

Special Types Application



Policy Term From: _____ To _____

- Name (and "dba") _____
 Individual/Proprietorship Partnership Corporation Other Business Phone Number _____
- Mailing Address _____ City _____ State _____ Zip _____
- Premises Address _____ City _____ State _____ Zip _____
- Person to contact for inspection (name and phone number) _____
- 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

- Describe business _____
 Years experience _____ New Venture? Yes No
- 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
- Have you ever filed for Bankruptcy? Yes No If yes, when _____ Explain _____
- Gross receipts last year _____ Estimate for coming year _____ Business for sale? Yes No
- Do you operate in more than one state? Yes No If yes, list states _____
- What is the largest city entered within your radius of operation? _____

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

Combined Single Limit BI & PD	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.
	Split Limits					
	Bodily Injury		Property Damage			
	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. Does applicant have attendant's E&O coverage? Yes No
13. What is the basis for driver(s) pay? Hourly _____ Trip _____ Mileage _____ Other, explain _____
14. Are drivers covered by Workers Compensation? Yes No Minimum years driving experience required _____
15. Are vehicles owner-driven only? Yes No Do you agree to report all newly hired operators? Yes No
16. Are drivers ever allowed to take vehicles home at night? Yes No If yes, will family members drive? Yes No
17. 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	Emergency Lights & Sirens (Yes or No)	ALS	Advanced Life Support	MTA	Medical Transportation	SP	Snow Plow
1			BLS	Basic Life Support	OR	Off Road Auto	SS	Street Sweeper
2			BV	Box Van	OV	Other Van	ST	Semi-Trailer
3			CP	Cherry Picker	PC	Police Car	T	Truck
4			CV	Cargo Van	PPT	Private Passenger Type	TA	Transfer Ambulance
5			F	Flower Car	PT	Pumper Truck	TR	Trailer
6			H	Hearse	PU	Pick Up	TT	Truck Tractor
7			L	Limo	PV	Passenger Van	UT	Utility Trailer
8			LT	Ladder Truck	RT	Rescue Truck	WT	Water Truck
9							Other, describe _____	
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							

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

19. Is the transportation of people your primary business? Yes No Are vehicles leased to drivers? Yes No
20. Do you transport physically disabled individuals? Yes No If yes, what percentage of the time _____
21. Is our policy to cover all vehicles owned, operated or under lease to applicant? Yes No If no, explain _____
22. Number of vehicles owned by you: Ambulances _____ Wheel Chair Vans _____ Priv. Pass. Types _____ Fire Trucks _____
Rescue Trucks _____ Police Cars _____ Hearses _____ Limos _____ Other _____
23. Number of vehicles leased to you: Ambulances _____ Wheel Chair Vans _____ Priv. Pass. Types _____ Fire Trucks _____
Rescue Trucks _____ Police Cars _____ Hearses _____ Limos _____ Other _____

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
/ /	/ /									
/ /	/ /									
/ /	/ /									

24. 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 _____
25. Have you ever been declined, cancelled or non-renewed for this kind of insurance? Yes No
If yes, explain _____

OPERATION INFORMATION — Complete only those sections relating to your operations.

AMBULANCE AND MEDICAL TRANSPORTATION VEHICLES

26. Do autos without lights and sirens have lifts, ramps or wheelchair tie downs? Yes No
If yes, show auto numbers from schedule _____
27. Do autos without lights and sirens have stretchers or gurneys? Yes No If yes, show auto numbers from schedule _____
28. How is gurney or wheelchair securely clamped for transportation? _____
29. Any autos operated 24 hours per day? Yes No If yes, show auto numbers from schedule _____
30. Is special driver training given? Yes No If yes, explain _____
31. What methods and qualifications are used for driver selection? _____
32. Are you the primary response unit for emergency (911) calls? Yes No
33. What percent of your ambulance dispatches are: Emergency (Code 3 or 4)? _____ % Non-Emergency (Code 1 or 2)? _____ %
34. What procedure is required of drivers as they approach a red light? _____
35. Is your operation privately owned? Yes No
36. If privately owned, are you affiliated with a taxi or other transportation company? Yes No If yes, explain _____

DRIVER TRAINING PROGRAMS

37. Is operation part of a school curriculum? Yes No Is classroom instruction given? Yes No
38. Are all driver training autos equipped with dual brakes? Yes No If no, identify by auto number from schedule any that do not have dual brakes _____
39. Are autos equipped with any other dual controls? Yes No If yes, explain _____
40. Is there any personal use of the automobiles? Yes No

FIRE DEPARTMENTS

41. Is your operation owned by a municipality? Yes No
42. What procedure is required of drivers as they approach a red light? _____
43. Is special driver training given? Yes No What methods are used for driver selection? _____
44. Are volunteers allowed to drive? Yes No If yes, is the same driver selection and special training used? Yes No
45. Do ladder truck drivers have special training? Yes No How many runs/calls are made per year per fire truck? _____
46. Is your operation volunteer? Yes No

FUNERAL DIRECTORS

47. Are hearses also used as ambulances? Yes No If yes, what percent is ambulance _____
48. Are limousines used for other purposes? Yes No If yes, explain and show percentage _____

LAW ENFORCEMENT AGENCIES

- 49. Are officers given training in defensive driving? Yes No Are officers given training in high-speed and pursuit driving? Yes No
- 50. What procedure is required of drivers as they approach a red light? _____

SECURITY PATROLS

- 51. Do vehicles operate 24 hours a day? Yes No Any special training? Yes No Are weapons carried? Yes No
- 52. Percentage of surveillance _____% Patrolling _____%

53. Additional comments: _____

FILING INFORMATION

- 54. Is an FHWA filing required? Yes No If yes, MC number _____
 What authority do you have? Broker Common Contract
- 55. If you hold a Brokers license, identify name filed with FHWA, FHWA docket no. and receipts from brokerage operations _____

- 56. If you are an interstate regulated carrier, identify your registration or base state _____
- 57. Is an intrastate filing needed? Yes No If yes, show state and permit number _____
- 58. Show exact name and address in which permits are issued _____
- 59. Is MCS 90 endorsement needed? Yes No
- 60. Is our policy to cover all vehicles owned, operated or under lease to applicant? Yes No If no, explain _____

- 61. Do you enter Canada? Yes No Do you enter Mexico? Yes No If yes, where _____

- 62. Have you ever changed your operating name? Yes No Do you operate under any other name? Yes No
- 63. Do you operate as a subsidiary of another company? Yes No
- 64. Do you own or manage any other transportation operations that are not covered? Yes No
- 65. Do you lease your authority? Yes No Do you appoint agents or hire independent contractors to operate on your behalf? Yes No
- 66. Have you purchased, sold or applied for authority over the past 3 years? Yes No
- 67. Have you ever lost or had authority withdrawn, or have you been/are under probation by any regulatory authority (FHWA, PUC, etc.)? Yes No
- 68. Is evidence/certificate(s) of coverage required? Yes No
- 69. Please explain any "yes" answer to questions 62 through 68 _____

- 70. 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
- 71. Do you barter, hire or lease any vehicles? Yes No If yes, explain _____
- 72. 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



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