



PROFESSIONAL and GENERAL LIABILITY APPLICATION NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT) SERVICES (Edition 06.2026)

Section 1: Applicant Information

1. Applicant Name: _____
2. Mailing Address: _____
3. Location Address: _____
(If multiple names and locations, please attach list)
4. Telephone Number: _____ Website Address: _____ Date Established: _____

Section 2: Business Details

5. Entity Type: ☐ Corporation ☐ Individual ☐ LLC ☐ Partnership ☐ Other: _____
6. Status: ☐ For Profit ☐ Non-Profit
7. Funding is: Medicare _____% Medicaid _____% Private Pay _____% Other: _____

Section 3: Coverage Requested

8. Effective Date: _____
9. Liability Limits: \$ _____ / \$ _____
10. Deductible: \$ _____

Section 4: Operations Overview

11. Please check all categories that describe services rendered by your organization.

Service Type	Description	% of Operations
☐ Non-Emergency Medical Transportation	Transportation of patients/clients between residences, healthcare facilities, physician offices, or dialysis centers. Drivers are generally non-medical personnel and may have First Aid and/or CPR certification.	_____%
☐ Ambulette / Medical Van Service	Transportation of patients requiring limited medical assistance or wheelchair/stretchers accommodations. Services may include facility-to-facility or facility-to-home transports.	_____%
☐ Basic Life Support (BLS) Transportation	Ground ambulance services staffed by EMT-Basic personnel providing non-invasive medical care and monitoring during transport.	_____%
☐ Advanced Life Support (ALS) Transportation	Ground ambulance services staffed by Paramedics and/or Advanced EMTs capable of providing advanced medical interventions during transport.	_____%
☐ Emergency Medical Transportation	Emergency response services, including 911 or equivalent emergency dispatch calls.	_____%
Total Operations (Must equal 100%): _____%		

12. Specialty Operations: Does the applicant provide any specialty operations listed below?

☐ Yes ☐ No

a) If Yes, check all that apply:

☐ Air / Water Transportation	☐ Bariatric Transportation If Yes, _____% Min. 2 staff required: ☐ Yes ☐ No	☐ Organ/Tissue or Donation Transportation
☐ Mobile ICU / NICU / PICU	☐ Dispatch Services	☐ Special Events (sports/concerts/fairs)
☐ International Transportation	☐ School / Youth Transportation	☐ Involuntary Transportation (psych or correctional facilities)
☐ Funeral Homes / Mortuary Services	☐ Ridesharing / Taxi / Black Car Services	☐ Other (Describe):

b) Do you subcontract your services to others?

☐ Yes ☐ No

13. Does the applicant have any ancillary operations not stated above?

☐ Yes ☐ No

If Yes, please provide details: _____

If Yes, does the applicant maintain separate professional and general liability coverage for these operations with limits equal to or greater than those specified in Section 3 of this application?

☐ Yes ☐ No

14. Is the applicant engaged in, owned by, associated with, or controlled by any other businesses?

☐ Yes ☐ No

If Yes, please provide details: _____

If Yes, does the applicant maintain separate professional and general liability coverage for these operations with limits equal to or greater than those specified in Section 3 of this application?

☐ Yes ☐ No

15. Please provide the number of completed transports and corresponding gross revenues by service type for the most recent 12-month period and the projected next 12 months:

New ventures: Complete projected figures only.

Service Type	Number of Transports		Gross Revenue	
	Last 12 months	Projected Next 12 Months	Last 12 months	Projected Next 12 Months
Private Passenger Vehicle			\$	\$
Wheelchair			\$	\$
Stretcher / Gurney			\$	\$
Non-Emergency BLS Ambulance			\$	\$
Non-Emergency ALS Ambulance			\$	\$
Critical Care Ambulance			\$	\$
Other (Specify):			\$	\$
TOTALS			\$	\$

Section 5: Dispatch & Operations

16. How are transportation requests dispatched? (Check all that apply)

- ☐ 911 ☐ In-House ☐ Third-Party ☐ Healthcare Facility ☐ Broker Network
☐ Mobile App /Online Scheduling Platform ☐ Other (Please describe): _____

17. Do you provide CPR / First Aid / Medical Training?

☐ Yes ☐ No

If Yes, is training given to staff only?

☐ Yes ☐ No

18. Radius of Operations: _____

Section 6: Vehicles & Equipment

19. Please indicate the NUMBER of vehicles for each category below: (Check all that apply)

- ☐ Private Passenger Vehicle (PPV): _____
☐ Wheelchair Van: _____
☐ Ambulette: _____
☐ BLS Ambulance: _____
☐ ALS Ambulance: _____
☐ Other Vehicles (Please specify): _____
 TOTAL NUMBER OF VEHICLES: _____

20. Wheelchair Transport:

a) What types of wheelchairs are transported by the applicant? (Check all that apply)

- ☐ No wheelchair transport
☐ Manual Wheelchairs ☐ Powered / Electric Wheelchairs ☐ Bariatric Wheelchairs
☐ Reclining Wheelchairs ☐ Specialty / Custom Wheelchairs ☐ Other (Please describe): _____

b) Do you have a mandatory lift assistance requirement?

☐ Yes ☐ No

c) Are wheelchair passengers ever transported without the use of a restraint system?

☐ Yes ☐ No

21. Stretcher Transport:

a) Does the applicant provide stretcher or gurney transportation services?

☐ Yes ☐ No

If Yes, complete following:

b) What types of stretchers are utilized in transportation vehicles? (Check all that apply)

- ☐ Manual Stretchers ☐ Powered/Electric Stretchers ☐ Bariatric Stretchers
☐ Specialty / Critical Care Stretchers ☐ Other (Please describe): _____

c) What stretcher securement system(s) are used within transportation vehicles?

- ☐ Floor-Mounted Locking ☐ Four-Point Securement ☐ Manufacturer-Approved Integrated Securement
☐ Other (please describe): _____

22. How frequently are personnel trained on the proper use of wheelchair and stretcher loading, securement, and passenger restraint systems? (Check all that apply)

- ☐ Upon Hire / Initial Orientation
 ☐ Annually
 ☐ Semi-Annually
☐ Following an Accident or Incident
 ☐ Following Equipment Changes
 ☐ Other (please describe): _____

Section 7: Staffing & Credentials

23. Employee and Independent Contractor Details:

a) List the **NUMBER** and type of **PERSONNEL**:

(If owner-operated, describe contingency plans in the event of owner unavailability)

	EMPLOYEES		INDEPENDENT CONTRACTORS	
	Full-Time	Part-Time	Full-Time	Part-Time
Driver Only				
First Aid / Red Cross				
CPR Certified				
EMT – Basic				
EMT Advanced/Intermediate				
Paramedic				
Nurse (RN / LPN)				
Physician/Medical Director				
All others (Describe):				
TOTAL				

b) Are all personnel required to maintain applicable licenses, certifications, and continuing education requirements? ☐ Yes ☐ No

c) Does the applicant verify and document licenses, certifications, and driving records prior to hire and at regular intervals thereafter? ☐ Yes ☐ No

If Yes, how often are credentials re-verified?

☐ Annually
 ☐ Every 2 Years
 ☐ Upon Renewal
 ☐ Other: _____

24. Are you seeking coverage under this proposed insurance for the independent contractors? ☐ Yes ☐ No
 If No, is coverage at equal or greater limits maintained by each independent contractor? ☐ Yes ☐ No

25. Do you sell, rent, or otherwise provide any equipment or products to others? ☐ Yes ☐ No
 (If Yes, please complete the Huntersure Durable Medical Equipment Application)

26. Screening and Policies:

- a) Do you conduct pre-employment screening and investigation? ☐ Yes ☐ No
 b) Are employees required to actively participate in continuing education? ☐ Yes ☐ No
 c) Do you prepare job descriptions and instructional manuals for your staff? ☐ Yes ☐ No
 d) Do you have a written incident/occurrence reporting policy and procedures? ☐ Yes ☐ No

27. Check all the following that are collected, verified, and maintained for each staff member during the hiring process:

- | | | |
|---|--|--|
| ☐ Applications/Resumes | ☐ Criminal Background Checks | ☐ Licensure Verification |
| ☐ Drug Testing | ☐ Education/Training/Competence | ☐ Sex Abuse Registry Checks |

28. Are there proficiency requirements for newly hired drivers?

☐ Yes ☐ No

If Yes, check all training requirements that apply:

- ☐ Orientation ☐ First Aid ☐ Defensive Driving ☐ CPR ☐ Passenger Assist

29. Are all drivers and transportation personnel formally trained in the proper procedures for loading, unloading, transferring, securing, and transporting passengers utilizing wheelchairs, stretchers, or other mobility devices?

☐ Yes ☐ No

If Yes, how frequently is training provided? (Check all that apply)

- ☐ Upon Hire / Initial Orientation ☐ Annually ☐ Semi-Annually ☐ Following an Accident

If No, please explain: _____

30. Does the applicant maintain written policies and procedures in place to refuse a client who is under the influence of alcohol and/or mood-altering drugs, violent/combative, requires emergency care or requires transportation for non-medical reasons?

☐ Yes ☐ No

31. Does the applicant maintain written policies and procedures in place to that no one under the age of 18 years old is transported without their parent or legal guardian?

☐ Yes ☐ No

Section 8: Regulatory and Inspection

32. Disclosure of Disciplinary or Legal History:

Attach a detailed explanation for any **YES** answers below:

Has the applicant or have any of the employees:

a) Ever been subject to disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital, or professional association?

☐ Yes ☐ No

b) Ever been convicted of any act committed in violation of any law or ordinance (other than traffic offenses)?

☐ Yes ☐ No

c) Ever been treated for alcoholism or drug addiction?

☐ Yes ☐ No

d) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused, accepted only on special terms, or voluntarily surrendered?

☐ Yes ☐ No

Section 9: Insurance History

Currently valued loss runs for all prior coverage are required.

33. Professional Liability Coverage – Last 5 Years: (If none, state none)

Carrier	Limit	Deductible	Premium	Expiration (MM/DD/YYYY)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If expiring insurance is a **claims-made** policy, provide retroactive date: _____



34. General Liability Coverage – Last 5 Years: (If none, state none)

Carrier	Limit	Deductible	Premium	Expiration (MM/DD/YYYY)

If expiring insurance is a **claims-made** policy, provide retroactive date: _____

35. Does the applicant currently maintain Commercial Automobile Liability coverage? ☐ Yes ☐ No

Commercial Automobile Liability limit must be equal to or greater than the PL/GL limit requested.

Carrier: _____ Liability Limit: _____ Expiration Date: _____

☐ **Required Attachment: Please provide a copy of the current Commercial Automobile Liability Declarations Page**

Section 10: Claims and Incidents

36. Has any insurer canceled or refused to renew similar insurance in the past 5 years? ☐ Yes ☐ No
(If Yes, attach details)

37. Has any claim been made against the insured or its employees that would be covered by this policy in the past 5 years? ☐ Yes ☐ No

If Yes, please attach a completed Huntersure Claims Supplement (one for each claim or incident reported)

38. Is the applicant aware of any circumstances that may result in a claim against the insured or its employees that would be covered under this policy? (If Yes, attach details) ☐ Yes ☐ No

Signature and Attestation

Application for Claims-Made Professional Liability Insurance

The undersigned declares that to the best of his/her knowledge the statements herein are true. Signing of this Application does not bind the undersigned to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a Policy be issued, and that this Application will be attached and become part of such Policy, if issued. Underwriters hereby are authorized to make any investigation and inquiry in connection with this Application, as they deem necessary.

FOR KENTUCKY RISKS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime.

ELECTRONIC SIGNATURE: If the application is e-signed, it must be accompanied by the verification page or proof that it was securely e-signed along with the date, time stamp, and originating email address.

Name of Applicant: _____

Please Print

Title

Signature: _____

Name

Date

(NOTE: Application must be signed by the owner or president or principal)

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Page 6 of 6