National Casualty Company

Home Office:
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Property/Casualty Division:
8877 North Gainey Center Drive • Scottsdale, Arizona 85258
1-800-423-7675 • Fax (480) 483-6752

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?**_____ **% wheelchair/stretcher 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**:
   - ❑ General driver orientation
   - ❑ Primary first aid
   - ❑ CPR
   - ❑ Human relations skills
   - ❑ Emergency vehicle evacuation
   - ❑ Defensive driving
   - ❑ Advanced first aid
   - ❑ Passenger assistance training
   - ❑ Nonmedical emergency training

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

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 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such 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)

SCOTTSDALE INSURANCE COMPANY®

National Casualty Company

Scottsdale Indemnity Company

FIRST PARTY BENEFITS COVERAGE—PENNSYLVANIA

A. Medical Expense Benefit: Coverage to reimburse you for reasonable and necessary medical treatment and services incurred.

B. Income Loss Benefit: Coverage to replace a portion of lost income and reimburse you for expenses in securing replacement services.

C. Accidental Death Benefit: A death benefit paid in the event of the death of an injured person due to a covered auto accident.

D. Funeral Benefit: Coverage to pay for direct funeral, burial and other related expenses incurred as a result of the death of an insured person due to a covered accident.

According to Pa. C. S. Title 75 Chapter 17, you are required to purchase a minimum of $5,000, Medical Expenses. All other options listed below (including a higher limit of Medical Payments) are choices for you to make. Indicate your choice of options shown below for each coverage. Then date and sign this form and return to your Agent.

BENEFIT LEVEL OPTIONS: (Include your choice by marking the box with a "X" for each coverage or for your choice of Combination Benefits option).

A. MEDICAL EXPENSES: Per Person, Per Accident with minimum and maximum benefits as shown:

❑ $5,000 $ _____ ❑ $10,000 $_____ ❑ $25,000 $_____ ❑ $50,000 $_____ ❑ $100,000 $_____

B. INCOME LOSS: Per Month, Per Person, Per Accident with minimum and maximum benefits as shown:

❑ None-Rejected ❑ $1,000/$ 5,000 $_____ ❑ $1,000/$15,000 $ _____ ❑ $1,500/$25,000 $ _____

❑ $2,500/$50,000 $ _____

C. ACCIDENTAL DEATH: Per Person, Per Accident with minimum and maximum benefits as shown:

❑ None-Rejected ❑ $ 5,000 $_____ ❑ $10,000 $_____ ❑ $25,000 $ _____

D. FUNERAL EXPENSE: Per Person, Per Accident with minimum and maximum benefits as shown:

❑ None-Rejected ❑ $1,500 $ _____ ❑ $2,500 $_____

OR

COMBINATION BENEFITS: This coverage is a combination of benefits. Do not complete this section if you have elected to purchase any of the above options.

❑ $ 50,000 ($2,500 Funeral and $10,000 Accidental Death Benefits) $_____

❑ $100,000 ($2,500 Funeral and $10,000 Accidental Death Benefits) $_____

❑ $177,500 ($2,500 Funeral and $25,000 Accidental Death Benefits) $_____

❑ $277,500 ($2,500 Funeral and $25,000 Accidental Death Benefits) $_____

AND

EXTRAORDINARY MEDICAL BENEFIT (EMB): Extraordinary Medical Benefits Coverage is an optional coverage. It pays the medical expenses of eligible persons for accidents covered under your policy. Payments under this coverage begin only when covered medical expenses exceed $100,000 and capped at the lifetime limit of $1,000,000.

The first $100,000 of medical expenses are not covered by this coverage. If you select the Extraordinary Medical Benefits Coverage and your First Party Medical Benefits limit is less than $100,000, you will be responsible for the difference.

❑ Do not include; ❑ $100,000 ❑ $300,000 ❑ $500,000 ❑ $1,000,000.

_____ _____

Named Insured Policy Number

_____ _____

First Named Insured Position

_____ _____

Signature of First Named Insured Date

SCOTTSDALE INSURANCE COMPANY®

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UNINSURED MOTORIST (UM) COVERAGE LIMITS OFFER—PENNSYLVANIA

Named Insured:_____

Policy Number: _____

Uninsured motorist coverage provides protection for damages incurred as a result of an accident with an uninsured motor vehicle. Pennsylvania law requires Uninsured Motorist protection be offered, but the purchase is optional. There is an additional premium for this coverage. Coverage can be rejected by the signing of a separate form.

If you have decided to purchase Uninsured Motorist (UM) protection, the law allows you to select a limit no less than $35,000 or no more than the Combined Bodily Injury and Property Damage Coverage Limit this policy presently provides. We have provided several options for the Uninsured Motorist (UM) limit.

Please check the box indicating the limit for either a combined coverage limit or split limit with or without stacked limits. Stacking means you can claim a total of the amounts of uninsured motorist coverage assigned to each vehicle in your policy. If you reject stacked limits, each vehicle insured under the policy will have its own limits of uninsured motorist coverage. There is an additional premium for this coverage. Stacked coverage can be rejected by the signing of a separate form.

Please indicate your choice(s) below:

Uninsured Motorist (UM)

Non-stacked		Stacked	
Combined Limits	Split Limits	Combined Limits	Split Limits
❑ $ 35,000	❑ $ 15,000/$ 30,000	❑ $ 35,000	❑ $ 15,000/$ 30,000
❑ $ 50,000	❑ $ 50,000/$ 100,000	❑ $ 50,000	❑ $ 50,000/$ 100,000
❑ $ 100,000	❑ $100,000/$ 300,000	❑ $ 100,000	❑ $100,000/$ 300,000
❑ $ 250,000	❑ $250,000/$ 500,000	❑ $ 250,000	❑ $250,000/$ 500,000
❑ $ 500,000	❑ $500,000/$ 1,000,000	❑ $ 500,000	❑ $500,000/$ 1,000,000
❑ $ 750,000		❑ $ 750,000	
❑ $1,000,000		❑ $1,000,000	

By signing and dating this limits offer, I am selecting the above limits for Uninsured Motorists (UM). I act on full authority of all insureds under this policy. I realize these limits will remain unchanged on future policies unless I notify the insurance company in writing.

_____ _____

First Named Insured Position

_____ _____

Signature of First Named Insured Date

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REJECTION OF STACKED UNINSURED MOTORIST COVERAGE LIMITS—PENNSYLVANIA

By signing this waiver, I am rejecting **stacked** limits of uninsured motorist under the policy for myself and members of my household under which the limits of coverage available would be the sum of limits for each motor vehicle insured under the policy. Instead, the limits of coverage that I am purchasing shall be reduced to the limits stated in the policy. I knowingly and voluntarily reject the stacked limits of coverage. I understand that my premiums will be reduced if I reject this coverage.

Named Insured

Policy Number

First Named Insured

Position

Signature of First Named Insured

Date

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REJECTION OF UNINSURED MOTORIST PROTECTION—PENNSYLVANIA

By signing this waiver, I am rejecting uninsured motorist coverage under this policy, for myself and all relatives residing in my household. Uninsured coverage protects me and relatives living in my household for losses and damages suffered if injury is caused by the negligence of a driver who does not have any insurance to pay for losses and damages. I knowingly and voluntarily reject this coverage.

Named Insured

Policy Number

First Named Insured

Position

Signature of First Named Insured

Date

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UNDERINSURED MOTORIST (UIM) COVERAGE LIMITS OFFER—PENNSYLVANIA

Named Insured:_____

Policy Number: _____

Underinsured motorist coverage provides protection for damages incurred as a result of an accident with an underinsured motor vehicle. Pennsylvania law requires Underinsured Motorist protection be offered, but the purchase is optional. There is an additional premium for this coverage. Coverage can be rejected by the signing of a separate form.

If you have decided to purchase Underinsured Motorist (UIM) protection, the law allows you to select a limit no less than $35,000 or no more than the Combined Bodily Injury and Property Damage Coverage Limit this policy presently provides. We have provided several options for the Underinsured Motorist (UIM) limit.

Please check the box indicating the limit for either a combined coverage limit or split limit with or without stacked limits. Stacking means you can claim a total of the amounts of underinsured motorist coverage assigned to each vehicle in your policy. If you reject stacked limits, each vehicle insured under the policy will have its own limits of uninsured motorist coverage. There is an additional premium for this coverage. Stacked coverage can be rejected by the signing of a separate form.

Please indicate your choice(s) below:

Underinsured Motorist (UIM)

Non-stacked		Stacked	
Combined Limits	Split Limits	Combined Limits	Split Limits
❑ $ 35,000	❑ $ 15,000/$ 30,000	❑ $ 35,000	❑ $ 15,000/$ 30,000
❑ $ 50,000	❑ $ 50,000/$ 100,000	❑ $ 50,000	❑ $ 50,000/$ 100,000
❑ $ 100,000	❑ $100,000/$ 300,000	❑ $ 100,000	❑ $100,000/$ 300,000
❑ $ 250,000	❑ $250,000/$ 500,000	❑ $ 250,000	❑ $250,000/$ 500,000
❑ $ 500,000	❑ $500,000/$1,000,000	❑ $ 500,000	❑ $500,000/$1,000,000
❑ $ 750,000		❑ $ 750,000	
❑ $1,000,000		❑ $1,000,000	

By signing and dating this limits offer, I am selecting the above limits for Underinsured Motorists (UIM). I act on full authority of all insureds under this policy. I realize these limits will remain unchanged on future policies unless I notify the insurance company in writing.

_____ _____

First Named Insured Position

_____ _____

Signature of First Named Insured Date

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REJECTION OF STACKED UNDERINSURED MOTORIST COVERAGE LIMITS—PENNSYLVANIA

By signing this waiver, I am rejecting **stacked** limits of underinsured motorist coverage under the policy for myself and members of my household under which the limits of coverage available would be the sum of limits for each motor vehicle insured under the policy. Instead, the limits of coverage that I am purchasing shall be reduced to the limits stated on the policy. I knowingly and voluntarily reject the stacked limits of coverage. I understand that my premiums will be reduced if I reject this coverage.

Named Insured

Policy Number

First Named Insured | Position

Signature of First Named Insured | Date

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REJECTION OF UNDERINSURED MOTORIST PROTECTION—PENNSYLVANIA

By signing this waiver, I am rejecting underinsured motorist coverage under this policy, for myself and all relatives residing in my household. Underinsured coverage protects me and relatives living in my household for losses and damages suffered if injury is caused by the negligence of a driver who does not have enough insurance to pay for all losses and damages. I knowingly and voluntarily reject this coverage.

Named Insured

Policy Number

First Named Insured

Position

Signature of First Named Insured

Date