No

15. Do you notify your Non-emergency Passengers whenever a vehicle is running late? ☐ N/A ☐ Yes ☐ No

16. Do you maintain documentation evidencing all medical equipment purchases, maintenance, calibration and service? ☐ Yes ☐ No

17. Do you maintain files in compliance with all applicable regulatory standards? ☐ Yes ☐ No

18. Do you utilize an Incident and/or Accident Reporting Form? ☐ Yes ☐ No

A. If yes, how long do you maintain these forms? _____ **Years**

19. Do you hire independent Medical Transportation Businesses? ☐ Yes ☐ No

If yes, please answer A-D.

A. Do you obtain a Certificate of Insurance from each independently contracted Medical Transportation Business evidencing General Liability and Workers Compensation Limits equal to, or greater than, your own General Liability and Workers Compensation Limits? ☐ Yes ☐ No

B. Do you require all independently contracted Medical Transportation Businesses to add you onto their General Liability policy as an Additional Insured? ☐ Yes ☐ No

C. Do you require all independently contracted Medical Transportation Businesses to contractually hold you harmless? ☐ Yes ☐ No

D. Are all Certificates of Insurance kept on file for a minimum of 5 years? ☐ Yes ☐ No

20. Do you hire independent Medical Transportation Drivers (i.e. other than those employed by the businesses addressed above in question 19)? ☐ Yes ☐ No

If yes, please answer A-B.

A. Do you verify that all applicable Licenses are up-to-date for each independently contracted Medical Transportation Driver? ☐ Yes ☐ No

B. Do you obtain an MVR for each independently contracted Medical Transportation Driver and review it for acceptability using the same standards used to evaluate your own Drivers? ☐ Yes ☐ No

21. Do you have a Medical Director and/or any Medical Practitioners or Physicians on staff? ☐ Yes ☐ No

A. If yes, do you obtain evidence of Medical Malpractice Insurance from each applicable individual on an annual basis? ☐ Yes ☐ No

22. Does your Medical Director review trip reports to confirm that all applicable protocols are being followed? ☐ Yes ☐ No

23. Do your operations include any of the following **(please check all that apply)**: ☐ Yes ☐ No

- ☐ Advance Life Support (ALS)
- ☐ Basic Life Support (BLS)
- ☐ Air Ambulances
- ☐ Bus Operations
- ☐ Organ Transplant Transportation

24. Is your business owned and/or operated by a hospital or any other type of medical facility? ☐ Yes ☐ No

25. Are vehicles equipped with Emergency Equipment? ☐ Yes ☐ No

A. If yes, please check all that apply:

- ☐ Blood Pressure Equipment
- ☐ Defibrillator
- ☐ First Aid Kit
- ☐ Oxygen
- ☐ Oxygen Mask
- ☐ Vehicle Roadside Emergency Kit
- ☐ Other **(Describe)**: _____

26. Are vehicles equipped with Safety Equipment? ☐ Yes ☐ No

A. If yes, please check all that apply:

☐ Voice Activated GPS ☐ Driver Cam ☐ Other **(Describe below)**:

_____

27. Will each vehicle be staffed with at least one Employee with American Red Cross First Aid, CPR and Automated External Defibrillation (AED) Training and Certification? ☐ Yes ☐ No

SECTION V – PRIOR GENERAL LIABILITY AND PROFESSIONAL LIABILITY INSURANCE

1. Provide Insurance Company Names as well as your Limits, Deductibles and Premiums for the last 3 years:

Year	Insurance Company Name	General Liability Limits	Professional Liability Limits	General Liability Deductible	Premium
		$	$	$	$
		$	$	$	$
		$	$	$	$

2. In the last 3 years, has your insurance been Declined, Cancelled or Non-renewed? ☐ Yes ☐ No

A. If yes, please explain why: _____

_____

SECTION VI – GENERAL LIABILITY AND PROFESSIONAL LIABILITY CLAIMS HISTORY

1. Provide details for the last 3 years - **if none, please state "none"**:

Date of Loss	Description of Loss	Open/Closed?	Total Incurred
			$
			$
			$

AGENT INFORMATION:

Is this an account you currently write? ☐ Yes ☐ No

Appropriate Property ACORD Application is attached. ☐ Yes ☐ No

Appropriate Auto ACORD Application is attached. ☐ Yes ☐ No

Any Policy quoted may be subject to a Minimum Policy Premium.

Applicant and Producer Signatures:

APPLICANT: I UNDERSTAND THAT THIS APPLICATION FOR INSURANCE AND ANY POLICY ISSUED AS A RESULT OF THE APPROVAL OF THIS APPLICATION WILL **ONLY** PROVIDE INSURANCE FOR MEDICAL TRANSPORTATION OPERATIONS. I FURTHER UNDERSTAND THAT NO COVERAGE WILL BE PROVIDED FOR ANY OTHER BUSINESSES, OPERATIONS OR SERVICES UNLESS THEY ARE SPECIFICALLY ADDED TO ANY POLICY ISSUED FOR AN ADDITIONAL PREMIUM.

FRAUD WARNING: 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 INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO IS GUILTY OF INSURANCE FRAUD. THIS IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES. (FOR NEW YORK INSUREDS: AN ACT OF INSURANCE FRAUD SHALL BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED $5,000 AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.)

_____ _____

Applicant's Signature **Applicant's Title**

_____ _____

Applicant's Name **Date**

_____ _____

Producer's Signature **Producer's Name**