Cyber & Professional Lines Group
16501 Ventura Blvd. Suite 200, Encino, CA 91436
main (818) 382-2030

Medical Transportation Professional Liability and General Liability Insurance Application

THIS IS AN APPLICATION FOR A CLAIMS MADE AND REPORTED POLICY. THIS APPLICATION IS NOT A BINDER.

This application for Professional Liability and General Liability Insurance is intended to be used for the preliminary evaluation of a submission. When completed in its entirety, this application will enable the Underwriter to decide whether or not to authorize the binding of insurance. Please type or print clearly and answer all questions. If space is insufficient to answer any question fully, attach a separate sheet. Complete all required supplemental forms/applications. "You" and "Your", as used in this application, means the Applicant.

PLEASE ATTACH THE FOLLOWING:

- **A copy of the COI confirming current Commercial Auto Liability Coverage**
- **Currently valued loss runs for the last 5 years for Professional Liability, General Liability and Commercial Auto Liability**
- **A copy of the risk management company guidelines for patient loading and unloading, including wheelchair and stretcher patient transfers**

1. GENERAL INFORMATION			
Name of Applicant			
Physical Address		Phone	
City, State, Zip Code		County	
Mailing Address			
Website		Contact e-mail	

2. OPERATIONS

a. Date established

b. Applicant is a:

☐ Sole Practitioner (unincorporated) ☐ Sole Practitioner (incorporated) ☐ Corporation (for profit)
☐ Corporation (non-profit) ☐ Partnership ☐ Professional Association
☐ Other (describe):_____

c. Has the Applicant merged with any other entity in the past ten (10) years? ☐ Yes ☐ No
If **"YES"**, please provide details on a separate sheet of paper.

d. Is the Applicant contemplating a merger in the next eighteen (18) months? ☐ Yes ☐ No
If **"YES"**, please provide details on a separate sheet of paper.

e. Please check the category which best describes your organization. (Check all that apply if you offer multiple services.)

	Vehicle Type	**Description**
☐	Non-Medical Ambulette or Van Service	Services include transporting clients/patients from residential facilities/homes to physician offices; drivers are typically non-medical professionals with basic First Aid and/or CPR training.
☐	Non-Emergency Medical Transportation	Services include medical facility-to-facility transports by ambulance. EMT Basic or Intermediate personnel may accompany patients. This category encompasses Basic Life Support (BLS) and Advanced Life Support (ALS) services as defined by Medicare.
☐	Emergency Transportation	Services include response to 911 calls or the equivalent; EMT Basic, Intermediate and/or Paramedics may accompany patients.
☐	Other (Please provide a description of your organization if it does not readily reflect one of the above categories)	

3. COVERAGE DESIRED

a. Proposed Effective Date:	
b. Retroactive Date:	
c. Limit(s):	
d. Deductible(s):	

e. Does the company enter into any written or verbal service agreements that require this insurance? ☐ Yes ☐ No
If **"YES"**, please provide the name of any party requiring the Applicant to have this insurance.

4. SPECIALTY TRANSPORTS/SERVICES

(Additional Underwriting information will be needed for each service provided.)

a. Check all services that you provide:

- ☐ Air and/or Water transportation
- ☐ Bariatric Transportation
- ☐ Organ Delivery/Donation Transportation
- ☐ International Transportation
- ☐ Involuntary (Psych) Transportation
- ☐ Ridesharing Transportation
- ☐ School Transportation
- ☐ Escort/Travel Companion Services
- ☐ Travel Arrangement Services or Agencies
- ☐ Alarm Monitoring
- ☐ Dispatch Service for Others
- ☐ Other (specify): _____

b. Do you provide contracted or standby medical services for any of the following special events (check all that apply)?

- ☐ Car/Motorcross Races
- ☐ Concerts
- ☐ Professional Sports
- ☐ Other: _____
- ☐ Horse Races
- ☐ High School/College Sports
- ☐ Night Clubs

c. Do you subcontract your services **FOR** others? ☐ Yes ☐ No
If **"YES"**, please provide copies of contracts.

5. TRANSPORTS AND GROSS REVENUES

a. Please enter the number of transports and gross revenue:

Type of Service	# of transports		Gross Revenue	
	Last 12 months	Projected next 12 months	Last 12 months	Projected next 12 months
Critical/Specialty Care Ambulance			$	$
Emergency (BLS) Ambulance			$	$
Emergency (ALS) Ambulance			$	$
Non-Emergency (BLS) Ambulance			$	$
Non-Emergency (ALS) Ambulance			$	$
Non-Medical/Paratransit/WC			$	$
Other (specify):			$	$
Total			$	$

b. Indicate the percentage of trips that fall into the following categories:

Pre-Scheduled	_____%	Curb to Curb	_____%
On-Demand	_____%	Door to Door	_____%
Emergency	_____%	Door through Door	_____%

Age range of passengers: _____% under 18 _____% with Developmental or Intellectual Disabilities

_____

c. Radius of Operations

Average Miles per trip: _____ Total Fleet Miles Annual: _____

d. Does the operating status cross any state lines? ☐ Yes ☐ No

If **"YES"**, list states: _____

e. Are long-distance (more than 200 miles traveled in one leg of the trip) transport services provided? ☐ Yes ☐ No

If **"YES"**, please provide detail on the risk management protocols as well as staff details per trip.

6. DISPATCH

a. How are calls dispatched? (Check all that apply)

☐ 911 ☐ In-House ☐ Other (specify): _____

b. Is a record kept of each request for service? ☐ Yes ☐ No

c. Is a Patient Care Report (PCR) completed for each transport in which medical care, evaluation or observation has been performed? ☐ Yes ☐ No

d. Do you have protocols in place stating when Emergency Warning Systems (EWS) **must** be and **may** be activated? ☐ Yes ☐ No

e. What are your hours of operations?

f. What are the maximum hours allowed per shift, per driver?

7. VOCATIONAL TRAINING

a. Do you offer any CPR, First Aid or other medical training/certification for any persons other than employees? ☐ Yes ☐ No

If **"YES"** to question **7.a.** above, please answer the following:

(1) What is the total number of students per year? _____

(2) What certifications or degrees are offered? _____

(3) What are the annual receipts from this operation? _____

(4) If classes are conducted on site, what is the capacity of the classroom in number of students? _____

(5) How often are classes conducted? _____

For what duration? _____

8. STAFF

a. Please provide the number of:

	Employees		Independent Contractors		Volunteers	
	Full-Time	Part-Time	Full-Time	Part-Time	Full-Time	Part-Time
Emergency Medical Responder						
Critical Care Paramedics						
Paramedics						
Nurse (LPN or RN)						
Physicians						
Advanced EMT						
Emergency Medical Tech						
Ambulatory/Wheelchair Operators						
Other (please describe:)						

b. Total Staff Count:

c. Do you have a Medical Director on staff? ☐ Yes ☐ No

If **"YES"**, provide the name of the Medical Director: _____

d. Is your Medical Director board certified in emergency medicine? ☐ Yes ☐ No

e. If your Medical Director is a Physician, do you require evidence of his/her own professional liability insurance? ☐ Yes ☐ No

(A certificate of insurance evidencing the above information will be required to bind.)

f. Are all medical transports documented, with regular quality review by the Medical Director or other qualified person or group? ☐ Yes ☐ No

If not reviewed by the Medical Director, who is responsible for the review?

_____

9. EMPLOYEE HIRING PRACTICES

a. Are background checks performed on all employees, independent contractors and volunteers? ☐ Yes ☐ No

If **"YES"**, please check the level or type of criminal background checks you perform (check all that apply):

☐ County ☐ State ☐ Federal ☐ Sexual Offender Registry

b. Are all employees, independent contractors and volunteers screened for drugs and alcohol? ☐ Yes ☐ No

If **"YES"**, how often? _____

c. Which of the following is a standard part of your pre-employment review? (Check all that apply)

☐ Written Application ☐ Motor Vehicle Record (MVR) review ☐ Ride Along Driving Test

☐ Job Specific Physical Examination ☐ Employment background check

☐ Pre-employment drug test ☐ Other (specify): _____

d. Have you or any of your employees:

(1) ever been the subject of a disciplinary proceeding, investigation or reprimand by a governmental or administrative agency, hospital or professional association? ☐ Yes ☐ No

(2) ever been convicted for a violation of any law or ordinance other than traffic offenses? ☐ Yes ☐ No

(3) ever been treated for alcoholism or drug addiction? ☐ Yes ☐ No

(4) ever had any professional license or license to prescribe or dispense narcotics refused, suspended, revoked, non-renewed or accepted only on special terms, or ever voluntarily surrendered any such license? ☐ Yes ☐ No

If **"YES"** to any of the above, please explain:

10. DRIVER TRAINING/SAFETY

a. Do you have written driver criteria policies in place? ☐ Yes ☐ No

b. Are there experience requirements for newly hired drivers? ☐ Yes ☐ No

If **"YES"**, what are the requirements?

c. Is there a minimum age requirement for drivers? ☐ Yes ☐ No

If **"YES"**, what is the minimum age? _____

d. How many drivers are over age 65? | Under age 23?

e. How often are Motor Vehicle Reports (MVRs) checked for all drivers?

f. Do you have written criteria for acceptable MVRs? ☐ Yes ☐ No

g. Please describe your drivers' training (Check all that apply):

☐ General Driving Orientation ☐ Defensive Driving ☐ CPR ☐ Primary First Aid

☐ Advanced First Aid ☐ Passenger Assistance ☐ Non-Medical Emergency Training

☐ Emergency Vehicle Evacuation ☐ Proper Wheelchair/Stretcher Securement Procedures

h. Do you have a written safety program in place? ☐ Yes ☐ No

i. Name and title of the person(s) responsible for safety & risk management:

j. Name and title of person responsible for claims reporting:

k. Are there formal accident investigation and review procedures in place? ☐ Yes ☐ No

l. Is there a driver safety incentive plan in place? ☐ Yes ☐ No

If **"YES"**, please describe:

m. How frequently are employees required to take a driver training course/refresher:

n. Is there a progressive discipline policy for drivers involved in serious or multiple accidents/violations? ☐ Yes ☐ No

o. Is there a maximum number of driving violations allowed? ☐ Yes ☐ No

If **"YES"**, how many? _____

p. Is there a maximum number of accidents allowed? ☐ Yes ☐ No

If **"YES"**, how many? _____

q. Is there a post-accident drug testing policy in place? ☐ Yes ☐ No

r.	Do you have a violent patient restraint policy?	☐ Yes ☐ No
s.	Do you use global positioning systems (GPS) to monitor driver behavior?	☐ Yes ☐ No
t.	Are all vehicles equipped with cameras or accident event recorders?	☐ Yes ☐ No
u.	Are there restrictions on the use of cell phones/hand-held while operating vehicles?	☐ Yes ☐ No
v.	Do you perform pre-trip vehicle inspections?	☐ Yes ☐ No
w.	Do you perform post-trip vehicle inspections?	☐ Yes ☐ No
x.	Are call reports completed on every call and/or run?	☐ Yes ☐ No

11. VEHICLES

a. Please enter the number of units for each type of vehicle:

# of units	Type of Vehicle
_____	Advanced Life Support Ambulance
_____	Basic Life Support Ambulance
_____	Ambulette or Wheelchair Van
_____	Private Passenger Vehicles
_____	**Total units**

b. Are vehicles engaged with (check all that apply):

☐ Cardiac Monitors ☐ Pacemakers ☐ Defibrillators
☐ Ventilators ☐ Intubation Kits ☐ Oxygen
☐ Pulses Oximeters ☐ Emergency Cardiac ☐ In-Vehicle Cameras
☐ GPS Tracking ☐ Lift-Out/Pull-Out Ramps ☐ Mechanical Lifts

12. VEHICLE MAINTENANCE

a.	Do you utilize a written vehicle preventive maintenance program?	☐ Yes ☐ No
b.	How often is maintenance performed?	
c.	Do you maintain records listing vehicle defects and repairs?	☐ Yes ☐ No
d.	Are maintenance repair records on file for all vehicles?	☐ Yes ☐ No
e.	Do all vehicles comply with ADA standards?	☐ Yes ☐ No

13. PASSENGER ASSISTANCE

a.	Are drivers instructed to request permission to assist ambulatory and/or walker passengers prior to the passengers entering and exiting the vehicle?	☐ Yes ☐ No
b.	How many vehicles are equipped with passenger restraint system?	
c.	Do you have a mandatory lift assist policy?	☐ Yes ☐ No
d.	Do vehicles equipped with lifts or ramps exclusively transport non-ambulatory individuals?	☐ Yes ☐ No
e.	Are all persons involved in wheelchair transportation instructed in the proper use of securement equipment for all types of wheelchairs?	☐ Yes ☐ No
f.	Are all restraint systems designed with a "4-point tie-down" and "forward facing" features?	☐ Yes ☐ No

g. What types of wheelchairs are used to transport passengers?

☐ Portable ☐ Motorized ☐ Youth/Child Stroller ☐ Tri-Wheeler/Scooter
☐ Lightweight ☐ Heavy Duty Industrial ☐ Reclining/Tilting

h. How are wheelchairs secured to floor of vehicle?

☐ Fixed Access Locations ☐ Moveable Attachments ☐ Both

i.	Are wheelchair passengers ever transported without the use of a restraint system?	☐ Yes ☐ No
j.	Are passengers in scooter type chairs required to transfer to a wheelchair or a permanent seat after loading?	☐ Yes ☐ No

k.	Are wheelchair passengers ever permitted to ride in the vehicle in other than the designated securement locations?	☐ Yes ☐ No
l.	What types of stretchers do you use in your vans?	
m.	What type of stretcher vehicle securing system do you provide in your stretcher vans?	
n.	Do you use knee, hip, chest, and over the shoulder safety restraints on stretchers?	☐ Yes ☐ No
o.	Do employees load and unload stretchers? If **"YES"**, please provide a copy of the training procedures for loading and unloading clients.	☐ Yes ☐ No
p.	At what frequency are employees operating these vehicles trained in the use of these systems? ☐ Time of Hire ☐ Semi-Annually ☐ Annually ☐ Post-Accident ☐ Other (describe): _____	

14. NETWORK SECURITY AND PRIVACY CONTROLS

a.	Do you have a billing compliance program? If **"YES"**, when was it implemented: _____ If **"NO"**, do you outsource your billings to a third-party billing company?	☐ Yes ☐ No ☐ Yes ☐ No
b.	Is your practice using a current edition of the CPT manual?	☐ Yes ☐ No
c.	Is software used to ensure billing compliance?	☐ Yes ☐ No
d.	Who within your organization is responsible for billing compliance? Please include the person's name, title, qualifications and date of hire in this position and how often such person performs billing reviews?	
e.	Are you HIPAA compliant?	☐ Yes ☐ No
f.	Does your company use anti-virus software and firewall protection on all desktops, portable devices and mission critical servers, and is it updated in accordance with the software provider's recommendations?	☐ Yes ☐ No
g.	Do you enforce privacy and security policies that must be followed by all employees, contractors, or other individuals or organizations with access to your patients' information?	☐ Yes ☐ No
h.	Is all sensitive and confidential information stored on your organization's databases, servers and data file encrypted?	☐ Yes ☐ No
i.	Been placed on prepayment review by any local, state or federal government agency or by any private (commercial) payer?	☐ Yes ☐ No
j.	Been audited, investigated or sanctioned by any local, state or federal government agency or private (commercial) payer regarding Medicare/Medicaid billing practices, utilization of Medicate/Medicaid services or the delivery of health care services or reimbursement thereof?	☐ Yes ☐ No
k.	Been investigated for HIPAA, EMTALA or stark/anti-kickback violations?	☐ Yes ☐ No

15. COVERAGE HISTORY

a. Please provide details of professional liability coverage purchased in the last five (5) years to date:

Policy Period	Limits	SIR/ Deductible	Carrier	Annual Premium	Occurrence or Claims-Made	Retroactive Date

b. Please provide details of general liability coverage purchased in the last five (5) years to date:

Policy Period	Limits	SIR/ Deductible	Carrier	Annual Premium	Occurrence or Claims-Made	Retroactive Date

16. AUTOMOBILE LIABILITY INSURANCE INFORMATION

a.	Current Carrier	
b.	Limits of Liability	
c.	Deductible	

d.	Does the policy specifically exclude claims arising from loading and unloading of patients?	☐ Yes ☐ No
e.	Does the policy remain silent on the applicability of coverage for claims arising from loading and unloading of patients?	☐ Yes ☐ No

17. LOSS HISTORY

a.	Has any insurer cancelled or refused to renew any similar insurance during the past five (5) years?	☐ Yes ☐ No
b.	Has any application for Professional Liability or General Liability Insurance made on behalf of the Applicant, any predecessors in business, or present partners ever been declined, or has such insurance ever been cancelled, non-renewed or accepted only on special terms? **If "YES", please describe:**	☐ Yes ☐ No
c.	In the past five (5) years, has any claim been made, or legal action been brought, against you, any of your current or former officers, directors, owners, partners or employees, or any other person or entity proposed for this insurance? **If "YES", please complete a Claim Supplemental Form for each claim.**	☐ Yes ☐ No
d.	Are you or any other person or entity proposed for this insurance aware of any fact(s), incident(s), act(s), event(s), circumstance(s) or occurrence(s) that may result in any professional liability or general liability claim(s) being made against any person or entity proposed for this insurance? **If "YES", please complete a Claim Supplemental Form for each allegation or incident.**	☐ Yes ☐ No

NOTICE TO APPLICANT

The insurance for which you are applying will not respond to incidents about which any person proposed for coverage had knowledge prior to the effective date of the policy, nor will coverage apply to any claim or circumstance identified or that should have been identified in question 17.c. and 17.d. of this application.

NOTICE TO NEW YORK APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

The Applicant hereby acknowledges that he/she/it is aware that the limit of liability shall be reduced, and may be completely exhausted, by claim expenses and, in such event, the Insurer shall not be liable for claim expenses or any judgment or settlement that exceed the limit of liability.

I HEREBY DECLARE that, after inquiry, the above statements and particulars are true and I have not suppressed or misstated any material fact, and that I agree that this application shall be the basis of the contract with the Underwriters.

CERTIFICATION AND SIGNATURE

The Applicant has read the foregoing and understands that completion of this application does not bind the Underwriter or the Broker to provide coverage. It is agreed, however, that this application is complete and correct to the best of the Applicant's knowledge and belief, and that all particulars which may have a bearing upon acceptability as a Professional Liability and General Liability Insurance risk have been revealed.

It is understood that this application shall form the basis of the contract should the Underwriter approve coverage and should the Applicant be satisfied with the Underwriter's quotation. It is further agreed that, if in the time between submission of this application and the requested date for coverage to be effective, the Applicant becomes aware of any information which would change the answers furnished in response to any question of this application, such information shall be revealed immediately in writing to the Underwriter.

This application shall be deemed attached to and form a part of the Policy should coverage be bound.

Must be signed by an officer of the company.

Print or Type Applicant's Name	Title of Applicant
Signature of Applicant	Date Signed by Applicant

California Fraud Warning

For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.