☐ *STRATFORD INSURANCE COMPANY* ☐ *WESTERN WORLD INSURANCE COMPANY*

PUBLIC AUTO INSURANCE APPLICATION- PENNSYLVANIA

A. GENERAL

Applicant's Name: _____ Phone #: _____

Contact Person: _____ Proposed Effective Date: _____

Address: _____ Expiration Date: _____

Garaging Location(s) if different: _____

Is your business? 1. ☐ Individual ☐ Partnership ☐ Corporation ☐ Other _____

2. ☐ Seasonal ☐ Non-Profit ☐ Government Funded

Nature Of Business: _____ Years In Business: _____

Years Operating in Your Current Name: _____ Web Site: _____

Have you owned a similar business or had any change in ownership, management or name of your current business during the past 5 years? ☐ Yes ☐ No

If yes, please explain: _____

Is your business a subsidiary of another entity or does your business have any subsidiaries? ☐ Yes ☐ No

If yes, provide details: _____

B. COVERAGES REQUESTED (Provide limit where applicable.)

☐ Liability _____ ☐ PIP (No-fault _____ ☐ Physical Damage – *See Section G.*

☐ Scheduled Autos states only) ☐ Specified Causes/Collision, or

☐ Hired Autos ☐ Uninsured/Underinsured ☐ Comprehensive/Collision

☐ Non-Owned Autos Motorists _____ ☐ Other _____

☐ Medical Payments _____

C. OPERATIONS

1. Check each of the services you provide:

☐ Taxi ☐ Special Occasion Limousine ☐ Kid Cab ☐ Jeep Tour

☐ School Bus/Van ☐ Airport Limousine ☐ Employee Van Pool ☐ Other _____

☐ Church Bus/Van ☐ Executive Limousine ☐ Guide/Outfitter _____

☐ Casino Bus/Van ☐ Daycare Bus/Van ☐ Sightseeing _____

☐ Social Service Agency (Please describe): _____

☐ Shuttle Service (Between what destinations?) _____

2. Do you transport passengers for a fare? ☐ Yes ☐ No
3. Do you regularly transport elderly passengers? ☐ Yes ☐ No
4. Do you regularly transport passengers to medical facilities? ☐ Yes ☐ No
5. Do you regularly transport physically disabled passengers? ☐ Yes ☐ No
6. Are any vehicles equipped with wheelchair lifts? ☐ Yes ☐ No
7. What is the average number of hours per day each vehicle is operated? _____ Percent of night driving? _____
8. Is there any personal use of vehicles? ☐ Yes ☐ No

   If yes, please explain: _____
9. Are drivers allowed to take vehicles home when not in use? ☐ Yes ☐ No

   If yes, are there any relatives under 23 years of age residing in the driver's household? ☐ Yes ☐ No

   If yes, please explain: _____

10. Maximum radius of operations: _____ Miles

11. Territory (Largest Cities/Towns into, near or through which vehicles are operated.)

a. _____ b. _____ c. _____ d. _____

12. Do you travel to Michigan? ☐ Yes ☐ No If yes, how many days per month? _____

13. Do you travel to Ontario, Canada? ☐ Yes ☐ No

14. Do you lease, hire, rent, or borrow any vehicles from others? ☐ Yes ☐ No

If yes, what is your cost to lease, hire or rent vehicles? $ _____

15. Do you use independent contractors as drivers? ☐ Yes ☐ No

If yes, will their vehicles be scheduled on your policy? ☐ Yes ☐ No

16. **Filings:**

FHWA MC # _____ Base State: _____ State Filings: _____

D. DRIVERS (Add additional sheet(s) if necessary.)

Driver's Name (As shown on Driver's License)	Driver's License No. and State Where Licensed	Date of Birth	Date of Hire (Mo/Yr)	Years Licensed	Original CDL Date (if driving unit carrying 15+ passengers)	*Accidents or Violations in the Last Three Years (Yes/No)

***Please provide details for any accidents or violations.**

Are your employees covered by Workers' Compensation? ☐ Yes ☐ No

Do you agree to promptly report all new drivers? ☐ Yes ☐ No

Are all your drivers your employees? ☐ Yes ☐ No

E. PRIOR INSURANCE CARRIERS AND LOSS EXPERIENCE (Add additional sheet(s) if necessary.)									
Policy Dates	Insurance Carrier	Policy #	Premium	Aver-age No. of Power Units	*Total Liability Claims		*Total Physical Damage Claims		Cancelled or Non-Renewed? (Reason)
			$		#	$	#	$	
			$		#	$	#	$	
			$		#	$	#	$	
			$		#	$	#	$	
			$		#	$	#	$	

*This section should be completed unless you have attached loss runs for all years. Please describe any loss over $25,000:

Any drivers involved in more than one claim? ☐ Yes ☐ No Who? _____

If yes, is that driver currently employed? ☐ Yes ☐ No

F. VEHICLE INFORMATION (Add additional sheet, if necessary)					***G. PHYSICAL DAMAGE***				
	Model Year/Make	Body Type (Van, Limo, Bus, etc.)	Vehicle ID No.	Seating Capacity	Month/ Year of Purchase	Cost at Purchase	Amount of Insurance (Must equal present value)	Deduct-ible	*Loss Payee (Y/N)
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10.									
11.									
12.									
13.									
14.									

*Please list name and address of loss payee by vehicle: _____

_____

_____

Identify any vehicles equipped with wheelchair lifts: _____

Do you have a regular vehicle inspection and preventive maintenance program? ☐ Yes ☐ No

If yes, please describe: _____

Do you own any vehicles which will not be covered under this policy? ☐ Yes ☐ No

If yes, please list all vehicles not covered and the insurance carrier covering those vehicles: _____

_____

H. AGREEMENTS AND SIGNATURES

APPLICANT: I BELIEVE THE STATEMENTS IN THIS APPLICATION ARE TRUE AND CORRECT. I UNDERSTAND THAT THE INSURER WILL RELY ON THESE STATEMENTS IF A POLICY IS ISSUED. I AGREE TO PROMPTLY REPORT ALL FULL TIME AND PART TIME DRIVERS. MY EMPLOYEES UNDERSTAND THAT MOTOR VEHICLE REPORTS WILL BE ORDERED. ON THEIR BEHALF, I AUTHORIZE THE INSURER TO ORDER THESE REPORTS ON EACH DRIVER I EMPLOY OR CONTRACT. THIS APPLICATION ALONE DOES NOT BIND COVERAGE. **I UNDERSTAND THAT THIS POLICY DOES NOT PROVIDE ANY COVERAGE IN ONTARIO, CANADA.**

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 _____ Producer's Signature _____

Date _____ Date _____

Stratford Insurance Company

Supplement to Commercial Auto Application - Pennsylvania

First Party Benefits Notice

First Party Benefits

Medical Expense Benefit - Coverage to reimburse you for reasonable and necessary treatment and services incurred.

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

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

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.

Combination Benefits - Single limit for all above coverages, with specific benefit limits as shown under E. below.

Extraordinary Medical Benefit (EMB) - Under this option, first party benefits coverage may be extended to provide an EMB which will pay medical/rehabilitation costs for you and your family members residing in your household. These benefits are more than $100,000 for each person injured as the result of an auto accident, up to a lifetime benefit limit of $1,000,000 for each person. Since you are only required to carry $5,000 medical expense coverage under your first party benefits and EMB coverage only pays expenses that exceed $100,000, you may have a gap in coverage between your selected first party benefits and EMB coverage.

Benefit Options

Indicate your choice below by marking an [X] in one box for each option A through D, **OR** one box for option E:

A. Medical Expense
☐ $5,000 (minimum) ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ $100,000

B. Income Loss
☐ None (minimum) ☐ $1,000/5,000 ☐ $1,000/15,000 ☐ $1,500/25,000 ☐ $2,500/50,000

C. Accidental Death
☐ None (minimum) ☐ $5,000 ☐ $10,000 ☐ $25,000

D. Funeral Expense
☐ None (minimum) ☐ $1,500 ☐ $2,500

OR

E. Combination Benefits
☐ $50,000 ($2,500 Funeral Expenses and $10,000 Accidental Death)
☐ $100,000 ($2,500 Funeral Expenses and $10,000 Accidental Death)
☐ $177,500 ($2,500 Funeral Expenses and $25,000 Accidental Death)
☐ $177,500 ($2,500 Funeral Expenses and $25,000 Accidental Death)

AND

F. Extraordinary Medical Benefit
☐ I do NOT wish to purchase this coverage.
☐ I wish to purchase this coverage at the following limit: ☐ $100,000 ☐ $300,000 ☐ $500,000 ☐ $1,000,000

I have had the first party benefits and options fully explained to me and have indicated my choices above. I understand that these choices will continue in effect unless I notify the Company or my agent in writing.

Signature of First Named Insured _____ Date _____

Stratford Insurance Company

Uninsured Motorist Options - Pennsylvania

OPTION 1 - Uninsured Motorist (UM) Protection

UM insurance provides protection for loss from bodily injury caused by an owner or operator of an uninsured motor vehicle. The law no longer requires you to buy UM protection. This coverage is now optional. Please make your selection below:

☐ I select Uninsured Motorist Coverage at
$_____per person, $_____per accident; OR
$_____single limit per accident.

(Note: Your UM limit may not exceed your policy's Bodily Injury Liability Coverage Limit.)

_____ _____
Signature of First Named Insured Date

OR

☐ **REJECTION OF UNINSURED MOTORIST PROTECTION**

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 or damages. I knowingly and voluntarily reject this coverage.

_____ _____
Signature of First Named Insured Date

OPTION 2 - Rejection of Stacked Limits for Uninsured Motorist Coverage

If you have chosen to purchase UM coverage, your next option is to determine if you wish to stack the limits of this coverage. "Stacking" means the UM limit of your policy can be multiplied by the number of vehicles insured under your policy. If you want to stack this coverage, do not sign the waiver below. If you reject stacked limits, each vehicle will have its own limits of UM coverage. You will save on this part of your premium if you reject stacking.

REJECTION OF STACKED UNINSURED COVERAGE LIMITS

By signing this waiver, I am rejecting stacked limits of uninsured 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 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.

_____ _____
Signature of First Named Insured Date

All choices indicated above will apply to all current and subsequent policies unless written notification is received by the Company or its representative.

Stratford Insurance Company

Underinsured Motorist Options - Pennsylvania

OPTION 1 - Underinsured Motorist (UIM) Protection

UIM insurance provides protection for loss from bodily injury caused by an owner or operator of a vehicle who does not have enough insurance to pay for your damages. The law no longer requires you to buy UIM protection. This coverage is now optional. Please make your selection below:

☐ I select Underinsured Motorist Coverage at
$_____per person, $_____per accident; OR
$_____single limit per accident.

(Note: Your UIM limit may not exceed your policy's Bodily Injury Liability Coverage Limit.)

_____ _____
Signature of First Named Insured Date

OR

☐ **REJECTION OF UNDERINSURED MOTORIST PROTECTION**

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 any insurance to pay for losses or damages. I knowingly and voluntarily reject this coverage.

_____ _____
Signature of First Named Insured Date

OPTION 2 - Rejection of Stacked Limits for Underinsured Motorist (UIM)Coverage

If you have chosen to purchase UIM coverage, your next option is to determine if you wish to stack the limits of this coverage. "Stacking" means the UIM limit of your policy can be multiplied by the number of vehicles insured under your policy. If you want to stack this coverage, do not sign the waiver below. If you reject stacked limits, each vehicle will have its own limits of UIM coverage. You will save on this part of your premium if you reject stacking.

REJECTION OF STACKED UNDERINSURED COVERAGE LIMITS

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 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.

_____ _____
Signature of First Named Insured Date

All choices indicated above will apply to all current and subsequent policies unless written notification is received by the Company or its representative.