

# Benchmark

## MANAGEMENT GROUP, INC.

1730 Park Street, Suite 214 Naperville, IL 60563  
 Phone: (630) 778-7000 Fax: (630) 778-7007

### Public Auto Supplemental Application Social Service and Ambulance

1. What is the primary purpose of your operation and how are these services provided? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Number of years in business: \_\_\_\_\_ Number of years under current management: \_\_\_\_\_

2. Is this operation for: .....  profit  nonprofit  
 Source of funding: \_\_\_\_\_

3. What are the total number of trips per year? \_\_\_\_\_  
 Percent wheelchair/stretchers transport: \_\_\_\_\_  
 Of those, what is the number of emergency? \_\_\_\_\_ and non-emergency? \_\_\_\_\_

4. How many of the vehicles have lights and sirens? \_\_\_\_\_

5. Who dispatches your calls?  911  Outside sources  In-house by your own employees or volunteers

6. Do you distribute any medical supplies or equipment? .....  Yes  No  
 If yes, please provide details: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

7. Indicate number of individuals who drive and/or provide client care (full-time, part-time, pair or volunteer): \_\_\_\_\_

	EMT BASIC	EMT ADVANCED	EMT PARAMEDIC	OTHER	NONE
EMPLOYEES					
VOLUNTEERS					

If "other" marked above, please explain: \_\_\_\_\_

8. Identify the types of special driver training programs that your drivers receive:

- |   |  |
|---|--|
| <input type="checkbox"/> General driver orientation   | <input type="checkbox"/> Defensive driving             |
| <input type="checkbox"/> Primary first aid            | <input type="checkbox"/> Advanced first aid            |
| <input type="checkbox"/> CPR                          | <input type="checkbox"/> Passenger assistance training |
| <input type="checkbox"/> Human relations skills       | <input type="checkbox"/> Nonmedical emergency training |
| <input type="checkbox"/> Emergency vehicle evacuation |  |

9. What is your criteria for driver selection? \_\_\_\_\_  
 \_\_\_\_\_

10. What safety procedures are in place? \_\_\_\_\_  
 \_\_\_\_\_

11. Do you have specific wheelchair tie-down procedures? .....  Yes  No

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

12. Is there an accident review procedure? .....  Yes  No

If yes, briefly describe: \_\_\_\_\_  
\_\_\_\_\_

13. What type of vehicle maintenance is there? \_\_\_\_\_  
\_\_\_\_\_

14. Does Applicant have professional coverage? .....  Yes  No

Policy No.: \_\_\_\_\_ Term: \_\_\_\_\_  
Name of carrier: \_\_\_\_\_

15. Has this service ever operated under another name? .....  Yes  No

If yes, what name? \_\_\_\_\_

16. Are all vehicles owned by you? .....  Yes  No

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

Are they leased, etc.? .....  Yes  No

Give details: \_\_\_\_\_  
\_\_\_\_\_

17. Do employees use their own vehicles in your business? .....  Yes  No

If yes, describe how often and if there is client transport: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

18. Any other pertinent information about your business: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

19. A. In which major cities does applicant provide transportation (list cities): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

B. Of Applicant's total operations, what percentage involves transportation in these major cities? \_\_\_\_\_

20. Does Applicant have General Liability coverage? .....  Yes  No

Policy No.: \_\_\_\_\_ Term: \_\_\_\_\_  
Carrier: \_\_\_\_\_

21. Are all drivers covered by Worker's Compensation? .....  Yes  No

If yes, provide carrier name: \_\_\_\_\_  
\_\_\_\_\_

22. Are MVR's ordered prior to allowing employee to drive? .....  Yes  No

**FRAUD WARNING APPLICABLE IN THE STATE OF NEW YORK:**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for commercial insurance or a statement of claim for any commercial or personal insurance benefits containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who, in connection with such application or claim, knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the value of the subject motor vehicle or stated claim for each violation.

**FRAUD WARNING:**

Any person who knowingly and with intent to defraud any insurance company or other 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 such person to criminal and civil penalties.

APPLICANT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

(Must be signed by an active owner, partner, or executive officer.)

AGENT NAME: \_\_\_\_\_ AGENT LICENSE NUMBER: \_\_\_\_\_

**(Applicable to Florida Agents Only)**