

Are all vehicles both titled and registered to the named insured? Yes No
 Are any filings 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, please 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 are carrying Auto liability coverage? Yes No

Do you require these employees to carry a minimum Auto limit of liability? Yes No

If yes, what minimum Auto limit is required?

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

If yes:

Please describe this 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

HISTORICAL EXPOSURE:

Year	# of Power Units
Proposed Year	
Current/Expiring Year	
1 st Prior Year	
2 nd Prior Year	
3 rd Prior Year	
4 th Prior Year	

DRIVER PROFILE:

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

	EMT BASIC	EMT ADVANCED	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

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? Yes No
 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 enquiry has been made to obtain the answers to the questions on this supplemental application. He/She certifies that the answers are true, correct and complete to the best of his/her knowledge. 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.

Completed by (Signature and Title of Applicant):

Date: