PASSENGER TRANSPORT & NEMT SUPPLEMENTAL

Covers emergency and non-emergency medical transport, livery and passenger transport. Complete with CWCO-SUP-CORE and ACORD 125/126/127. CWCO-SUP-AUTO carries the vehicle and driver sched

NAME OF APPLICANT | EFFECTIVE DATE REQUESTED | DATE ESTABLISHED

LOCATION ADDRESS | CITY | STATE / ZIP | WEBSITE

INSURED CONTACT NAME | CONTACT PHONE | CONTACT EMAIL

A ORGANIZATION & SERVICE MIX

% EMERGENCY TRANSPORT | % NON-EMERGENCY — AMBULANCE | % NON-EMERGENCY — TRANSPORT | % LIVERY / NON-MEDICAL PASSENGER

Organization type:

- ☐ Volunteer
- ☐ Individual
- ☐ Partnership
- ☐ Corporation — for profit
- ☐ Corporation — non-profit
- ☐ Municipality
- ☐ Hospital affiliated
- ☐ Franchise
- ☐ Other

IF MUNICIPAL — FULLY DESCRIBE THE MUNICIPALITY'S INTEREST, CONTROL AND FINANCIAL SUPPORT. IF OTHER, EXPLAIN.

Type of service provided (check all that apply):

- ☐ Air ambulance
- ☐ Ambulance
- ☐ Alarm monitoring
- ☐ Disaster recovery
- ☐ Dispatch service for others
- ☐ Emergency service at special events
- ☐ Fire department with ambulance
- ☐ Fire department without ambulance
- ☐ First responder
- ☐ Individual EMT
- ☐ Paramedic
- ☐ Rescue squad with ambulance
- ☐ Rescue squad without ambulance
- ☐ Search and rescue
- ☐ Special events standby
- ☐ Wheelchair / stretcher van
- ☐ Ambulatory transport
- ☐ Public livery / limousine
- ☐ Shuttle service
- ☐ School or student transport
- ☐ Other (describe below)

POPULATION OF AREA SERVED | RADIUS OF OPERATION (MILES) | ANNUAL SALES / RECEIPTS ($) | ANNUAL NUMBER OF TRANSPORTS

WHAT STATES IS THE APPLICANT LICENSED OR CERTIFIED IN? PROVIDE DETAILS OF WHAT THE LICENSE OR CERTIFICATION ALLOWS THE APPLICANT TO DO.

A1 Is the applicant affiliated with any other entity? ☐ Yes ☐ No
IF YES, EXPLAIN

A2 Is the applicant owned by, operated by, or affiliated with a hospital, nursing home or assisted living facility? ☐ Yes ☐ No
IF YES, EXPLAIN

B FLEET & PERSONNEL

OPERATIONAL AMBULANCES | STAND-BY AMBULANCES | CHAIR CARS / VANS / MINI VANS | SEDANS / LIVERY VEHICLES | TOTAL VEHICLES

NUMBER OF EMTS | NUMBER OF PARAMEDICS | NUMBER OF FIRST RESPONDERS | # VOLUNTEER MEMBERS | # PAID MEMBERS

B1 Does the applicant use subcontractors for any transport? ☐ Yes ☐ No
IF YES, EXPLAIN

B2 Do all non-emergency transport drivers hold current CPR or AED certification? ☐ Yes ☐ No
IF YES, EXPLAIN

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B3 Are all clinical personnel currently licensed or certified at the level of service provided? ☐ Yes ☐ No

IF YES, EXPLAIN

CURRENT AUTO INSURER	AUTO LIABILITY LIMITS	MINIMUM DRIVER AGE / YEARS EXPERIENCE REQUIRED

A complete vehicle schedule must be attached. Use CWCO-SUP-AUTO Section E.

C PATIENT POPULATION & HIGHER-HAZARD TRANSPORT

C1 Does the applicant transport prisoners or psychiatric patients? ☐ Yes ☐ No

IF YES, EXPLAIN

C2 Does the applicant transport bariatric patients, or patients requiring specialized lift equipment? ☐ Yes ☐ No

IF YES, EXPLAIN

C3 Does the applicant transport unaccompanied minors? ☐ Yes ☐ No

IF YES, EXPLAIN

C4 Does the applicant transport patients on ventilators, IV drips, or other continuous clinical support? ☐ Yes ☐ No

IF YES, EXPLAIN

C5 Does the applicant provide standby coverage at special events, sporting events or mass gatherings? ☐ Yes ☐ No

IF YES, EXPLAIN

C6 Does the applicant hold contracts with any government agency, managed care organization, or broker network? ☐ Yes ☐ No

IF YES, EXPLAIN

% WHEELCHAIR-BOUND PASSENGERS	% STRETCHER PASSENGERS	% AMBULATORY PASSENGERS	AVERAGE PASSENGERS PER TRIP

D WRITTEN PROCEDURES & TRAINING

Documented procedure and training is the primary differentiator in this class.

D1 Are there written procedures requiring documentation of all incidents? ☐ Yes ☐ No

D2 Are there written procedures and documented training for loading and unloading? ☐ Yes ☐ No

D3 Are there written procedures and documented training for wheelchair locking and tie-down? ☐ Yes ☐ No

D4 Are there written emergency and accident reporting procedures with documented training? ☐ Yes ☐ No

D5 Are there written HIPAA regulations and policies with documented training? ☐ Yes ☐ No

D6 Are background checks performed on all employees, including criminal background check, sex offender registry, and references? ☐ Yes ☐ No

IF YES, EXPLAIN

D7 Are motor vehicle records pulled at hire and reviewed at least annually for every driver? ☐ Yes ☐ No

IF YES, EXPLAIN

D8 Is drug and alcohol testing performed, and is the applicant enrolled in a DOT testing consortium where required? ☐ Yes ☐ No

IF YES, EXPLAIN

D9 Are vehicles inspected before each shift, with documented pre-trip and post-trip checklists? ☐ Yes ☐ No

IF YES, EXPLAIN

D10 Is a written infection control and biohazard disposal procedure in place? ☐ Yes ☐ No

IF YES, EXPLAIN

E CLAIMS & PRIOR INSURANCE

Attach three years of general liability, professional liability and commercial auto loss runs.

E1 Has the applicant had previous insurance for this enterprise? ☐ Yes ☐ No

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COVERAGE	CARRIER	POLICY TERM	LIMITS	PREMIUM ($)	RETRO DATE

E2 During the past three years, have any claims been presented to a current or prior carrier? ☐ Yes ☐ No

DATE OF LOSS	DESCRIPTION OF CLAIM	PAID ($)	RESERVED ($)	STATUS

E3 Is the applicant, or any person for whom insurance is requested, aware of any circumstance that may result in a claim? ☐ Yes ☐ No
IF YES, EXPLAIN

E4 Has any application for liability insurance been denied, or any policy cancelled or non-renewed, in the past three years? ☐ Yes ☐ No
IF YES, EXPLAIN

E5 Has the applicant had any incident or claim alleging sexual molestation or other misconduct? ☐ Yes ☐ No
IF YES, EXPLAIN

If yes to E5, CWCO-SUP-ABUSE must be completed in full and the incident narrated separately.

F INDIVIDUAL & VOLUNTEER PROVIDERS

Complete only if the applicant is an individual provider or a volunteer fire department with paramedics, EMTs or first responders.

WHAT TYPE OF ENTITY DOES THE APPLICANT PROVIDE SERVICES FOR, AND WHAT TYPE OF EMERGENCY SERVICES ARE PERFORMED?

F1 Does the applicant have any supervisory duties? ☐ Yes ☐ No
IF YES, EXPLAIN

F2 Is the applicant a nurse practitioner, advanced practical nurse, or physician's assistant? ☐ Yes ☐ No
IF YES, EXPLAIN

Forward a copy of all current certifications and licenses with the submission.

G ADDITIONAL INSUREDS & INFORMATION

ADDITIONAL INSURED NAME	ADDRESS, CITY, STATE, ZIP	DESCRIBE INTEREST

ANYTHING ELSE AN UNDERWRITER SHOULD KNOW — ACCREDITATION, CONTRACT QUALITY, FLEET UPGRADES, OR PLANNED CHANGES

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H REPRESENTATIONS & SIGNATURE

The undersigned declares that the statements and answers given in this supplemental are true, complete and correct to the best of their knowledge, and that no material fact has been withheld or misstated. The applicant agrees that this supplemental, together with all ACORD applications and attachments, forms the basis of any submission to insurers and may be relied upon by them. Signing this supplemental does not bind coverage. This supplemental must be signed by an owner, partner or officer of the applicant.

FRAUD NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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 such person to criminal and civil penalties. (State-specific fraud warnings apply; see state amendatory notice.)

APPLICANT / AUTHORIZED SIGNATURE (TYPE FULL NAME)	TITLE	DATE

PRODUCER — CORY WASHINGTON & CO. LLC	PRODUCER SIGNATURE (TYPE FULL NAME)	DATE

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