EXECUTIVE INSURANCE PROFESSIONALS
SUBMISSIONS@EXECINS.COM
P: 800-779-4095
F: 866-779-4331

AUTOMOBILE PARA-TRANSIT

SUPPLEMENTAL APPLICATION

Insured: ______________________ Effective Date: ______________

I. GENERAL INFORMATION

OWNERSHIP

☐ Active ☐ Absentee ☐ Delegate through Supervisors

Years in business: __________ Years of experience - same industry: __________

Other currently owned businesses which are separately insured? ☐ Yes ☐ No

If *YES*, identify these entities and explain any interchange of labor and/or vehicles with these different affiliates:

OPERATIONS

Number of locations: __________

Description of locations:

Hours of operation: __________ to __________ # of days per week: __________ # of daily shifts: __________

# of employees: Full time: __________ Part time: __________ Seasonal: __________ Volunteers: __________

Is this operation? ☐ Profit ☐ Nonprofit Source of nonprofit funding: ______________________

II. HIRING PRACTICES

Employment Application	☐ Yes	☐ No	Drug/Substance Abuse Rehab Program	☐ Yes	☐ No
Reference Checks	☐ Yes	☐ No	Random Drug Testing	☐ Yes	☐ No
Audiometric Testing	☐ Yes	☐ No	Motor Vehicle Record Check	☐ Yes	☐ No
Pre/Post Employment Physical	☐ Yes	☐ No	Pathogenic Test (i.e. lead)	☐ Yes	☐ No
Volunteer Labor Used	☐ Yes	☐ No	Orthopedic Back Test	☐ Yes	☐ No
Temporary Labor Used	☐ Yes	☐ No			

Do you lease workers? ☐ Yes ☐ No

If *YES*, describe the type of labor leased and identify the leasing company:

Do you lease work to others? ☐ Yes ☐ No

If *YES*, describe the type of work done by your workers for others:

Identify which of the following driver hiring criteria you have in place:

Require CDL or other specialized license when required? ☐ Yes ☐ No

Road test given prior to hire? ☐ Yes ☐ No

Orientation in vehicle with experienced driver? ☐ Yes ☐ No

III. FLEET INFORMATION

Describe the vehicle types used in your business:

VEHICLE TYPE	DESCRIPTION OF USE	# OF VEHICLES
Private passenger or light truck		
Passenger van with 8 or less passengers		
Wheelchair accessible passenger van with 8 or less passengers		
Passenger van with 9 or more passengers		
Wheelchair accessible passenger van with 9 or more passengers		
Ambulance		
Other: ____________________		

Radius of operations: ______________________________

List major cities that you operate in:

Are all vehicles both titled and registered to the named insured? ☐ Yes ☐ No

Are any filing required? ☐ Yes ☐ No

If *YES*, provide ICC or PUC docket # or relevant filing name and number:

Are any of your vehicles equipped with:

Lift out/Pull out ramps? ☐ Yes ☐ No

Mechanical lift? ☐ Yes ☐ No

Wheelchair passenger/patient restraint system? ☐ Yes ☐ No

Ambulatory passenger/patient safety restraint system? ☐ Yes ☐ No

Are your ambulance vehicles ever used for emergency use? ☐ Yes ☐ No

If *YES*, what % of the operating time do your ambulance vehicles have their emergency lights flashing? _________%

Do any of your passenger vans have seating for more than 20 passengers? ☐ Yes ☐ No

If *YES*, how many? ______________________________

Do any of your passenger vans have seats that do not face toward the front of the vehicle? ☐ Yes ☐ No

If *YES*, how many? ______________________________

Do you have a company policy regarding personal use of company autos by employees or executives or their family members? ☐ Yes ☐ No

If *YES*, describe: ______________________________

How long has this policy been in place? ______________________________

Is this policy in writing? ☐ Yes ☐ No

Do any of your employees use their own vehicles in the course of employment twice a week or more? ☐ Yes ☐ No

If *YES*:

How many employees do this on a regular basis? ______________

Do you require evidence that these employees to carry a minimum auto limit of liability? ☐ Yes ☐ No

If YES, what minimum auto limit is required? ☐ Yes ☐ No

Do you lease or rent vehicles for your use on a short term basis (daily/weekly/monthly)? ☐ Yes ☐ No

If *YES*:

Please describe the exposure and the length of the average lease/rental:

How many times per year is this done? ______________________________

What type of vehicles do you rent or lease? ______________________________

Do you ever rent or lease vehicles with drivers? ☐ Yes ☐ No

If *YES*, how often and what are the vehicles used for?

What is the estimated annual cost of hire? ______________________________

Do you carry Professional Liability coverage? ☐ Yes ☐ No

IV. HISTORICAL EXPOSURE

YEAR	# OF POWER UNITS
Proposed Year	
Current/Expiring Year	
1st Prior Year	
2nd Prior Year	
3rd Prior Year	
4th Prior Year	

V. DRIVER PROFILE

Indicate number of individuals who drive and/or provide patient care:

	EMT BASIC	EMT ADV	EMT PARAMEDIC	OTHER	NONE
Employees					
Volunteers					

Select types of special training programs that your drivers receive:

☐ Primary First Aid
☐ Advanced First Aid
☐ CPR
☐ Emergency Vehicle Evacuation
☐ Passenger Assistance Training
☐ Non-Medical Emergency Training

How are drivers paid? ☐ Hourly ☐ Per trip ☐ Other: ___________________________

If OTHER, Please describe: ____

How many drivers are 70 years of age or older? _________________

How many drivers are 21 years of age or younger? _________________

Who dispatches your calls? ☐ Outside source ☐ In house by your employees or volunteers

VI. CONTROLS

Describe your standards for an acceptable MVR or attach a copy of written criteria:

Are any exceptions made to the above acceptable MVR criteria?

If *YES*, please describe:

Do you have a written vehicle maintenance program? ☐ Yes ☐ No

Do you have your own facilities to maintain your vehicles? ☐ Yes ☐ No

If *YES*, are the mechanics FMCSR-Certified? ☐ Yes ☐ No

If you do not have your own vehicle maintenance facility, comment on how you monitor the maintenance of your vehicles:

____

Are daily pre trip inspections performed? ☐ Yes ☐ No

Is there a formal auto accident review program in place? ☐ Yes ☐ No

If *YES*, please describe:

Do you provide auto related safety incentive awards? ☐ Yes ☐ No

If *YES*, please describe:

Do you have a written auto safety program? ☐ Yes ☐ No

If *YES*, please attach.

Do you have any restrictions on the use of cell phones while operating vehicles? ☐ Yes ☐ No

Do you subcontract work to others? ☐ Yes ☐ No

If *YES*, are certificates of insurance obtained? ☐ Yes ☐ No

What limits of liability do you require? ______________________________

Do your passenger vans and/or ambulance vehicles contain permanently installed video cameras? ☐ Yes ☐ No

If *YES*, how are the cameras positioned? ☐ Front only ☐ Front and cargo area

The undersigned is an authorized representative of the applicant and certifies that reasonable inquiry has been made to obtain the answers to the questions on this supplemental application. He/she certifies that the applicable fraud notices herein have been read and understood. He/she acknowledges their continuation under the applicable state insurance fraud acts and certifies that all such information provided herein complies with such acts in disclosure and truthfulness.

SIGNATURES

______________________________ ______________________________

Applicant's Signature *Applicant's Title*

____

Date