Public Application

COLUMBIA INSURANCE COMPANY
NATIONAL FIRE & MARINE INSURANCE COMPANY
NATIONAL INDEMNITY COMPANY
NATIONAL INDEMNITY COMPANY OF MID-AMERICA
NATIONAL INDEMNITY COMPANY OF THE SOUTH
NATIONAL LIABILITY & FIRE INSURANCE COMPANY

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)	
Combined Single Limit BI & PD	Split Limits					**IF PHYSICAL DAMAGE COVERAGE DESIRED – REFER TO FOLLOWING PAGE.**
	Bodily Injury		Property Damage			
	Each Person	Each Accident	Each Accident			**COMPLETE HIRED AND NON-OWNED SUPPLEMENT IF COVERAGE DESIRED.**

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
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

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
Railroad Employees (a) For Profit (b) Not For Profit
Farm Labor Bus (c) For Profit (d) Not For Profit
Other (e) For Profit (f) Not For Profit
ICB Inter-City Bus (attach route scheduled)
L Limousine (a) Transportation to Airport ≥ 50%
(b) Super-Stretch (> 120") (c) Regular
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

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	
						☐ Comprehensive ☐ 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: _____

Notice Concerning the Waiver of Personal Injury Protection (PIP) Coverage – Commercial Automobile Liability Insurance (Maryland)

You have the choice of purchasing certain Personal Injury Protection (PIP) Coverages. Before deciding whether to purchase or waive this coverage, please read the following carefully.

Full PIP Coverage provides the following protection, without regard to fault:

1. It covers you and members of your family residing with you who are injured in **any** motor vehicle accident; any one injured while in your vehicle; and pedestrians injured **by** your vehicle.

2. The **minimum** coverage is $2,500. You may purchase additional amounts of . PIP coverage may be used to cover:
   A. All reasonable and necessary medical expenses incurred within 3 years of injury; and
   B. 85 percent of actually incurred lost wages; or
   C. If the injured person is not employed at the time of injury, any reasonable and necessary expenses to provide for essential services which that person would have provided for the care and maintenance of his or her family or household.

If you do **not** sign the waiver, you will automatically receive the full PIP protection described above. Your PIP premium will be $_____ (annually/policy period).

You may only waive PIP coverage for:

1. The named insured (you);
2. All listed drivers on the policy; and
3. Members of your family who are 16 years of age or older and reside with you in your household.

The waiver prevents the **named** insured (you) from collecting PIP benefits under **any** motor vehicle liability insurance policy issued in the State of Maryland or another form of security authorized to be used in place of a motor vehicle liability insurance policy.

The waiver prevents individuals described in category 2 or 3 above from collecting PIP benefits under your policy. In addition, the waiver prevents these individuals from collecting PIP benefits under any other policy of motor vehicle liability insurance policy issued in the State of Maryland or another form of security authorized to be used in place of a motor vehicle liability insurance policy unless the individual:

- Is the first named insured under the other policy; and
- Has not waived PIP benefits under the other policy; and
- Is not a named insured under any policy of motor vehicle liability insurance where a waiver of PIP benefits is in effect.

The waiver does not impair the rights of other individuals such as pedestrians or minor children from collecting PIP under your policy.

If you decide to sign the waiver, your PIP premium will be _____ percent of the full PIP coverage. The total premium will be $_____ (annually/policy period).

If you decide **not** to sign the waiver, your insurance company may not refuse to write your insurance coverage.

In order to waive the PIP benefits, you must sign an affirmative waiver form and submit it to your insurance company. If you do not sign the waiver, your insurance company must provide all coverages and benefits described above, and in Section 19-505 of the Insurance Article.

Waiver of Personal Injury Protection (PIP)
Coverage–Commercial Automobile
Liability Insurance (Maryland)

I hereby confirm that I have fully read and understood the attached notice, required by Section 19-506 of the Insurance Article, and I understand and agree that the company, in reliance upon my signature as the first named insured/applicant, will not provide the Personal Injury Protection (PIP) coverage, required by Section 19-505 and described in the attached notice provided to me with this waiver. This coverage is waived for any injury which may be sustained by:

1. Anyone listed as a named insured on the policy;

2. All drivers listed on the policy; and

3. All members of the named insured's family living in the insured's household who are 16 years of age or older.

I further understand and agree that the waiver of Personal Injury Protection (PIP) benefits under the policy being applied for waives coverage for PIP benefits for anyone described above under any other policy issued in the State of Maryland, or another form of security authorized to be used in place of a motor vehicle liability insurance policy, unless the individual is one described in Category 2 or 3 above, and:

— Is the first named insured under the other policy;

— Has not waived PIP benefits under the other policy; and

— Is not a named insured under any policy of motor vehicle liability insurance where a waiver of PIP benefits is in effect.

I affirmatively waive the benefits required by Section 19-505 of the Insurance Article (PIP). I understand and agree that this waiver of coverage shall be applicable to the policy or binder of insurance described below on all future renewals of the policy and on all replacement policies unless I notify the Company in writing to the contrary, with the effective date of such change being no earlier than the receipt date by the Company of my written notification.

_____

Signature of first named insured/applicant

Date_____Policy/binder number_____

Agent Producer Name_____Code_____

Company Name_____

MARYLAND NOTICE

Regarding

Uninsured Motorists Coverage

(Bodily Injury and Property Damage)

UNINSURED MOTORISTS COVERAGE is included in your policy at the minimum limits required by the State Financial Responsibility Law, 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 uninsured motor vehicle or those whose Liability limits are less than the limits of your Uninsured Motorists Coverage.

Higher limits of Uninsured Motorists Coverage may be purchased at an additional premium provided that the limits selected do not exceed the bodily injury liability limits of the policy.

To be certain that the policy is issued with the Uninsured Motorists Coverage limits that you want, please indicate your desired coverage limits below and sign and date this form, where provided, as your indication of approval of the limits selected.

COVERAGE PURCHASE OPTION

I have had this coverage fully explained to me and I wish to purchase Uninsured Motorists Coverage at the following limits, which do not exceed the Liability Coverage limits of my policy:

Split limit policies – Uninsured Motorists Coverage

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

or,

Single limit policies – Uninsured Motorists Coverage

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

_____ _____

Date Signed Signature of Named Insured (Representing all Insureds)

*Property Damage Uninsured Motorists Coverage is subject to a $250 per accident deductible.

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 and will be carried forward on all future renewal policies without additional notice.

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 _____

_____	_____	_____
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