PARATRANSIT SUPPLEMENTAL APPLICATION

The statements herein are true and correct as made to THE WRIGHT RISK CONSULTANTS. I understand the company will make decisions based on accuracy of statements given. Any misrepresentation could void the policy.

AGENCY- The Wright Risk Consultants **Phone: 731-300-2210**

PRODUCER- Phillip Wright **Phone: 731-300-2210**

Your Company Name: _____

Address: _____

Phone #_____ Contact Person _____

FEIN or SSN: _____Business Website Address _____

Are any filings required? Yes_____ No_____ If yes, provide ICC/PUC docket # _____

How many years under current ownership?_____ Do you have subsidiaries or are you affiliated with any other companies?_____ If so, give name and explain_____

Number of years in business? _____ If a new venture, have you driven for, or been associated with any other transportation companies? Yes_____ No_____

If yes, give name address, and dates _____

Has your insurance been cancelled, or refused renewal by any company? _____

With whom do you have contracts to provide transportation services? _____

What cities do you operate within? _____

What is radius of operation and percentage of each? 0-50 miles ____% 51-200 miles _____% 200+ miles____%

Do you contract services to others? _____ If yes, explain _____

Annual Runs:

	Projected Next Year	Current Year	Last Year
Ambulatory			
Wheel Chair			
Stretcher			
Emergency			
Other			

What percentage (to total 100%) of your trips are: Non-Emergency Medical_____%

Disabled/Handicapped_____% Scheduled Shuttle Service _____% Other_____% (Explain other)_____

What percentage of trips fall within the following: Curb-to-Curb_____% Door-to Door_____%

Door-through-Door_____%

Are clients accepted on a pre-arranged basis? _____

Do you transport unscheduled passengers? _____ Explain if yes_____

Age of clients: _____% younger than 18 _____ % 18 to 60 years _____ % Older than 60

Do you administer any anesthesia? _____ If yes, explain _____

What are your annual receipts? _____ Prior Year? _____ 2 years prior? _____

What limits of Liability do you require? _____

What limits of Professional Liability do you require?_____

Auto Coverage: VEHICLES

Name of current Auto Carrier?_____

Limits of Liability_____Does your Auto Liability cover Loading and Unloading?_____

Are vehicles stores on premises overnight? _____ Are there guard dogs on the premises?_____

How many shifts do you run?_____ Do you have a vehicle maintenance program? _____

What is projected annual mileage? _____

Special Equipment:

Life-Out/Pull-Out Ramps_____ If yes, # of vehicles _____

Mechanical Lifts _____ If yes, # of vehicles_____

Wheelchair Passenger/Patient Safety Restraint System ____ If yes, # of vehicles _____

Automatic Braking Sensor or other Accident-Avoidance Technology?____ If yes, # of vehicles ____

Driver's Seat Vibration or Alarm _____ If yes # of vehicles_____

In-Vehicle Camera _____If yes, are all vehicles equipped? _____

Provide a description of all Vehicles including: Year, Make, Model, Cost New or Current Value and Special Equipment. Loss Runs will be required for past three years – we will assist you in obtaining those reports.

DRIVERS

Are written applications used for hiring? _____ How often are driver MVRs checked? _____

What is minimum age for drivers? _____ Minimum years of driving experience? _____

Do you have a driver training program? _____ Do you hold safety meetings_____? How often?_____

Are drivers trained to assist elderly and/or handicapped passengers? _____

Are ALL person involved in wheelchair transportation trained in wheelchair securement?_____

Is there a drug testing policy? _____Describe_____

Is post-accident drug testing policy in place? _____ Describe_____

Have any drivers completed an accident prevention course? _____If yes, percentage of drivers? ____

Provide a list of all drivers to include: Names, Date of Birth, and Driver License number. Do you have current MVRs?