

# JIA Insurance Agency, LLC

## Paratransit NEMT Ambulance Liability Application

### Business Information

Company legal Name:	Expiration date of your current policy:
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Company Address:

What Is your company structured as: <input type="checkbox"/> Corporation <input type="checkbox"/> LLC <input type="checkbox"/> Other:	Provide your Federal Employer Identification Number (FEIN):	Number of years your company has been operating:
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Please include a brief description of your company's operations:

Are any state and/or federal filings required?  Y  N If yes, please list permit numbers and states:

How many vehicles does your company operate:  
 Ambulances \_\_\_\_\_ Buses \_\_\_\_\_ Vans /Ambulettes \_\_\_\_\_ Passenger Cars \_\_\_\_\_ Other (please specify): \_\_\_\_\_

What is your radius of operation (in miles)? \_\_\_\_\_ Does the operating radius cross any state lines?  Y  N

Name three major cities you frequently travel to:

What is your annual revenue? \$.....

List the officers of your company and their ownership percentages:

What are your hours of operation?  
 Monday -Friday \_\_\_\_\_ AM - \_\_\_\_\_ PM Saturday \_\_\_\_\_ AM - \_\_\_\_\_ PM Sunday \_\_\_\_\_ AM - \_\_\_\_\_ PM

Type of service: (check all that apply)

<input type="checkbox"/> Ambulance	<input type="checkbox"/> Non-Emergency Medical	<input type="checkbox"/> School Transportation
<input type="checkbox"/> Special Needs Transportation	<input type="checkbox"/> Social Service Organizations	<input type="checkbox"/> Taxi/Limo/General Transportation
<input type="checkbox"/> Other:		

Indicate the number of annual calls:

Emergency (911) _____	Non-911 Dispatch Services _____	Wheelchair Transports _____
Ambulatory Transports _____	Non- Emergency (Ambulance) _____	School Transports _____
Other:		

Percentage breakdown of your business by service type (ensure columns adds to 100%):

Wheelchair .....	Curb to curb .....	Prescheduled .....
Stretcher .....	Door to door .....	On-Demand .....
Passenger .....	Door through door .....	Emergency .....
100%	100%	100%

### Wheelchair

Do vehicles equipped with lifts or ramps exclusively transport non-ambulatory individuals?  Y  N

Is all equipment factory installed during vehicle construction?  Y  N

Are all people involved in wheelchair transportation instructed in the proper use of security equipment for all types of wheelchairs?  Y  N

What types of wheelchairs are accommodated within the vehicles:

<input type="checkbox"/> Portable	<input type="checkbox"/> Motorized	<input type="checkbox"/> Youth/Child Stroller
<input type="checkbox"/> Lightweight	<input type="checkbox"/> Reclining/Tilting	<input type="checkbox"/> Heavy Duty Industrial
<input type="checkbox"/> Tri-Wheeler/Scooter		

### Stretcher

How many vehicles are equipped with stretcher equipment? \_\_\_\_\_  
 What types of stretchers are used in the vehicles?  
 Do you use knee, hip, chest, and over the shoulder safety restraints on stretchers?  Y  N  
 Do employees load and unload stretchers?  Y  N  
 If yes, what training on loading and unloading clients is provided? \_\_\_\_\_  
 Does an attendant accompany stretcher clients?  Y  N  
 If yes, is the attendant:  
 An employee  An employee of the organization requesting transport  A personal assistant of the client

Are you aware of any circumstances which may result in a claim?  Y  N  
 If yes, please provide full details: \_\_\_\_\_

**Current Vehicle Information**

VIN Number	Stated Value	Ramp, Lift, or N/A	Seating Capacity
	\$		
	\$		
	\$		
	\$		
	\$		
	\$		
	\$		
	\$		
	\$		
	\$		
	\$		
	\$		

\*Vehicle Information Table Overflow on pg. 4

Are your vehicles equipped with cameras?  Y  N  
 If yes: What is the make and model? \_\_\_\_\_ Are the cameras:  Front- facing  Rear- facing  
 Who monitors the cameras? \_\_\_\_\_

**Auto Insurance Limits**

Symbols:  2  7  8  9  
 Auto Liability: \$..... Uninsured Motorist: \$..... Med Payments: \$.....  
 Comp/ Collision Deductible: \$..... Would you like to carry rental car coverage?  Y  N

**General Liability Limits**

<b>General Liability:</b>	<b>Professional Liability:</b>	<b>SAM Liability:</b>
OCC: \$      AGG: \$	OCC: \$      AGG: \$	OCC: \$      AGG: \$

**Previous Vehicle Information**

Policy Term	Vehicle Count	Number of Transports
Expiring:		
First Prior:		
Second Prior:		
Third Prior:		
Fourth Prior:		

**Driver Information**

Last, First	DOB	Driver's License Number


\*Driver Information Table Overflow on pg. 4

Please indicate the number of drivers that fall into the following categories:

Total Number of Drivers: \_\_\_\_\_ Full- Time Drivers: \_\_\_\_\_ Volunteer Drivers: \_\_\_\_\_  
 Part- Time Drivers: \_\_\_\_\_ Backup Drivers: \_\_\_\_\_ Contracted Drivers: \_\_\_\_\_

What percentage of drivers are trained in the following:

CPR \_\_\_\_\_ Advanced First Aid \_\_\_\_\_ General Driver Orientation \_\_\_\_\_  
 Defensive Driving \_\_\_\_\_ Passenger Assistance \_\_\_\_\_ Emergency Vehicle Evacuation \_\_\_\_\_  
 Primary First Aid \_\_\_\_\_ Non-Medical Emergency Training \_\_\_\_\_ Proper Wheelchair/Stretcher Securement Procedures \_\_\_\_\_

Indicate the procedures used in the employee/driver selection process:

- Written Application       Criminal Background Check       Pre-employment Drug Testing  
 Physical Examination       Written Driving Exam       Road Test  
 Motor Vehicle Record Check       References Check       Physical Abilities Test

Is there a minimum age requirement for drivers?  Y       N      If yes, what is the minimum age? \_\_\_\_\_

**Additional Insureds**

List additional insureds below: \_\_\_\_\_  
 \_\_\_\_\_

**Loss Payees (Financed Vehicles)**

Bank Name	Address	VIN Number

**Previous Insurance Information**

Please provide the insurance details from prior carriers up to 5 years below.

**Professional Liability Insurance Coverage Information**

Company	Policy Number	Limits of Liability	Retention/ Deductible
		\$ / \$	\$ / \$
		\$ / \$	\$ / \$
		\$ / \$	\$ / \$
		\$ / \$	\$ / \$
		\$ / \$	\$ / \$

**General Liability Insurance Coverage Information**

Company	Policy Number	Limits of Liability	Retention/ Deductible
		\$ / \$	\$ / \$
		\$ / \$	\$ / \$
		\$ / \$	\$ / \$
		\$ / \$	\$ / \$
		\$ / \$	\$ / \$

**Auto Liability Insurance Coverage Information**

Company	Policy Number	Limits of Liability	Retention/ Deductible
		\$ / \$	\$ / \$
		\$ / \$	\$ / \$
		\$ / \$	\$ / \$
		\$ / \$	\$ / \$
		\$ / \$	\$ / \$

**Current Vehicle Information Overflow**

VIN Number	Stated Value	Ramp, Lift, or N/A	Seating Capacity
	\$		
	\$		
	\$		
	\$		
	\$		
	\$		
	\$		
	\$		
	\$		
	\$		
	\$		
	\$		
	\$		
	\$		
	\$		

**Driver Information Overflow**

Last, First	DOB	Driver's License Number