

CMT New Business Regular Supplemental Questionnaire
- FOR USE WITH ALL CMT CLASSES EXCEPT RURAL TAXI-
(To be used in conjunction with FULLY completed ACORD applications)

Name of Insured: _____

GENERAL INFORMATION

Number of Years: In Business: _____ Current Ownership: _____ Current Management in Place: _____
 Does the insured have a website Yes No. If Yes, what is the address? _____
 Have you ever operated under a different name: Yes No If "Yes", what name: _____
 Does insured have filings Yes No DOT # _____ MC # _____ PUC # _____
 Exact Name on Filing: _____
 Insured's annual transportation revenue: _____ Insured's annual mileage: _____
 Complete Description of **ALL** Operations (including any case work, home healthcare, hospice care, or community education as applicable): _____

HISTORICAL VEHICLE DATA (MUST BE PROVIDED)

Vehicles By Seating Capacity:	1-8 Passengers	9-20 Passengers	>20 Passengers	PPT/Service
Proposed Year				
Current Year				
Prior Year				
Second Prior Year				
Third Prior Year				
Fourth Prior Year				

Expiring Premiums: Liability: _____ # Units: _____ Physical Damage: _____ # Units: _____

OPERATIONS

As a % of total trips: Wheelchair: _____% Stretcher transportation: _____%
 As a % of total trips: Curb to Curb: _____% Door to Door: _____% Door through Door: _____%
 As a % of total trips: Pre-Scheduled: _____% On-Demand: _____%
 Radius, as a % of total trips: 0-50 miles: _____% 51-200 miles: _____% 200+ miles: _____%

Does the insured subcontract **FOR** others? Yes No. If yes, provide copies of contracts.
 Does the company enter into any written or verbal agreements to provide service? Yes No.
 Does the company borrow or lease agents, servants, or employees from others? Yes No.
 Does the company lease or loan vehicles to others? Yes No.
 Does the company have any home nursing or healthcare operations? Yes No.
 Does the company have any contracts to provide transportation for railroad employees? Yes No.

In what cities does insured provide transportation?

City	% of Trips	City	% of Trips

SAFETY & CLAIMS MANAGEMENT

Name and title of the person responsible for safety & risk management: _____
 Describe his/her duties: _____

 Name and title of person responsible for claims reporting: _____

Describe the insured's accident review program: _____

Are cameras or accident event recorders (AER's) installed in vehicles for the purpose of driver behavior modification and/or accident analysis and evaluation? When were the cameras/AER's implemented? How many units? What vendor/technology? Are you using a managed service program? _____

Does the insured hold safety meetings: Yes No
 How often are they held? _____
 Is attendance mandatory: Yes No

VEHICLE MAINTENANCE:

Describe the insured's preventive maintenance program: _____

Does the insured have the following:

Documentation of Repairs: Yes No Pre-Trip Inspections: Yes No
 Post-Trip Inspections: Yes No Driver Trouble Reports: Yes No
 Periodic In-depth Inspections: Yes No

What is the insured's vehicle replacement policy? _____
 Where are vehicles stored after hours? What security is provided? _____
 If vehicles are stored at driver's homes, what provisions are made for vehicle security? _____

What is the maximum value of vehicles stored at each location?

	Location #1	Location #2	Location #3
Inside			
Outside			

WHEELCHAIR INFORMATION:

Number of vehicles equipped with:

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

Is all equipment factory installed during vehicle construction? Yes No

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? Yes No

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

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

What types of wheel chairs that can be accommodated by your vehicles (check all that apply):

heavy duty industrial reclining/tilting
 lightweight motorized
 portable tri-wheeler/ scooter
 youth/child stroller other _____

Are passengers in tri-wheelers required to transfer to a wheelchair or a permanent seat after loading? Yes No

Are wheelchair passengers ever permitted to ride in the vehicle in other than the designated securement locations? Yes No

Are ALL persons involved in wheelchair transportation instructed in the proper use of securement equipment for all types of wheelchairs? Yes No

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 in your stretcher vans? _____

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

Who does the loading and unloading of the stretchers? _____

What training is provided if employees load and unload? _____

Does an attendant accompany stretcher clients? Yes No.

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? Yes No

Do any vehicles respond to 911 calls directly or indirectly? Yes No

Do you perform any emergency runs/trips? Yes No

Are lights/sirens used to facilitate movement through traffic? Yes No

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? Yes No

Do any of the crew member's duties preclude the use of their safety belt? Yes No

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 _____

EMPLOYEES

Number of Employees: _____

Full time drivers: _____

Vehicle maintenance: _____

Regular part time drivers: _____

Dispatchers: _____

Back-up drivers: _____

Volunteer drivers: _____

Total non-medical employees: _____

Medical employees (EMT's, paramedics etc.): _____

Other (number and description of duties): _____

Average annual driver turnover (%): _____

Is workers compensation insurance provided for all crewmembers? _____ Name of company _____

Describe driver hiring procedures: _____

Are MVR's ordered prior to hiring: Yes No. What criteria are used for acceptability? _____

Are MVR's ordered and reviewed on ALL drivers at least annually? Yes No

Describe driver orientation program: _____

Are all drivers/EMT's required to take a driver training/vehicle operators course? _____

What **percentages** of drivers are trained in the following?

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

If volunteer drivers are used, are they subject to the same hiring guidelines and training as the regular drivers:
 Yes No. Comments: _____

Are employment applications required: Yes No. Comments: _____

Are previous employment references checked: Yes No. Comments: _____

Do you require new drivers to have previous commercial driving experience? Yes No

Are pre-employment physicals performed: Yes No. Comments: _____

Are drug tests performed: Yes No. If yes, frequency: _____

Are criminal background checks performed on **all** drivers? Yes No. If yes, describe criteria used to determine acceptability: _____

Are back-up drivers required to follow the same hiring, MVR and training criteria as regular drivers: Yes No.

Are driver files kept: Yes No

Is there an employee manual: Yes No.

If policy is to provide coverage for Private Passenger Type autos, please describe insured's policy as to personal use of these vehicles. **If written, provide a copy.** _____

Is there any personal use of insured vehicles? Yes No. If Yes, describe: _____

If No, how is it monitored? _____

Medical certificates should be provided on all drivers over the age of 70 who have a CDL. If not, provide any medical qualification report currently in use. Please attach any policies, procedures or programs used specifically for these drivers that serve to insure their fitness for duty and ability to operate assigned vehicles safely.

HIRED & NON-OWNED:

Does the insured's operations include any case work, home healthcare, hospice care, or off-site community education services? Yes No.

Do any employees use their own autos in the insured's business: Yes No. If yes, how many: _____

Do these employees transport clients: Yes No. If yes, how often: _____

Does the insured require proof of insurance from these employees: Yes No. If yes, what are the minimum auto limits required: _____

Does the insured use subcontractors for any of his operations: Yes No. If yes, describe: _____

Provide the annual "cost of hire" of these subcontractors: \$ _____

Does the insured require minimum limits from the subcontractor? Yes No. If yes, what limits: _____

Is the insured added as an additional insured on the subcontractor's policy? Yes No.

Provide copies of contracts with subcontractors. Attached Yes No. If no, explain: _____

APPLICANT'S STATEMENT

I hereby declare that the statements made in this application and the contents of the other documents are true and correct and agree that any policy of insurance that may be issued now or in the future will

be based on the warranties and representations contained therein.

Applicant:

Signature of Officer/Manager Date

Print full name Title

Producer:

Signature Date

Print full name Agency