

Public Application



Policy Term From: _____ To _____

1. Name (and "dba") _____
 Individual/Proprietorship Partnership Corporation Other Business Phone Number _____
2. Mailing Address _____ City _____ State _____ Zip _____
3. Premises Address _____ City _____ State _____ Zip _____
4. Person to contact for inspection (name and phone number) _____
5. Have you ever had insurance with one of the companies listed at the top of this page? Yes No
 If yes, Policy Number(s) _____ Effective Date(s) _____

DESCRIPTION OF OPERATIONS

6. Describe business _____
 Years experience _____ New Venture? Yes No
7. Is this your primary business? Yes No If no, explain _____
 Is your business seasonal? Yes No Is your business for hire/for profit? Yes No
8. Have you ever filed for Bankruptcy? Yes No If yes, when _____ Explain _____
9. Gross receipts last year _____ Estimate for coming year _____ Business for sale? Yes No
10. Do you operate in more than one state? Yes No If yes, list states _____
11. What is the largest city entered within your radius of operation? _____

LIABILITY COVERAGE — Complete for desired coverages by indicating limits of insurance.

LIABILITY				Medical Payments	Personal Injury Protection (where applicable)	IF PHYSICAL DAMAGE COVERAGE DESIRED – REFER TO FOLLOWING PAGE. COMPLETE HIRED AND NON-OWNED SUPPLEMENT IF COVERAGE DESIRED.
Combined Single Limit BI & PD	Split Limits		Property Damage			
	Bodily Injury					
	Each Person	Each Accident	Each Accident			

APPLICABLE PERSONAL INJURY PROTECTION, UNINSURED AND/OR UNDERINSURED MOTORISTS INSURANCE SELECTION/REJECTION PAGE IS REQUIRED TO BE COMPLETED AND SIGNED BY THE NAMED INSURED WITH THE SUBMISSION OF THIS APPLICATION.

DRIVER INFORMATION — If additional space is needed, attach separate listing.

Driver's Name	Date of Birth	Driver's Licenses				Experience	
		State	Number	Class/Type (i.e. CDL)	Years Licensed (in Class/Type)	Type of Unit (Bus, Van, etc.)	No. of Years
1.							
2.							
3.							
4.							
5.							

No. Years Previous Commercial Driving Experience	Date of Hire	Accidents and Minor Moving Traffic Violations in Past 5 Years				Major Convictions (DWI/DUI, Hit & Run, Manslaughter, Reckless, Driving While Suspended/ Revoked, Speed Contest, other felony)		Employee (E) Ind. Cont. (IC) Owner/Op. (O/O) Franchisee (F)
		No. of Accidents	Date(s)	No. of Violations	Date(s)	Describe Conviction	Date(s)	

PLEASE ATTACH DETAILED EXPLANATION OF ACCIDENTS LISTED ABOVE.

12. What is the basis for driver(s) pay? Hourly _____ Trip _____ Mileage _____ Other, explain _____
13. Are drivers covered by Workers Compensation? Yes No Minimum years driving experience required _____
14. Are vehicles owner-driven only? Yes No Do you agree to report all newly hired operators? Yes No
15. Are drivers ever allowed to take vehicles home at night? Yes No If yes, will family members drive? Yes No
16. Do you order MVR's on all drivers prior to hiring? Yes No Driver's maximum driving hours _____ daily, _____ weekly

SCHEDULE OF AUTOS/VEHICLES — Describe all vehicles for which application is made for insurance.

Veh. No.	Model Year	Vehicle Make	Body Type/Model	Full Vehicle Identification Number	Orig. Mfg. Seating Cap.	Principal Garaging Location (City & State)	Radius of Operation	Annual Mileage Per Vehicle	(A) Anti-Lock Brakes, (B) Air Bags or (C) Wheelchair Lift
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									

PURPOSE OF USE ABBREVIATION MUST BE SELECTED FOR EACH VEHICLE

Veh. No.	Purpose of Use	Length of Limo Stretch	AB Airport Bus or Van	APS Airport Parking/Rental Car Shuttle	AT Athlete Bus (a) Professional Athlete (b) Non-Professional Athlete	BB Bingo/Casino Bus	SBG Boy/Girl Scout Bus	CB Charter Bus (a) Interstate (b) Intrastate	CHB Church Bus	CTB City Transit Bus (Urban Bus)	CRB Courtesy Bus (a) Hotel (b) Medical (c) Other	DC Day Care/Day Nursery	ET Employee Transportation	ME Musician & Entertainer Bus (a) Professional Entertainer (b) Non-Professional Entertainer	MV Medivan/Medical Transport/Non-Emergency Ambulance (a) For Profit (b) Not For Profit	PT Prisoner Transfer	SB School Bus (a) Public Owned (b) Other (c) Private or Parochial Owned	SC Senior Citizens Center Auto	SH Shuttle (a) Tourist (b) Wilderness (c) All Other	SSB Sightseeing Bus	SKB Ski Bus	SSA Social Service Agency (a) Group Home (b) Other	TX Taxicab	TM Tram	T Trolley	
1																										
2																										
3																										
4																										
5																										
6																										
7																										
8																										
9																										
10																										

PHYSICAL DAMAGE COVERAGE — Complete spaces below in detail for each respective auto/vehicle described above.

Veh. No.	Date Purchased	Cost When Purchased	Current Stated Value (excluding permanently attached equipment)	Value of Permanently Attached Equipment	Total Stated Amount to be Insured	Physical Damage Deductible	
						<input type="checkbox"/> Comprehensive <input type="checkbox"/> Spec. C of Loss	Collision
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

17. Any loss payees? Yes No If yes, give name and address of mortgagee/loss payee for each vehicle _____

LOSS EXPERIENCE — Provide prior insurance carriers information for past full three years.

Policy Term		Insurance Company Name	No. of Motor Powered Vehicles	No. of Accidents	Premium		Total Amount Claims Paid & Reserves			
From	To				Liab	Phys Dam	BI	PD	Comp/Coll	Other
/ /	/ /									
/ /	/ /									
/ /	/ /									

- 18. Is any applicant aware of any facts or past incidents, circumstances or situations which could give rise to a claim under the insurance coverage sought in this application? Yes No If yes, provide complete details _____
- 19. Have you ever been declined, cancelled or non-renewed for this kind of insurance? Yes No
If yes, explain _____
- 20. Is the transportation of people your primary business? Yes No Are vehicles leased to drivers? Yes No
- 21. Do you transport physically disabled individuals? Yes No If yes, what percentage of the time? _____
- 22. Are vehicles equipped with fare box or meter? Yes No Do you have a scheduled route? Yes No
- 23. Do you ever transport unscheduled passengers? Yes No Minimum number of hours rented _____ Minimum charge _____
- 24. Number of vehicles owned Limos _____ Vans _____ Buses _____ Other _____
- 25. Number of vehicles leased Limos _____ Vans _____ Buses _____ Other _____

FILING INFORMATION

- 26. Is an FHWA filing required? Yes No If yes, MC number _____
What authority do you have? Broker Common Contract
- 27. If you hold a Brokers license, identify name filed with FHWA, FHWA docket no. and receipts from brokerage operations _____
- 28. If you are an interstate regulated carrier, identify your registration or base state _____
- 29. Is an intrastate filing needed? Yes No If yes, show state and permit number _____
- 30. Show exact name and address in which permits are issued _____
- 31. Is MCS 90 endorsement needed? Yes No
- 32. Is our policy to cover all vehicles owned, operated or under lease to applicant? Yes No If no, explain _____
- 33. Do you enter Canada? Yes No Do you enter Mexico? Yes No If yes, where _____

- 34. Have you ever changed your operating name? Yes No Do you operate under any other name? Yes No
- 35. Do you operate as a subsidiary of another company? Yes No
- 36. Do you own or manage any other transportation operations that are not covered? Yes No
- 37. Do you lease your authority? Yes No Do you appoint agents or hire independent contractors to operate on your behalf? Yes No
- 38. Have you purchased, sold or applied for authority over the past 3 years? Yes No
- 39. Have you ever lost or had authority withdrawn, or have you been/are under probation by any regulatory authority (FHWA, PUC, etc.)? Yes No
- 40. Is evidence/certificate(s) of coverage required? Yes No
- 41. Please explain any "yes" answer to questions 34 through 40 _____

- 42. Do you have agreements with other carriers for the interchange of vehicles or transportation of passengers? Yes No
If yes, attach a copy of current agreements and complete the following:
 - (a) With whom has such agreement(s) been made? _____
 - (b) Do the parties named in (a) carry automobile liability insurance? Yes No
If yes, name of insurance company and limits of liability (Bodily Injury & Property Damage) _____
 - (c) Under whose permit does each of the parties to the agreement(s) operate? _____
 - (d) Is there a hold harmless in the agreement(s)? Yes No
- 43. Do you barter, hire or lease any vehicles? Yes No If yes, explain _____
- 44. Additional comments: _____

VIRGINIA NOTICE

Regarding

Uninsured Motorists Coverage and Medical Expense and Income Loss Benefits

UNINSURED MOTORISTS COVERAGE provides protection for persons who are legally entitled to recover damages because of bodily injury (including resulting death) or damage to property (property damage*) from an owner or operator of an uninsured motor vehicle.

This coverage is included in your policy at limits equal to the policy's bodily injury liability limits. You may, however, reject such increased limits and select any limits lower than the policy's liability limits, but not less than the minimum financial responsibility limits.

UNDERINSURED MOTORISTS COVERAGE is included if you purchased additional limits of Uninsured Motorists Coverage, to provide protection for persons who are legally entitled to recover damages because of bodily injury (including resulting death) or damage to property (property damage*) from an owner or operator of an insured motor vehicle, whose Liability Coverage limits were, at the time of loss, less than the injured person's Uninsured Motorists Coverage limits.

To be certain that your policy is issued correctly, please indicate your choice ("X" indicates your choice) of the options available, then sign and date this form as your acknowledgment of your choice.

UNINSURED MOTORISTS COVERAGE PURCHASE OPTION

Additional limits - Uninsured Motorists Coverage (including Underinsured Motorists Coverage). I have had this coverage fully explained to me and I wish to purchase additional limits of Uninsured Motorists Coverage, at the following limits, which do not exceed the Liability Coverage limits of my policy:

Split limit policies - Total Limits (basic and additional) - Uninsured Motorists Coverage:

\$ _____ per person, \$ _____ per accident Bodily Injury and \$ _____ per accident *Property Damage Uninsured Motorists Coverage;
or,

Single limit policies - Total Limit (basic and additional) - Uninsured Motorists Coverage:

\$ _____ per accident, combined single limit Bodily Injury and *Property Damage Uninsured Motorists Coverage.

*Property Damage Uninsured Motorists Coverage is subject to a \$200 per accident deductible.

OPTIONAL COVERAGE or LIMITS REJECTION of UNINSURED MOTORISTS COVERAGE

Rejection of additional limits Uninsured Motorists Coverage (including Underinsured Motorists Coverage). I have had this coverage fully explained to me and I do not wish to purchase additional limits of Uninsured Motorists Coverage. I understand that by selecting this option I waive any and all State Statutory protection afforded with regard to additional limits of this coverage.

MEDICAL EXPENSE AND INCOME LOSS BENEFITS SELECTION

Medical Expense Benefits - Choose one:

Reject
 Accept If accepting, choose one: \$500 \$1000 \$2000 \$5000

Income Loss Benefits - Choose one:

Reject
 Accept

I have indicated my choice above ("X" indicates my choice):

Date Signed _____

Signature of Named Insured (Representing all Insureds) _____

(Until you advise us otherwise in writing, your choice, as indicated above, will continue regardless of any addition or change in Auto coverage on your current policy or addition of any Scheduled Autos.)

SIGNATURE IS ALSO REQUIRED ON LAST PAGE OF APPLICATION

MUST BE SIGNED BY THE APPLICANT PERSONALLY

No coverage is bound until the Company advises the Applicant or its representative that a policy will be issued and then only as of the policy effective date and in accordance with all policy terms. The Applicant acknowledges that the **Applicant's Representative named below is acting as Applicant's agent and not on behalf of the Company. The Applicant's Representative has no authority to bind coverage, may not accept any funds for the Company, and may not modify or interpret the terms of the policy.**

The Applicant agrees that the foregoing statements and answers are true and correct. The Applicant requests the Company to rely on its statements and answers in issuing any policy or subsequent renewal. The Applicant agrees that if its statements and answers are materially false, the Company may rescind any policy or subsequent renewal it may issue.

If any jurisdiction in which the Applicant intends to operate or the Interstate Commerce Commission requires a special endorsement to be attached to the policy which increases the Company's liability, the Applicant agrees to reimburse the Company in accordance with the terms of that endorsement.

The Applicant agrees that any inspection of autos, vehicles, equipment, premises, operations, or inspection of any other matter relating to insurance that may be provided by the Company, is made for the use and benefit of the Company only, and is not to be relied upon by the Applicant or any other party in any respect.

The Applicant understands that an inquiry may be made into the character, finances, driving records, and other personal and business background information the Company deems necessary in determining whether to bind or maintain coverage. Upon written request, additional information will be provided to the Applicant regarding any investigation.

The Applicant represents that she/he has completed all relevant sections of this Application prior to execution and that the Applicant has personally signed below (or if Applicant is a Corporation, a corporate officer has signed below).

Will premium be financed? Yes No If yes, with whom _____

IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

Witness Applicant's Signature Date

TO BE COMPLETED BY APPLICANT'S REPRESENTATIVE

Is this direct business to your office? _____ If not, explain _____

Is this new business to your office? _____ If not, how long have you had the account? _____

How long have you known applicant? _____

REQUEST TO COMPANY GENERAL AGENT:

Please quote Please bind at earliest possible date and issue policy

Please issue policy effective _____ Coverage was bound by _____
(Time and Date Bound by General Agent) (Name of Person in Company General Agency's Office Binding Coverage)

Applicant's Representative's Name and Address Phone No.



Delaware Valley Underwriting Agency, Inc.

ADDENDUM TO APPLICATION

Insured's/Applicant's Name: _____

TO BE ATTACHED TO AND MADE A PART OF ALL APPLICATIONS

It is agreed that the following FRAUD STATEMENTS are attached to the application:

APPLICABLE IN THE STATE OF PENNSYLVANIA:

WARNING: Any person who knowingly and with intent to defraud any insurance company or another 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.

APPLICABLE IN THE STATE OF NEW YORK:

WARNING: Any person who knowingly and with intent to defraud any insurance company or another 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.

APPLICABLE IN ALL OTHER STATES:

WARNING: Any person who knowingly and with intent to defraud any insurance company or another 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 the person to criminal and (NY: substantial) civil penalties. (Not Applicable in CO, HI, NE, OH, OK, OR, IN, DC, LA, ME and VA insurance benefits may also be denied)

I have read and accept the above (To be signed by the Insured/Applicant)

Insured/Applicant Signature

Date