Professional & General Liability Application for Non-Emergency Medical Transportation (NEMT) Services

1. Name of Applicant: _____
(as it should appear on the policy)

2. Mailing Address: _____

3. Location Address: _____
(If more than one location address, please attach a location list with a breakdown in gross receipts and transports per state if there is multi-state exposure)

4. Telephone Number: _____ Website Address: _____

5. Exposure:

Gross Receipts for the Past 12 Months:	$
Estimated Gross Receipts for the Next 12 Months:	$
Number of Ambulatory Patient Transports for the Past 12 Months:	
Estimated Number of Ambulatory Patient Transports for the Next 12 Months:	
Number of Wheelchair Patient Transports for the Past 12 Months:	
Estimated Number of Wheelchair Patient Transports for the Next 12 Months:	
Number of Stretcher Patient Transports for the Past 12 Months:	
Estimated Number of Stretcher Patient Transports for the Next 12 Months:	

6. Have all drivers gone through formal training in the proper techniques to load, unload and secure during transit patients/clients who are in wheelchairs or stretchers?

Yes ☐ No ☐ N/A (no wheelchair/stretcher transports) ☐

7. Are all drivers required to verify that all patients/clients are properly and securely strapped into their wheelchairs with no obstructions or additional cushions prior to moving the client?

Yes ☐ No ☐ N/A (no wheelchair transports) ☐

8. Does the applicant own or manage any other businesses or locations not shown on this application?

Yes ☐ No ☐

If yes, is there separate professional and general liability coverage for these other operations elsewhere at a minimum of $1M/$3M limits and does the applicant agree to maintain separate coverage in force for these other operations throughout the duration of this policy?

Yes ☐ No ☐

9. Services Provided:

Type of Service	**Yes**	**No**
Emergency transportation services		
First aid services (e.g. to a sporting event, music festival, etc?)		
Air or watercraft transportation		
Mobile Intensive Care		
School Transportation Services		
Transportation to/from a prison, jail, youth detention center or other similar type of facility		
Transportation for Non-Medical Reasons		

If yes to any of the above, please give details including type, location, number of patient encounters, and frequency:

_____

_____

10. Staffing Information:

	Number of Staff		
	Employed	**Contracted**	**Volunteer**
Advanced First Aid/Red Cross Certification			
CPR Certification Only			
EMT Basic			
EMT Advanced/Intermediate			
EMT Paramedic			

	Employed	**Contracted**	**Volunteer**
Nurse			
Physician			
Non-Medical Drivers (with none of the above certifications)			
Other (please describe):			

11. Do you require contracted staff (if any) to carry their own Professional Liability Insurance & secure certificates of Insurance as evidence of such coverage?

Yes ☐ No ☐ If yes, at what limits? $_____ / $_____

If no, is coverage desired with shared limits on this policy? Yes ☐ No ☐

12. Please confirm which of the following you obtain, review, verify and keep on file as part of the employee/ independent contractor hiring & screening process:

	Yes	**No**
Employment Application		
Criminal Background Checks		
Drug / HIV/ Hepatitis Testing		
Licenses Held		
Education/Training/Competence		
Multi-State Registry		

13. Additional employment related questions:

	Yes	**No**
Do you question prospective employees/independent contractors about prior claims or suits?		
Are employees required to actively participate in continuing education?		
Do you prepare job descriptions and instructional manuals for your staff?		
Do you have a written incident/occurrence reporting policy and procedures?		
Are all owners/employees/independent contractors current on any training that is required by the state or any other governing body, and is there proof of any required training on file at the home/facility for review?		

14. Is the applicant a member of any association or certified or accredited by any governing body? If yes, give details:

_____

_____

15. Do you sell, rent or otherwise provide any equipment to products or others? Yes ☐ No ☐

If yes, please complete the supplement for Durable Medical Equipment Sales/Rentals.

16. Will you transport anyone under the age of 18 years old?

Yes ☐ No ☐

If yes, is a parent or guardian required to accompany them? Yes ☐ No ☐

If no, please provide details: _____

17. Please complete the table below showing the applicant's Professional Liability coverage for last 5 years: (if none, state none)

Carrier	Limit	Deductible	Premium	Expiration Date	Retro Date (if applicable)

18. Please complete the table below showing the applicant's General Liability coverage for last 5 years: (if none, state none)

Carrier	Limit	Deductible	Premium	Expiration Date	Retro Date (if applicable)

19. Has the applicant or have any of their employees (please attach a detailed explanation for any "yes" answers):

	Yes	No
a) Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association?		
b) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?		
c) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same?		
d) Ever had an application for Professional Liability Insurance made on their behalf which has been declined or has their insurance ever been cancelled or renewal refused?		

20. Has any claim ever been made against the firm or any of its employees?

Yes ☐ No ☐ **If yes, please attach completed claims supplement.**

21. Is the applicant aware of any circumstances which may result in any claim against him, the firm, his predecessors in business, or any of the present or past Partners or Officers?

Yes ☐ No ☐ **If yes, please attached a separate sheet with date(s) and details.**

Application for Claims-Made Professional Liability Insurance

The undersigned declares that to the best of his/her knowledge the statements herein are true. Signing of this Application does not bind the undersigned to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a Policy be issued, and that this Application will be attached and become part of such Policy, if issued. Underwriters hereby are authorized to make any investigation and inquiry in connection with this Application, as they deem necessary.

Name of Applicant: _____
Please Print Title

Signature: _____
Name Date

(NOTE: Application must be signed by the owner or president or principal)