GenStar

SUPPLEMENTAL APPLICATION
PROFESSIONAL LIABILITY
NON-EMERGENCY MEDICAL TRANSPORTATION SERVICE
Miscellaneous Healthcare Facilities Program

This application must be completed, signed and dated by the applicant. All questions must be answered completely. The information is required to make an underwriting and pricing evaluation. Your answers are considered legally material to that evaluation. If any question does not apply, indicate NOT APPLICABLE. If space is not sufficient to properly answer the question, please provide the details in the Additional Information section of this form or you may attach a separate page using your letterhead. To use this form, you may mouse click on a field or move between fields using the tab key. To check a box, you may mouse click or press the space bar.

I. GENERAL INFORMATION

Applicant Name:
Entity Name Website:
Primary Office Address: Telephone No.:
City: County:
State: ZIP:

II. OPERATIONS

1. Hours of Operation:
2. Number of shifts maintained:
3. Number of shifts per 24 hours:
4. Radius of operation:
   - 0 - 25 miles %
   - 26 - 50 miles %
   - 51 or more miles %

   Must total 100%
5. Number of transports: Last 12 months: Projected next 12 months:
6. Description of Vehicles and number(e.g. ambulette, van with wheelchair accessibility, etc):

   _____
   _____
   _____
   _____
   _____
7. What measures are in place to ensure that drivers have the appropriate competencies, driving records and safe driving skills?

   _____
8. Are temporary/substitute drivers given written instructions regarding special drop off/pickup protocols? ☐ Yes ☐ No
9. Are background checks, including criminal checks conducted? ☐ Yes ☐ No
10. Do drivers receive basic first-aid training to be able to address issues that could arise while transporting the client (e.g. fainting, nausea)? ☐ Yes ☐ No

11. Are drivers instructed on measures to follow in the face of medical or other emergencies? ☐ Yes ☐ No

12. Do drivers receive bloodborne pathogen training and are their vehicles stocked with personal protective equipment (e.g. gloves) should the resident have episodes involving bodily fluids (e.g. vomiting, bleeding from a wound)? ☐ Yes ☐ No

13. Is the driver expected to monitor the resident for any changes in the resident's condition that may require immediate intervention? ☐ Yes ☐ No

14. Is the driver expected to assist the resident with getting in and out of the vehicle? ☐ Yes ☐ No

15. Does the driver receive training in the privacy protections of the Health Insurance Portability and Accountability Act (HIPAA)? ☐ Yes ☐ No

16. What measures are in place to ensure that vehicles are regularly inspected and maintained and that the vehicle registration is current?

_____

17. Is there an incident reporting mechanism in place? (QA? Client Survey?) ☐ Yes ☐ No
If **YES**, please describe below.

_____

18. Are you required to be licensed by your state? If so, please attach a copy of the license. ☐ Yes ☐ No

19. Additional Information:
If you would like to add additional comments relative to the above questions or would like to provide additional information about your business which may be useful to us in reviewing your application, please use this space.

_____

VII. ACKNOWLEDGEMENTS, AUTHORIZATION and SIGNATURE

This applicant declares that the information contained in this supplemental application is true and that no material facts have been suppressed or misstated. The applicant understands and acknowledges that the information contained in the application is deemed material and that any policy issued by the Company is done so in reliance upon the truth of the applicant's representations. This applicant understands that incorrect information could void coverage.

Signature: _____ Date: _____

Printed Name: _____ Title/Position (Officer, Partner, etc): _____