Fireman's Fund® Insurance Company

Protecting your future since 1863℠

AllParaPro Program Supplemental Application

Named Insured: _____ DBA: _____

General Information

1. Owners Name: _____ Email Address: _____
2. Number of Years: In Business: ____ Current Ownership: ____ Current Management in Place: ____
3. Is this a new venture? ☐ Yes ☐ No
4. Is the current named insured the original name of this organization? ☐ Yes ☐ No
   a. If "Yes", what name: _____
5. Are ICC, PUC or other filings required? ☐ Yes ☐ No

Operations

1. What is the primary purpose of your operation and how are these services provided?

   _____
2. List the major metropolitan area(s) served:
   a. _____ b. _____
3. Please provide names of organizations in which you have current contracts to provide transport services _____
4. Is transportation provided to non-medical destinations? ..... ☐ Yes ☐ No
   If yes provide details _____
   Daycare Centers _____% Heliport or Airport _____% Psychiatric Centers _____%
   Schools _____ % Shopping Centers _____% Workplaces _____% Senior Centers _____%
   Other _____% Describe: _____
5. The number of calls in the past 12 months? _____
6. The number of par-transit/wheelchair calls in the past 12 months: _____
7. Radius, as a % of total trips: 0-50 miles: ____% 51-200 miles: ____% 200+ miles: ____%
8. Does radius of operation extend beyond 200 miles? ☐ Yes ☐ No
9. Do any vehicles have any lights or sirens on them? ☐ Yes ☐ No
10. Is any medical care, first aid, or treatment of any kind done in any vehicles? ☐ Yes ☐ No
11. Is Hired or non-owned coverage desired? ☐ Yes ☐ No
    If yes, please indicate circumstances and frequency of non-owned auto use on company behalf.

    _____
12. Does the company lease or loan vehicles to others? ☐ Yes ☐ No
13. If yes explain _____
14. Do you ever transport non-dispatched passengers... ☐ Yes ☐ No.
    If Yes, explain _____
15. Does the insured subcontract **FOR** others? ☐ Yes ☐ No
    If yes, provide copies of contracts.
16. Does the company enter into any written or verbal agreements to provide service? ☐ Yes ☐ No
    If yes explain _____
17. Does the company borrow or lease agents, or employees from others? ☐ Yes ☐ No
18. Any other pertinent information about your business:

    _____

Safety & Claims Management

1. Safety Manager's Name, Cellphone Number & Email Address: _____
2. Is there an accident review procedure? ☐ Yes ☐ No
   If yes, describe _____
3. Onboard Monitoring (OBM) (black box, cameras, GPS, stickers)
   a) Type of system(s): _____
   b) Number of vehicles currently installed with each type of system:

Vehicle Maintenance

1. Describe vehicle maintenance program _____
2. Are daily vehicle inspection reports completed? ☐ Yes ☐ No
   Are periodic maintenance checks completed by a mechanic? ☐ Yes ☐ No
   Are vehicle maintenance records maintained by vehicle in designated files? ☐ Yes ☐ No

Wheelchair Information

1. Does the Company have written procedures for the use of wheelchair lifts? ☐ Yes ☐ No
2. Does the Company have written procedures in place for securing wheelchairs? ☐ Yes ☐ No
3. How many vehicles are equipped with the following wheelchair tie-down mechanism
4. 3 point tie-down _____ 4 point tie-down _____
5. Are any vehicles not equipped with both lap belts and shoulder harnesses for the passengers? ☐ Yes ☐ No
6. Describe wheelchair and stretcher tie-down procedures: _____
7. Do insured vehicles comply with all current ADA standards for:
   Lift out/Pull out ramps: ☐ Yes ☐ No
   Mechanical Lifts ☐ Yes ☐ No
8. Are the wheelchair securement devices inspected and documented as part of your regular vehicle inspection procedure? ☐ Yes ☐ No

Stretchers / Non-Emergency Ambulance

Employees

1. Are criminal background checks conducted on all drivers? ☐ Yes ☐ No
2. Is there a formal written and driving training program for all drivers? ☐ Yes ☐ No
3. Are all drivers road tested prior to official hire? ☐ Yes ☐ No
4. Does insured have a written policy in place that prohibits use of vehicle for any personal use? ☐ Yes ☐ No
5. Do employees use personal or non-company vehicles for company business? ☐ Yes ☐ No
   If yes please explain _____
6. Do your employees work more than one shift per day? ☐ Yes ☐ No
   If yes, provide shift details: _____
7. Is patient handling training provided?
8. Does the Company review motor vehicle reports prior to hiring a new driver? ☐ Yes ☐ No
9. After employing a driver, how often are MVR's reviewed? ☐ Annually ☐ Every 2-3 years ☐ More than 3 years
10. Does the Company have written criteria for acceptable Motor Vehicle Reports? ☐ Yes ☐ No
11. Do all drivers have the appropriate license commensurate with state or local law (CDL, etc.)? ☐ Yes ☐ No
12. Are employees required to take a Driver Training/Vehicle Operators Course? ☐ Yes ☐ No
    How often? ☐ At Hire Only ☐ Annually ☐ Semi-Annually ☐ Other
13. Does a file exist for each driver containing documentation for all of the above information? ☐ Yes ☐ No
14. Does the Company complete pre-hire drug testing? ☐ Yes ☐ No
15. Does the Company complete post-accident drug testing? ☐ Yes ☐ No

16. Does the company complete Random drug testing? ☐ Yes ☐ No
    If yes, please state Frequency and % of drivers tested_____
17. Do all drivers have 2 or more year experience working with passengers, special needs or the elderly? ☐ Yes ☐ No
    If no, explain_____
18. Describe the driver training programs that your drivers receive:_____

_____

_____

Hired & Non-owned

1. Is hired/non owned exposure more than just incidental, i.e. used in regular course of business ☐ Yes ☐ No

Applicant's Statement

This application does not bind YOU or US to complete the insurance, but it is agreed that the

Information contained herein shall be the basis of the contract should a policy be issued.

FRAUD WARNING:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

_____ _____ _____

Signature of Insured | Title | Date

_____ _____

Producer Signature | Date

Checklist:

1. Supplemental Application signed by the insured ☐ Yes ☐ No
2. Current applicable ACORD Applications for coverage's desired. Vehicle schedule should include 17 digit VIN#, radius, length of stretched vehicles and number of passengers. ☐ Yes ☐ No
3. Minimum of 4 years of hard copy loss runs valued within the last 60 days: ☐ Yes ☐ No
4. Current drivers list and MVR's. ☐ Yes ☐ No
5. Provide Details regarding fleet size over last 4 years:

Year	# Units	Avg Premium Per Unit