



APPLICATION

R.W. Scobie Group
Tower Special Facilities
N14 W23777 Stone Ridge Drive, Suite 140
Waukesha, WI 53188-1158
Phone: 800-472-6919 or 262-513-6000
Fax: 262-513-6010
www.rwscobie.com

Questions...? Contact

Kelly Tautges
Branch Manager
262-953-4341
kellyt@towerspecial.com

Charlene Prather-Glenton
Underwriter
262-953-4340
charlenepg@towerspecial.com



SECTION B: Business Organizational Data**Please Complete Every Item or Indicate N/A**

1. Does the Applicant/Owner currently own any other Entities or operate any other business? Yes No
 a. If yes, please explain and verify that separate General Liability insurance is in place for these operations: _____

2. Does the Applicant/Owner (Applicant being the Parent Company) currently own any Subsidiaries? Yes No
 a. If yes, please explain and verify that separate General Liability insurance is in place for these operations: _____

3. Is the Applicant/Owner currently listed as a Subsidiary of any other Company? Yes No
 a. If yes, please explain: _____

SECTION C: General Liability/Professional Liability Limits**Please Complete Every Item or Indicate N/A**

1. Desired Each Occurrence Limit/Each Professional Incident Limit/General Aggregate Limit:
 \$300,000/\$300,000/\$600,000 \$500,000/\$500,000/\$500,000 \$500,000/\$500,000/\$1,000,000
 \$1,000,000/\$1,000,000/\$1,000,000 \$1,000,000/\$1,000,000/\$3,000,000

SECTION D: Operations**Please Complete Every Item or Indicate N/A**

1. Total # of Employees: _____ Total # of F/T Employees: _____ Total # of P/T Employees: _____
2. Annual Driver turnover percentage: _____ %
3. What are your projected Annual Gross Sales for the current policy term? \$ _____
4. What is your Annual Budget for the current policy term? \$ _____
5. Please indicate the number of Non-emergency Medical Transport Vehicles you intend to use during the current term:
 Vehicles – **Without** Gurney Use: _____ Vehicles – **With** Gurney Use: _____
6. Indicate if you have employees with the following qualifications:
 EMT Paramedics RN LPN Other Licensed Healthcare Professional

SECTION E: Risk Management**Please Complete Every Item or Indicate N/A**

1. Do you meet all County, State and/or Federal Licensing requirements? Yes No
2. Describe the Owner's duties or involvement in the daily operations: _____

3. Describe the Executive Director's duties or involvement in the daily operations: _____

4. Describe the Manager's duties or involvement in the daily operations: _____

5. Are all potential Employees subject to a Pre-employment Screening process? Yes No
 If yes, your Pre-employment Screening process includes (check all that apply):
 Criminal Background Check Prior Employment Checks Reference Checks
 Other (Describe): _____
6. Do you have an Orientation Program in place for all new Employees? Yes No
 If yes, your Orientation Program includes a comprehensive review of the following (check all that apply):
 Accident Reporting Procedures Assigned Routes
 Commercial Vehicle Rules and regulations General Company Rules and Regulations
 HIPAA Regulations and Policies Lift Equipment Operation
 Passenger Loading and Unloading Procedures Vehicle Inspection Procedures
 Wheelchair Locking and Tie-down Procedures Other (Describe Below): _____

| | |
|---|---|
| 7. Are all Employees subject to Pre-employment and Random Drug Testing? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| a. If yes, is Testing conducted in compliance with DOT Drug Testing Regulations? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Do you have a written Progressive Disciplinary Plan in place for all Employees? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| a. If yes, is it reviewed annually with all Employees? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Do your Managers and/or Supervisors perform periodic Ride Checks with all Drivers? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Do all Employees know how to handle Passengers with highly contagious illnesses and Passengers that carry blood borne pathogens? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Are Passenger Assistants used when transporting medically fragile and/or severely disabled Passengers? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. If gurneys are used, does an EMT or Paramedic accompany the Passenger during transport? | <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 13. Are vehicles and/or Drivers equipped with 2 forms of communication equipment? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 14. Are vehicles equipped with emergency equipment? | |
| If yes, check all that apply: | |
| <input type="checkbox"/> Blood Pressure Equipment | <input type="checkbox"/> Defibrillator |
| <input type="checkbox"/> Oxygen | <input type="checkbox"/> Oxygen Mask |
| <input type="checkbox"/> Other (Describe): _____ | <input type="checkbox"/> First Aid Kit |
| | <input type="checkbox"/> Vehicle Roadside Emergency Kit |
| 15. Are vehicles equipped with Voice-activated GPS? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 16. Will each vehicle be staffed with at least one Employee with American Red Cross First Aid, CPR and Automated External Defibrillation (AED) Training and Certification? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 17. Do you notify your Passengers whenever a vehicle is running late? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 18. Do you maintain files in compliance with all applicable regulatory standards? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 19. Do you utilize an Incident and/or Accident Reporting Form? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| a. If yes, is a copy of each completed form always submitted to your Agent/Company? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 20. Do you hire independent Medical Transport Businesses? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If yes, please answer a-f. | |
| a. What percentage of your total operations is subcontracted to other Medical Transport Businesses? | _____ % |
| b. What are your annual subcontracted costs for these Medical Transport Businesses? | \$ _____ |
| c. Do you obtain a Certificate of Insurance from each independently contracted Medical Transport Business evidencing General Liability and Workers Compensation Limits equal to, or greater than, your own General Liability and Workers Compensation Limits? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. Do you require all independently contracted Medical Transport Businesses to add you to their General Liability policy as an Additional Insured? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e. Do you require all independently contracted Medical Transport Businesses to contractually hold you harmless? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| f. Are all Certificates of Insurance kept on file for a minimum of 5 years? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 21. Do you hire independent Medical Transport Drivers (i.e. other than those employed by the businesses addressed above in question 20)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If yes, please answer a-d. | |
| a. What percentage of your total operations is subcontracted to other Medical Transport Drivers? | _____ % |
| b. What are your annual subcontracted costs for these Medical Transport Drivers? | \$ _____ |
| c. Do you verify that all applicable Licenses are up-to-date for each independently contracted Medical Transport Driver? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. Do you obtain an MVR for each independently contracted Medical Transport Driver and review it for acceptability using the same standards used to evaluate your own Drivers? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

SECTION F: Prior General Liability and Professional Liability Insurance

1. If no prior General Liability or Professional Liability Insurance, check this box:

2. Provide Insurance Company Names as well as your Limits, Deductibles and premiums for the last 3 years:

| Year | Insurance Company Name | General Liability Limits | Professional Liability Limits | General Liability Deductible | Premium |
|------|------------------------|--------------------------|-------------------------------|------------------------------|---------|
| | | \$ | \$ | \$ | \$ |
| | | \$ | \$ | \$ | \$ |
| | | \$ | \$ | \$ | \$ |
| | | \$ | \$ | \$ | \$ |

3. In the last 3 years – has your insurance been Declined, Cancelled or Non-renewed? Yes No
 a. If yes, please explain why: _____

SECTION G: General Liability and Professional Liability Claims History

1. Provide details for the last 3 years – if none, please state “none”:

| Date of Loss | Description of Loss | Open/Closed? | Total Incurred |
|--------------|---------------------|--------------|----------------|
| | | | \$ |
| | | | \$ |
| | | | \$ |

SECTION H: Automobile Coverages Requested (Provide limit where applicable)

Liability _____ Medical Payments – See Section N Physical Damage – See Section L
 Scheduled Autos Uninsured Motorists \$100,000/\$300,000 Specified Causes/Collision, or
 Hired Autos Underinsured Motorists \$100,000/\$300,000 Comprehensive/Collision
 Non-Owned Autos Other _____

SECTION I: Automobile Operations

1. Check each of the services you provide:

| | | | |
|--|---|--|--------------------------------------|
| <input type="checkbox"/> Taxi | <input type="checkbox"/> Special Occasion Limousine | <input type="checkbox"/> Kid Cab | <input type="checkbox"/> Jeep Tour |
| <input type="checkbox"/> School Bus/Van | <input type="checkbox"/> Airport Limousine | <input type="checkbox"/> Employee Van Pool | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Church Bus/Van | <input type="checkbox"/> Executive Limousine | <input type="checkbox"/> Guide/Outfitter | _____ |
| <input type="checkbox"/> Casino Bus/Van | <input type="checkbox"/> Daycare Bus/Van | <input type="checkbox"/> Sightseeing | |
| <input type="checkbox"/> Social Service Agency (Please Describe): _____ | | | |
| <input type="checkbox"/> Shuttle Service (Between what destinations?): _____ | | | |

2. Do you transport passengers for a fare? Yes No

3. Do you regularly transport elderly passengers? Yes No

4. Do you regularly transport passengers to medical facilities? Yes No

5. Do you regularly transport physically disabled passengers? Yes No

6. Are any vehicles equipped with wheelchair lifts? Yes No

7. What is the average number of hours per day each vehicle is operated? _____ Percentage of night driving? _____

8. Is there any personal use of vehicles? Yes No
 If yes, please explain: _____

9. Are drivers allowed to take vehicles home when not in use? Yes No
 If yes, are there any relatives under 23 years of age residing in the driver’s household? Yes No
 If yes, please explain: _____

10. Maximum radius of operations: _____ Miles

SECTION K: Prior Insurance Carriers and Loss Experience (Add additional sheet(s) if necessary)

| Policy Dates | Insurance Carrier | Policy # | Premium | Average No. of Power Units | *Total Liability Claims | | *Total Physical Damage Claims | | Cancelled or Non-Renewed? (Reason) |
|--------------|-------------------|----------|---------|----------------------------|-------------------------|----|-------------------------------|----|------------------------------------|
| | | | | | # | \$ | # | \$ | |
| | | | \$ | | # | \$ | # | \$ | |
| | | | \$ | | # | \$ | # | \$ | |
| | | | \$ | | # | \$ | # | \$ | |
| | | | \$ | | # | \$ | # | \$ | |
| | | | \$ | | # | \$ | # | \$ | |

*This section should be completed unless you have attached loss runs for all years. Please describe any loss over \$25,000

Any drivers involved in more than one claim? Yes No Who? _____
 If yes, is that driver currently employed? Yes No

SECTION L: Vehicle Information (Add additional sheet(s) if necessary)

| | Model Year/Make | Body Type (Van, Limo, Bus, etc.) | Vehicle ID No. | Seating capacity | Vehicle Equipped with Gurney = G Lift = L | Amount of Insurance (Must be equal to present value) | Deductible | *Loss Payee (Y/N) |
|-----|-----------------|----------------------------------|----------------|------------------|---|--|------------|-------------------|
| 1. | | | | | | | | |
| 2. | | | | | | | | |
| 3. | | | | | | | | |
| 4. | | | | | | | | |
| 5. | | | | | | | | |
| 6. | | | | | | | | |
| 7. | | | | | | | | |
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| 9. | | | | | | | | |
| 10. | | | | | | | | |
| 11. | | | | | | | | |
| 12. | | | | | | | | |
| 13. | | | | | | | | |
| 14. | | | | | | | | |

*Please list name and address of loss payee by vehicle: _____

Do you have a regular vehicle inspection and preventative maintenance program? Yes No
 If yes, please describe: _____

Do you own any vehicles which will not be covered under this policy? Yes No
 If yes, please list all vehicles not covered and the insurance carrier covering those vehicles: _____

SECTION M: Rejection of Medical Payments Coverage

This coverage provides medical or chiropractic payments for protection of all persons using the insured motor vehicle from losses resulting from bodily injury or death. You may reject this coverage by signing below. Your rejection will apply on all renewals unless you give us written notice otherwise.

Applicant's Signature: _____ Date: _____

SECTION N: Agreements and Signatures

APPLICANT: I believe the statements in this application are true and correct. I understand that the insurer will rely on these statements if a policy is issued. I agree to promptly report all full time and part time drivers. My employees understand that motor vehicle reports will be ordered. On their behalf, I authorize the insurer to order these reports on each driver I employ or contract. **This application alone does not bind coverage. I understand that this policy does not provide any coverage in Ontario, Canada.**

Fraud Warning: 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 crime.

Applicant's Signature: _____ Producer's Signature: _____

Date: _____ Date: _____

Agency Name and Address:
