



Simplycity — Investor Brief

VERSION	2.0 27 September 2026 Confidential concept material
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TAGLINE	Urban air, made simple.



This is the long-form companion to the investor deck, written for prospective investors, care partners, operators, infrastructure partners and public stakeholders. It contains planning assumptions and illustrative pricing hypotheses. They are not audited forecasts, regulatory approvals, contractual commitments or performance guarantees. We don't ask readers to believe the assumptions; we ask them to help fund the experiments that test them.

1. What Simplicity is

Simplicity is the coordination and assurance platform for regulated urban drone services, starting with time-critical medical samples in Amsterdam. Our longer-term vision is a civic operating system that lets drones earn a place in the city. Today we sell something narrower and more concrete: mission coordination, release gating, an auditable record and evidence reporting for one corridor at a time.

Our stage, stated plainly: working software prototype + defined operating concept + reference aircraft envelope + initial business model + validation plan. The platform is real and live at simplicity.nl against simulated aircraft. We have no operational service, customers or revenue yet.

2. The problem

Urban drone services are not primarily an aircraft problem. Aircraft that can carry 2–3 kg over 30+ km already exist. What doesn't exist is a way for five independent parties to run one flight as a single, accountable service:

One flight needs	Owned by
Clinical request and chain of custody	Care provider
Aircraft, crew, operational authorisation	Licensed operator
Aircraft performance and technical data	OEM
Pad, site access, ground safety	Hub / site owner
Permission and oversight	City / authority
One release decision and one audit record across all of them	Nobody, today

Today, time-critical diagnostic samples cross Amsterdam by road through variable traffic. Replacing a courier run with a flight means coordinating a route, authorised sites, weather and dispatch, clinical custody, oversight and evidence that the city benefits.

3. Why now

1. The rules exist, and they are demanding. EU Regulation 2019/947 set a risk-based “specific” category, and the U-space rules (2021/664) have applied since January 2023. Operators need an operational authorisation, and getting one takes structured evidence.
2. Residents accept a clear use case. In Amsterdam's own 2022 survey (Onderzoek en Statistiek, n = 536), 84% of residents were positive about drones for emergency assistance and a large majority were positive about medicine delivery. Parcel delivery ranked lowest. Privacy (79%), safety (77%) and noise (51%) were the named concerns.
3. Healthcare has time-critical flows. Urgent samples moving between hospitals and laboratories have measurable time value and a small number of accountable parties.
4. Medical drone flights are already happening in the Netherlands. The ANWB / Isala Meppel–Zwolle pilot has completed 800+ flights and has been extended to mid-2027 with the Ministry of Infrastructure and Water Management, KPN and LVNL. The use case is being validated, and the next question is how to repeat it.
5. Cities want evidence, not demos. Whoever can measure and publish safety, noise and service performance earns the next route.

4. What we are, and are not

We are	We are not
A neutral mission-coordination layer	An aircraft manufacturer
A trust and evidence system for urban air services	A delivery company or logistics carrier
A fleet-agnostic integration layer for operators and OEMs	The aircraft operator, unless deliberately licensed for that role
A corridor-launch partner for cities and care networks	A substitute for the authority, OEM safety case or clinical process

5. The product: Flow, Trust, Impact

Flow: mission orchestration

Flow turns a clinical transport request into a releasable mission. Route volume, aircraft and operator availability, weather, pad capacity, energy and maintenance are checked against 12 release gates. Stale data fails closed. Flow then manages launch release, live progress, diversions, exceptions and closure.

Trust: shared assurance

Trust gives hospitals, operators, hub owners and authorities the visibility their role needs. A hash-chained, tamper-evident ledger records every decision, custody scan, alert and human intervention.

Impact: evidence of public value

Impact records service reliability, elapsed time, route compliance, energy use and measured noise, so that a city and a care coalition can decide with evidence whether a corridor should continue, change or scale.

6. Who pays whom

The care provider buys a transport outcome. The operator is paid for flying. Simplycity is paid for making the whole corridor work as one system.

Stakeholder	Role in the corridor	Economic relationship
Care provider (hospital / lab network)	Buys the transport outcome; owns clinical custody	Primary customer. Pays the operator per flight, and Simplycity for setup, orchestration and platform
Licensed operator	Flies the aircraft; holds the operational authorisation	Paid per flight by the care provider; may resell Simplycity inside its fee
Simplycity	Coordination, release gating, audit, reporting	Setup + per-mission + per-corridor platform fees
Hub / site owner	Pads, access, ground safety	Site agreement (a cost, not revenue)
City / authority	Permission, oversight, public acceptance	Pays EUR0 in our base case. Governance reporting is upside only
OEM	Supplies aircraft and technical data	Supplier to the operator; integration retainer possible

Why pay Simplycity rather than just hire the operator? An operator's tools cover its own fleet. The care provider needs one release decision across five parties, an unbroken custody chain, and evidence the authority will accept, whichever operator or aircraft flies. Neutrality is the product: a hospital can switch or add operators without rebuilding its workflow.

7. The wedge: the 17-minute Amsterdam care corridor

The 17-minute care corridor

REFERENCE MISSION PROFILE - SCHEMATIC, NOT TO SCALE - A PLANNING TARGET, NOT A DELIVERED SERVICE



Reference mission profile and 17-minute timeline (schematic)

The first service is intentionally narrow: moving time-critical medical samples between controlled care hubs and laboratories. The routes can be repeated, the service value can be measured, the stakeholders are identifiable, and safety and acceptance work stays concentrated instead of spreading citywide.

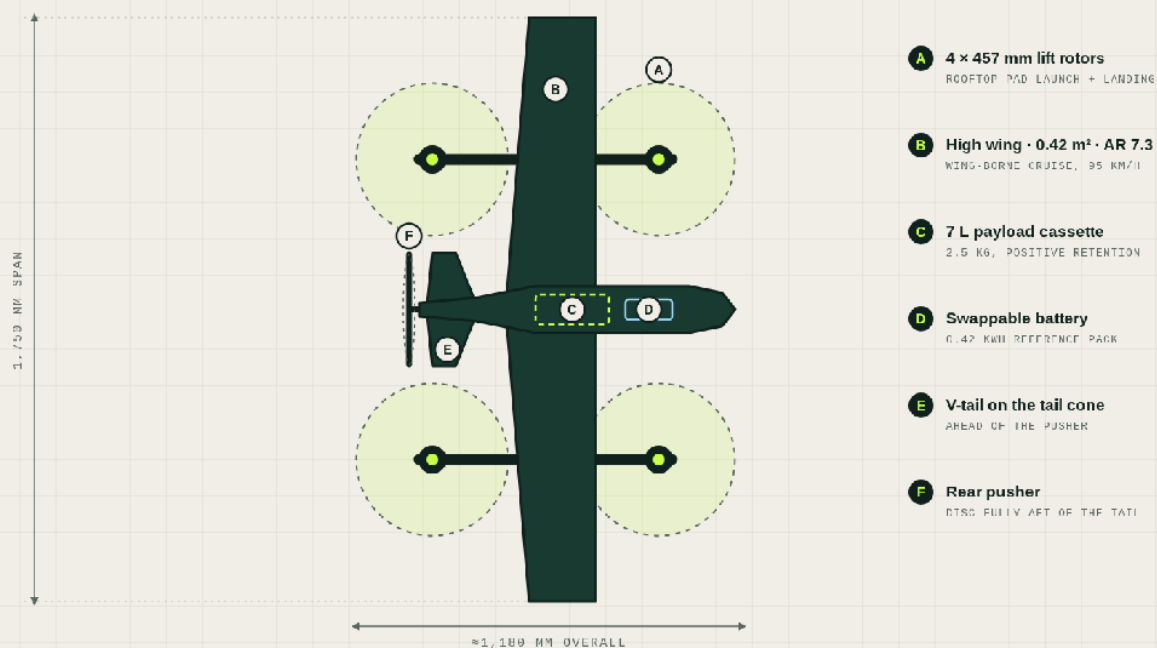
Reference planning scenario: an 18 km direct route, 95 km/h wing-borne cruise, and a 17-minute door-to-door target including launch release and receiving handover. This is not a delivered service.

Why this route?	Today's answer	Status
Road time, same trip	~45 min door-to-door, traffic-dependent	Planning estimate: to measure
Air time target	17 min door-to-door	Target: to prove in supervised flights
Eligible movements per week	Urgent samples only, not routine runs	To count with an anchor partner
Clinical time sensitivity	Samples where turnaround time changes a clinical decision	To validate with clinicians
First customer	An Amsterdam hospital-laboratory network	Target profile: not yet signed
Regulatory construct	Operator-held operational authorisation for this route	Pathway to define (section 12)

8. SC-17 CAREWING: why a reference aircraft exists

SC-17 CAREWING

REFERENCE CONFIGURATION · TOP VIEW · CONCEPT DIAGRAM, NOT A BUILT AIRCRAFT



SC-17 CAREWING reference configuration: concept top view drawn to the blueprint dimensions

SC-17 is not a Simplicity product. It is a supplier-neutral reference configuration that makes the corridor requirements specific enough to evaluate OEM candidates and design the platform interface.

Reference envelope	Planning value
Configuration	Battery-electric fixed-wing quadplane
Payload	2.5 kg / 7 L target cassette
Span / MTOM	1.75 m / 13.6 kg target
Cruise / nominal range	95 km/h / 35 km planning envelope
Reference route	18 km, 17-minute door-to-door target

The first-order mission model uses 0.170 kWh of nominal aircraft energy, or 0.221 kWh with a 30% contingency reserve, against 0.336 kWh of usable planned battery energy. These are requirements-model inputs, not proven aircraft performance. Real OEM aircraft will be scored against the OEM-neutral requirements specification (SC17-OEM-Neutral-Requirements.md). If a candidate beats the reference, it wins.

9. Economics

All figures are illustrative pricing hypotheses to be validated with the first care partner and operator. They come from the live, editable model at simplicity.nl/platform/economics.html. The model assumes no aircraft resale, no fleet margin and no unvalidated volume curve.

9.1 Customer economics: what one movement costs the hospital

Per sample movement	Road	Air
Courier (hypothesis range EUR35–60)	EUR45	—
Operator flight (hypothesis range EUR40–90)	—	EUR60
Hub / ground handling (hypothesis EUR5–10)	—	EUR8
Simplicity (derived from 9.2 at 12 movements/day)	—	EUR27
Total	EUR45	EUR95

Air will probably cost more per movement than road: here, about EUR50 more for about 28 minutes saved (~EUR1.80 per minute). The business stands only if, for the samples that need it, the time saved and the reliability are worth that premium. This is the first thing the pilot must measure, and these figures will be replaced by a real operator quote and a courier benchmark.

9.2 Simplicity unit economics: one mature corridor, city pays EUR0

Revenue line	Hypothesis	Who pays
Corridor setup	EUR60,000 one-time	Care sponsor
Mission orchestration	EUR9 per mission	Care provider / operator
Platform (Flow + Trust)	EUR5,500 per corridor per month	Care provider / operator
Integration retainer	EUR18,000 per partner per year	OEM / operator
Impact / governance reporting	EUR24,000 per corridor per year	Authority: excluded from the base case

At 12 movements/day over 300 days (3,600 per year), with direct costs of EUR0.60 per mission and EUR2,500 per corridor per month, one mature corridor yields about EUR98k recurring revenue, EUR66k contribution, a 67% gross margin and EUR27 Simplicity revenue per movement. Adding city reporting as upside lifts a corridor to about EUR122k.

9.3 Scale economics

Movements / corridor / day	Recurring revenue / corridor	Gross margin	Corridors to break even*	Corridors to EUR1m ARR	Corridors to EUR5m ARR
6	EUR82k	62%	13	12	61
12 (base case)	EUR98k	67%	10	10	51
30	EUR147k	76%	6	7	34

*Break-even is measured against today's lean fixed cost (EUR705k/yr), so read it as a lower bound; a 10-corridor company would carry a larger team.

What this says:

- One corridor cannot carry the company. The pilot corridor is a funded proof.
- Utilisation is the biggest unknown. Going from 12 to 30 movements a day cuts the corridors needed for EUR1m ARR from about 10 to about 7. The pilot must measure it.
- EUR5m ARR is a network business. 34–51 corridors means several cities and several operators, which only works if Simplicity stays neutral across operators and OEMs.

9.4 Revenue phases

Phase	Stage	Who pays for what
1 · Land	Pilot corridor	Care sponsor pays setup, integration and mission fees
2 · Build	Commercial corridor	Care provider or operator pays platform + per-mission orchestration on a renewing contract
3 · Productise	Multi-corridor city	Adds assurance and governance reporting on reused templates
4 · Compound	Network	Multi-operator, multi-OEM, multi-city on one interface and one trust record

Each phase adds a revenue layer only after the previous one is proven.

10. Go-to-market

1. Land one high-trust care coalition. An anchor care provider, a licensed operator, hub owners and a municipal working group.
2. Build one auditable corridor. Integrate the selected aircraft and operator, configure the hub workflow, and show authorities measurable control.
3. Productise the launch playbook. Reuse route, hub, custody, reporting, data-contract and acceptance templates for

the next corridor.

4. Compound integrations and data across corridors and cities.

Intended moat: a hypothesis, not yet demonstrated. Operational integrations, regulatory workflow knowledge, corridor-specific data, stakeholder relationships, standard OEM/operator interfaces and a historical trust record. Why wouldn't an operator or OEM build this themselves? They can, for their own fleet. A hospital, a city or a second operator needs a layer that none of the competing suppliers controls.

11. Competitive landscape

Medical drone logistics is no longer hypothetical in the Netherlands or Europe, and we say so plainly.

Who	What they have done	How Simplicity relates
ANWB Medical Drones (NL)	A consortium with Isala, KPN, LVNL and the Ministry of Infrastructure and Water Management; Avy aircraft. 800+ BVLOS flights between Isala Meppel and Zwolle, pilot extended to mid-2027.	Proves the demand and that the regulator will engage. It is one operating consortium on one route, not a reusable, fleet-agnostic coordination layer. A potential partner, not only a competitor.
Avy (Amsterdam)	Electric VTOL aircraft OEM/operator with BVLOS experience; the aircraft in the ANWB corridor.	A candidate integration partner.
Apian (UK)	6,000+ pathology samples flown for Synnovis between Guy's and St Thomas'; now deploying Matternet aircraft to the Synnovis Blackfriars hub (~20,000 samples/day processed).	The closest analogue to our model, and evidence that an integration/coordination layer is fundable. Not active in the Dutch market as far as public information shows.
U-space service providers	Certified airspace-level services: geo-awareness, flight authorisation, network identification.	Infrastructure we sit above and consume. Their data feeds the route and weather release gates.

The honest reading: the service is being proven in the Netherlands, one route at a time. Nobody yet offers the reusable layer that lets a second, third or tenth corridor start from a proven workflow rather than from scratch.

12. Regulatory pathway: an operationally authorised corridor, not a pre-approved one

The honest starting point. ILT (the Dutch Human Environment and Transport Inspectorate) states that BVLOS flights in the Netherlands can currently only take place in controlled or "atypical" airspace, and that the standard BVLOS scenario (STS-02) covers sparsely populated areas only. An urban BVLOS corridor therefore needs a bespoke authorisation route. This is our largest timeline risk, which is why the plan starts with authority engagement, not flights.

1. Authority engagement. Early dialogue with ILT, the municipality and hospital sites on route, airspace and ground-risk options.
2. ConOps and risk assessment. The operator leads the SORA-based assessment; Simplicity supplies the workflow, gate logic and evidence design.
3. Supervised demonstrations. Measured aircraft, energy, noise and exception data, under whatever permission each stage allows.
4. Limited pilot under an operational authorisation. The operator holds the authorisation; Simplicity is the coordination and audit record.

Simplicity never holds the flight authorisation unless it deliberately decides to become an operator.

13. Platform proof: built, validating, to prove

Built	Validating next (none signed yet)	To prove
12 operational release gates on live data; stale data fails closed	Anchor healthcare partner	Supervised flights on the route
4 scripted scenarios, 3 of them failure cases (denial, weather, link loss)	Licensed operating partner	Clinical workflow and custody in practice
90 API routes, including a documented OEM/operator integration contract	Aircraft / OEM candidate	Customer willingness to pay per movement

Hash-chained, tamper-evident trust ledger and custody chain	Hub / site owners	Corridor utilisation (movements per day)
Real sign-up, verification and admin review; real map	Municipal working group	A viable regulatory pathway
Automated safety, security and custody test coverage		

Also completed: the SC-17 reference configuration and first-order sizing, the OEM-neutral requirements specification, a role-by-role walkthrough, and a public document library at </resources/deliverables>.

14. Validation plan

Hypothesis	Experiment	Evidence	Decision it drives
A 17-minute service is possible on this route	Supervised flights on the reference route	Measured door-to-door times, diversions	Continue, or change the route
Hospitals value the time saved	Structured interviews + a priced offer to the anchor partner	Stated and signed willingness to pay per movement	Pricing, and which samples are eligible
Enough eligible movements exist	Count urgent movements with the partner's lab data	Movements per day on the route	Corridor economics (6 / 12 / 30 per day)
Operator economics work	Formal quotes from 2+ licensed operators	EUR per flight at pilot volume	Customer price and corridor model
Residents accept the route	Before-and-after survey in the corridor impact area	Sentiment, noise complaints, sample size	Site and route selection
A regulatory pathway is viable	Authority engagement + operator SORA draft	Written feedback, conditions, timeline	Pilot design and timing
Simplicity can charge on top	Commercial pilot contract	Fees paid for setup, orchestration and platform	SaaS pricing for corridor 2

15. The pilot decision test

Can we deliver a critical sample more reliably than a road courier, and earn public trust while doing it?

- Safety: no unacceptable safety events, measured against the operator's authorised safety case; every exception recorded and reviewed.
- Service: $\geq 95\%$ of eligible missions delivered inside the agreed clinical window.
- Reliability: cancellation, diversion and intervention rates published in full; no cherry-picking.
- Acceptance: $\geq 70\%$ positive among residents sampled in the corridor impact area, surveyed before and after operations, with the sampling method and sample size published.
- Impact: measured noise and energy, compared with the road workflow it replaces.
- Economics: a validated price per movement and a documented cost to launch corridor 2.

16. Principal risks and mitigation

Risk	Mitigation
Customers won't pay the premium	Price test before the pilot; target only samples where time changes outcomes; no build-out before a signed sponsor.
Corridor utilisation is too low	Count real eligible movements first; design corridor 1 as a hub serving several sites, not one point-to-point line.
Approval timeline extends	Narrow, controlled route; authority engagement from month 0; stage spending by evidence gates.
OEM performance falls short	SC-17 stays supplier-neutral; score several candidates; change assumptions transparently.
Hub or community resistance	Survey sites early; publish measured rather than claimed noise; a clear incident process.

Clinical workflow harder than flight	Co-design with care partners; validate custody, temperature and exceptions before the pilot.
Platform not differentiated enough	Focus on multi-party release, audit and fleet-agnostic integration, not generic telemetry.
Capital intensity grows	No fleet ownership by default; hardware commitments only after coalition and route diligence.

17. The founder

Prabhat Kumar, Founder: aviation systems, electrification and product. An aerospace and electrical engineer building the coordination layer for regulated urban air services.

- IIT Kanpur: B.Tech., Aerospace Engineering.
- Erasmus Mundus: Master's in Electric Vehicle Propulsion & Control Systems.
- Electric aviation: battery management, power electronics, electric propulsion and controls.
- Systems engineering: embedded systems, CAN, motor control and high-power electrification. Currently working on electric aviation systems: propulsion, inverter/control and system integration.

"I have spent my career on the aircraft and propulsion side of electric aviation. Building the aircraft is no longer the hardest part. The hard part is making urban air services useful, coordinated and trusted across customers, operators, infrastructure and authorities. Simplycity is my attempt to build that missing layer."

Building the founding team. Simplycity is founder-led today. Product and customer discovery are founder-led, regulatory and aviation expertise is brought in per workstream, and healthcare validation is partner-led. Once the Amsterdam corridor is validated, a complementary co-founder will be added in healthcare/commercial partnerships or urban aviation operations.

18. The EUR750k pre-seed raise

About 12 months, from concept to a pilot decision. This is an illustrative plan; timing and cost depend on operator/OEM selection and regulatory scope.

Use of funds	EUR	Share	What it buys
Product & engineering	270,000	36%	Platform hardening, operator/OEM integration, clinical workflow
Corridor launch & operations	165,000	22%	Route/hub survey, supervised demonstrations, measurement
Safety & regulatory	120,000	16%	ConOps and risk-assessment support, authority engagement
Partnerships & clinical	75,000	10%	Anchor-partner validation, pricing and eligibility study
Founder & company	75,000	10%	Lean founder costs, legal, finance, tooling
Contingency	45,000	6%	Unknown integration, site or timeline issues
Total	750,000	100%	

The plan is deliberately lean: founder-led, with specialist engineering and regulatory expertise contracted per workstream rather than hired ahead of validation. It does not include aircraft manufacturing or fleet purchase. At the end of the round we expect to have: a signed anchor healthcare partner; a contracted licensed operating partner; a selected aircraft (scored against SC-17); a defined regulatory pathway with written authority feedback; the reference route demonstrated under supervision; measured operational, noise and energy data; validated customer pricing per movement; a go/no-go decision on the first commercial corridor; and a qualified pipeline for corridor 2.

Period	Milestone	Evidence of progress
Months 0–2	Coalition and service definition	Anchor care partner, operator dialogue, route and payload brief

Months 2–4	Corridor feasibility and authority engagement	Route/hub survey, supplier scorecard, ConOps, initial risk work
Months 4–6	Platform + integration MVP	Dispatch, custody, stakeholder view, OEM/operator data interface
Months 6–8	Supervised demonstrations	Measured aircraft, energy, noise, workflow and exception data
Months 8–10	Limited-pilot readiness	Operating model, maintenance/hub processes, validated pricing
Months 10–12	Pilot decision and scale package	KPI review, cost-to-scale, city-launch playbook, corridor-2 pipeline

19. What we want your view on

1. Is a coordination and assurance layer a valuable enough standalone business, or does it belong inside an operator?
2. Do Amsterdam medical samples make sense as the first wedge?
3. Who should own the commercial contract: the hospital, the lab network or the operator?
4. What evidence would you need before funding the first corridor?
5. Does the EUR750k milestone plan buy the right proof?
6. Which complementary co-founder capability would you prioritise first: healthcare/commercial, or aviation operations/regulatory?

The question isn't "should a city fill with drones?" It is: can we prove one essential route is safer, more reliable and more accountable than the status quo, and build the layer that lets that proof travel to the next city?

Sources

- Gemeente Amsterdam, Onderzoek en Statistiek, "Perceptie van drones in Amsterdam" (April 2022, n = 536): onderzoek.amsterdam.nl
- ILT, "Dronecategorie Specifiek": ilent.nl (accessed September 2026)
- ANWB Medical Drones, "Medische dronevluchten tussen Meppel en Zwolle verlengd tot medio 2027" (August 2026): anwb.nl/medical-drones
- Apian / Synnovis / Matternet expansion (June 2025): dronelife.com; logisticsmanager.com
- EU Regulations 2019/947 (UAS operations) and 2021/664 (U-space)

Document index

- SIMPLYCITY-Investor-Deck.pptx / .pdf: the 20-slide investor deck (business model, economics, the raise).
- SIMPLYCITY-Investor-Brief.md / .pdf: this long-form brief.
- SIMPLYCITY-Master-Pitch.pptx / .pdf: the 15-slide project pitch (what Simplycity is, the corridor, the SC-17 reference aircraft, the 12-month plan).
- SIMPLYCITY-Business-Model.md: role boundary, revenue model and competitive landscape.
- SC17-OEM-Neutral-Requirements.md: supplier selection and integration specification.
- SC17-Carewing-Blueprint.pdf: aircraft concept and engineering basis.

All are published for review at </resources/deliverables>.