



**Para-Transit Pro Application**  
(Must be attached to Acord Application)



**Para-Transit Pro**

PO Box 440549 Kennesaw, GA 30160  
Phone: (678) 290-2100  
www.thomcoins.com

Today's Date: \_\_\_\_\_

**BASIC INFORMATION:**

1. Named Insured: \_\_\_\_\_ 2. DBA: \_\_\_\_\_

3. Mailing Address: \_\_\_\_\_

4. Physical Address: \_\_\_\_\_

5. Phone: \_\_\_\_\_ 6. Fax: \_\_\_\_\_

7. Website Address: \_\_\_\_\_

8. Owners Name: \_\_\_\_\_ 9. Email Address: \_\_\_\_\_

10. Safety Manager's Name, Cellphone Number & Email Address: \_\_\_\_\_

11. Type Of Entity: Corporation Individual Partnership Joint Venture LLC

12. FEIN/Social Security Number: \_\_\_\_\_

13. Date business started under current ownership: \_\_\_\_\_ Is this a new venture? Yes No

14. Are ICC, PUC or other filings required? Yes No (If yes, provide copies.)

15. Is your business a subsidiary or division of a parent company? Yes No If yes, name of company: \_\_\_\_\_

16. Has your business, its owner(s), officers, directors or employees ever been party to any civil, criminal or regulatory proceedings resulting in an administrative sanction or license suspension or revocation? Yes No If yes, please explain on a separate sheet.

17. Has your business had a change of ownership in the past 3 years? Yes No  
If yes, please explain: \_\_\_\_\_

**OPERATIONAL INFORMATION:**

1. List the major metropolitan area(s) served:  
A. \_\_\_\_\_ B. \_\_\_\_\_

2. The number of para-transit/wheelchair calls in the past 12 months? \_\_\_\_\_  
The estimated para-transit/wheelchair calls in the next 12 months? \_\_\_\_\_

3. Please advise the following regarding the use of oxygen:
- a. Do you provide oxygen to passengers? Yes No
  - b. Do you transport passengers who are carrying a portable oxygen system? Yes No
  - c. Do you have a policy that requires the securement of the passenger's portable oxygen system? Yes No
  - d. Do you refill oxygen tanks? Yes No
  - e. Are your employees involved with the administration of oxygen? Yes No

4. Number of full and part time drivers:

\_\_\_\_\_ Employee Drivers  
 \_\_\_\_\_ Independent Contractors  
 \_\_\_\_\_ Owner-Operators  
 \_\_\_\_\_ EMT's  
 \_\_\_\_\_ TOTAL

5. What are the vehicle counts for the following classifications:

| Type of Auto              | As of Today | Renewal Date 1 year ago | Renewal Date 2 years ago |
|---------------------------|-------------|-------------------------|--------------------------|
| Wheelchair Vans           |             |                         |                          |
| Stretcher Vans            |             |                         |                          |
| Ambulatory Vehicles       |             |                         |                          |
| Service (all other autos) |             |                         |                          |

6. Patient Handling: Stretcher

a) Select all Stretcher types used at your service and give the brand and number of each type:

| Type of Stretcher       | Brand | Number |
|-------------------------|-------|--------|
| X-Frame                 |       |        |
| Fold Away Undercarriage |       |        |
| Power Cot               |       |        |
| Bariatric Cot           |       |        |
| Other                   |       |        |

b) Does your service use knee, hip, chest and over the shoulder safety restraints on your stretchers? Yes No

c) Does your service have a mandatory lift assist policy? Yes No

d) Select the engineering controls used at your service and given the brand and number of each type:

| Engineering Control                  | Brand | Number |
|--------------------------------------|-------|--------|
| Specialty Vehicles (Bariatric Units) |       |        |
| Ramps with Winches                   |       |        |
| Lateral Transfer Aids                |       |        |
| Motorized Stair Chairs               |       |        |
| Other                                |       |        |

7. Patient Handling: Wheelchair

a) Name the wheelchair tie-down occupant restraint system (WTORS) you use:

b) Provide product documentation that the WTORS meets SAE J2249 (WTORS) ISO 10542 standards.

c) If you do not use a commercially developed WTORS, please provide a copy of the section of your SOP that outlines the manner in which you use the system to tie down a wheelchair and restrain its occupant.

d) Please provide the section of your SOP that addresses the transportation of a scooter and its user.

8. Onboard Monitoring (OBM) (black box, cameras, GPS, stickers)

a) Brand name of system(s): \_\_\_\_\_

b) Date the system was installed: \_\_\_\_\_

c) Number of vehicles currently installed with the system: \_\_\_\_\_

d) Employee responsible for the management of the OBM:

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_

9. Is your service involved in activities or operations other than medical transportation? Yes No

If yes, explain: \_\_\_\_\_

### VEHICLE MAINTENANCE

1. Is a condition report completed on each transport vehicle and its equipment on each shift? Yes No

If no, please explain: \_\_\_\_\_

2. Does the maintenance schedule for your fleet meet or exceed the manufacturer's recommendations? Yes No

If no please explain: \_\_\_\_\_

3. Who performs the maintenance on your fleet? \_\_\_\_\_

Are they certified by the manufacturer? Yes No

4. Do you keep maintenance repair records on file for each vehicle? Yes No

If no, please explain: \_\_\_\_\_

5. Do you perform any after-market vehicle modifications? Yes No  
If no, please explain:

**HUMAN RESOURCE**

1. Please provide the following information for the person who is responsible for new employee orientation:

Name: \_\_\_\_\_ Title: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

2. Check all that apply to your employee selection process:

- Written Application Job Specific Physical Examination Psychological Testing Criminal Background Check  
MVR Check Obtain evidence of Pertinent Certification Licensure Post Employment Drug Screening

**SAFETY/RISK MANAGEMENT**

1. Is a record kept of each request for service? Yes No

2. Is a trip ticket for billing purposes completed for each transport? Yes No

3. Are your vehicles always locked when unattended? Yes No

4. Do you transport prisoners? Yes No

If yes, provide details: \_\_\_\_\_  
\_\_\_\_\_

5. Does your service maintain accident files? Yes No If yes, for how long do you keep the files? \_\_\_\_\_

6. Are safety violations (i.e. auto crashes) part of your progressive discipline process? Yes No

**WORKERS' COMPENSATION**

Name of Carrier: \_\_\_\_\_  
Policy #: \_\_\_\_\_ Eff. Dates: \_\_\_\_\_ to \_\_\_\_\_  
Employers Liability Limit: \$ \_\_\_\_\_  
Bodily Injury by Accident: \$ \_\_\_\_\_ Each Accident  
Bodily Injury by Disease: \$ \_\_\_\_\_ Policy Limit  
Bodily Injury by Disease: \$ \_\_\_\_\_ Each Employee

**LIMITS OPTIONS**

Automobile Liability Limits (check one):

- \$500,000 Combined Single Limit Bodily Injury & Property Damage  
\$1,000,000 Combined Single Limit Bodily Injury & Property Damage

General Liability Limits (check one):

- \$500,000 any one claim/\$1,000,000 annual aggregate  
\$1,000,000 any one claim/\$2,000,000 annual aggregate  
\$1,000,000 any one claim/\$3,000,000 annual aggregate

Excess Liability:

Please provide limit: \_\_\_\_\_

Inland Marine (medical equipment/inventory): Blanket limit: \_\_\_\_\_ Deductible: \$500 \$1,000

Auto Physical Damage Deductible Options (check one):

- \$500 \$1,000 \$2,000

Is Property Coverage desired? Yes No If yes, please complete the Acord Property application.

## FRAUD WARNINGS

**GENERAL FRAUD STATEMENT** (not applicable in Colorado, Florida, Hawaii, Massachusetts, Nebraska, Ohio, Oklahoma, Oregon and Vermont) Any person who knowingly and with intent to defraud any insurance company or another 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 the person to criminal and (NY: substantial) civil penalties. In the District of Columbia, Louisiana, Maine, Tennessee and Virginia, and Washington insurance benefits may also be denied.

**NOTICE TO COLORADO APPLICANTS: THIS NOTICE IS A PART OF YOUR APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**NOTICE TO FLORIDA APPLICANTS:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**NOTICE TO HAWAII APPLICANTS:** For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment or both.

**NOTICE TO OHIO APPLICANTS:** Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**NOTICE TO OKLAHOMA APPLICANTS:** WARNING: A person who knowingly and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**NOTICE TO OREGON APPLICANTS:** Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact, may be violating state law.

**NOTICE TO VERMONT APPLICANTS:** Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto, may be committing a crime, subjecting the person to criminal and civil penalties.

THE APPLICANT DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE APPLICANT AGREES THAT IF THE INFORMATION SUPPLIED ON THE APPLICATION BY THE APPLICANT CHANGES BETWEEN THE DATE OF THE APPLICATION AND THE EFFECTIVE DATE OF INSURANCE, APPLICANT WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS AND/OR AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

Applicant's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Producer's Signature: \_\_\_\_\_  
(Only applicable if using a producer)

Date: \_\_\_\_\_

Producer's License Number: \_\_\_\_\_

Exp Date: \_\_\_\_\_