FAIRMATIC

Non-Emergency Medical Transportation (NEMT) Supplemental Application

General Information

Named Insured: _____

Website: _____ **FEIN:** _____

Primary Address: _____

City: _____ State: _____ Zip:_____

Age of Business: _____ **Hours of Operation:** _____

Description of Operations:

_____

_____

_____

Operating as: [ ] Individual [ ] Partnership [ ] Corporation [ ] Other: _____

Total Revenue: _____ **Operating Budget:** _____

Does the insured have any taxi or limousine operations? [ ] Yes [ ] No

Qualification

If the answer to any of the following is "Yes," the risk is unacceptable*

I. **Are any vehicles equipped with lights and sirens?** [ ] Yes [ ] No

II. **Are there any emergency operations or servicing of 911 calls?** [ ] Yes [ ] No

III. **Are any vehicles above 15,000 lbs. Gross Vehicle Weight (GVW)?** [ ] Yes [ ] No

IV. **Are any vehicles above 8-passenger seating capacity?** [ ] Yes [ ] No

V. **Does the insured have any 24-hour operations?** [ ] Yes [ ] No

*Please reach out to your underwriter if you have any questions about the above guidelines or a particular submission.

Please attach the following with this completed Supplemental:

- Signed Acord
- List of driver names & DOBs
- List of driver phone numbers
- MVR reports
- Currently valued loss runs
- List of VINs, make & model

Exposure Details

In order to provide the most accurate quote, we will need the items below:

Total Annual Miles: _____

States of Operation:_____

City	% of Operations	City	% of Operations

I. **Pickups are:**

[ ] Pre Scheduled _____% [ ] On Demand _____%

II. **Services Provided:**

[ ] Door to Door _____% [ ] Door thru Door _____% [ ] Curb to Curb _____%

III. **Please list your primary source of requests for services:**

[ ] Medicaid/Medicare _____% [ ] Logisticare _____%

[ ] Private Pay _____% [ ] Other _____%

[ ] Private Insurance _____% Describe: _____

Vehicles

Vehicles Equipped with	Stretchers/Gurneys	Wheelchair Lifts/Ramps
#		

I. **Are ALL company vehicles stored overnight in a central location?** [ ] Yes [ ] No

II. **Where?** _____

III. **Are any employees allowed to take company vehicles home?** [ ] Yes [ ] No

IV. **Do any employees use personal vehicles for business operations?** [ ] Yes [ ] No

V. **Are any vehicles hired or leased?** [ ] Yes [ ] No

VI. **If so, please describe:**

_____

_____

VII. **How often are vehicles replaced? Please list criteria for replacement:**

_____

_____

VIII. **Does the insured have any of the following?**

Documentation of Repairs:	**Post-Trip Inspections:**	**Pre-Trip Inspections:**	**Periodic In-Depth Inspections:**
[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No

Drivers

I. **Number of**

Full time drivers: _____ Back-up drivers: _____

Part time drivers: _____ Contracted drivers: _____

II. **Average Annual Driver Turnover:** _____%

III. **Does the insured have a driver incentive program?** Yes No

IV. **Please mark driver hiring requirements:**

[ ] MVR Reports [ ] Criminal background check

[ ] Drug check [ ] Minimum age: _____

[ ] Driving test [ ] Other

[ ] Minimum years licensed: _____ Please describe: _____

V. **How often does the insured order and review MVRs for drivers?**

_____

VI. **What criteria is used for MVR acceptability?**

_____

Risk Management & Claims Reporting

I. **Name and title of the person responsible for risk management & claims reporting:**

_____

II. **Does the insured hold regular safety meetings?** [ ] Yes [ ] No

III. **How often are they held?** _____

IV. **Is attendance mandatory?** [ ] Yes [ ] No

Premium History

Period Term	Insurance Company	Auto Liability Premium	Physical Damage Premium
Current Year			
1st Prior Year			
2nd Prior Year			
3rd Prior Year			
4th Prior Year			