

- ☐ Interstate Fire and Casualty Company
☐ Chicago Insurance Company
☐ Interstate Indemnity Company
☐ Fireman's Fund County Mutual Insurance Company

Passenger Carriers Application

Section I - General Information

- Policy Period Desired _____
1. Your Name _____ Phone _____
 (dba) _____ Fax _____
2. Mailing Address _____ Website _____
3. Insured is: ☐ Individual ☐ Partnership ☐ Corporation ☐ Limited Liability Corp ☐ Other _____
4. Years operating this business _____ If new venture, number of years experience? _____
 Have you ever operated under another name? ☐ Yes ☐ No
 If Yes, what was the name of that operation? _____
 If this is a new venture, where did you get your experience? _____
 How much experience do you have in operating this type of business? _____
5. Has similar insurance ever been cancelled, declined or refused renewal? ☐ Yes ☐ No If Yes, explain: _____

Section II - Description of Operations

6. Please select from the following categories:
☐ School Bus/Head Start Are buses ☐ school owned ☐ independent contractor?
☐ Daycare
☐ Church Bus
☐ Sightseeing Bus
☐ Courtesy Bus (Be specific, i.e. Casino Bus, Outfitters/Guides, Bingo Bus, etc.) _____
 % of airport exposure _____
☐ Social Service Bus (Select one or combination of the following):
☐ Alcohol/Drug Rehabilitation Center
☐ Boy or Girl Scout Centers
☐ Domestic Violence Centers
☐ Homeless Shelters
☐ Psychiatric Counseling
☐ Youth Center
7. (a) Describe fully all operations conducted by you which involves the use of automobiles (passenger carrying or other): _____
 (b) Estimated length of operation per vehicle, per day _____ hours; _____ % is night driving.
8. (a) Do you ever have occasion to transport passengers who are physically or mentally handicapped? ☐ Yes ☐ No
 If Yes, explain fully _____
 (b) Are units equipped with lifts or ramps? ☐ Yes ☐ No
 (c) Explain how wheelchairs are secured _____
 (d) Are units equipped with seat belts? ☐ Yes ☐ No If yes, is usage mandated? _____
 (e) How are drivers trained to handle such equipment? _____

Section III - Area of Operations

9. Define normal areas of operation, i.e., Cities, States _____
10. Do you operate over a regular route? ☐ Yes ☐ No If yes, describe _____
11. List largest cities entered in each state _____
12. Radius of operation ☐ 0-100 ☐ 101-300 ☐ 301-500
13. Do you ever exceed 500 miles? ☐ Yes ☐ No If yes, explain _____

Section IV - Driver Information

14. Do you carry Worker's Compensation? ☐ Yes ☐ No.
15. Do you order motor vehicle reports on all your drivers within 30 days of employment? ☐ Yes ☐ No

16. Schedule all Drivers having access to vehicles (any additional drivers, please attach a list)

How are drivers paid? ☐ Per Hour ☐ Per Mile ☐ Other (describe) _____

Drivers Full Name	Date of Birth	Date Employed	Years Experience Comm'l Driving on like equip.	Drivers License # and State

Section V – Vehicle Information

Unit No.	Model Year	Trade Name	Vehicle Type i.e., Bus, Van	Complete VIN Number	Passenger Seating Capacity
1.					
2.					
3.					
4.					
5.					

Unit No.	Radius of Operation	Garaging Location
1.		
2.		
3.		
4.		
5.		

ATTACH SCHEDULE LISTING ANY ADDITIONAL EQUIPMENT

17. (a) Do others operate under your authority? ☐ Yes ☐ No. If yes, please explain _____

(b) Number of vehicles operating under your authority and types _____

(c) Do you hire any equipment? ☐ Yes ☐ No. If yes, what is estimated annual cost of hire? \$ _____

(d) Do you loan or rent any of your equipment to others? ☐ Yes ☐ No. If Yes, please explain _____

(e) Do you ever lease your authority to others? ☐ Yes ☐ No If yes, explain _____

(f) Is this insurance to cover all owned, leased and operated equipment? ☐ Yes ☐ No If no, please explain _____

18. Is there any personal use of the vehicles? ☐ Yes ☐ No. If Yes, explain fully _____

19. Do your drivers own and operate their own vehicles in your business? ☐ Yes ☐ No If yes, explain _____

Section VI - Safety and Maintenance

20. Is there a formal safety program in effect? ☐ Yes ☐ No. If yes, give details and/or attach a copy of your safety program _____

21. Explain your maintenance program. i.e., How often is maintenance done and by whom? _____

22. What criteria do you have in place for acceptability of drivers? _____

23. Do you have a driver training program? ☐ Yes ☐ No. If Yes, describe and/or attach a copy of the program: _____

24. Do you have a written accident reporting procedure? ☐ Yes ☐ No. If Yes, describe and/or attach a copy _____

25. Are periodic reviews of all drivers conducted? ☐ Yes ☐ No. If Yes, how often? _____

26. Is any action taken against a driver for having a chargeable accident or a poor motor vehicle record? ☐ Yes ☐ No.
If Yes, explain _____
27. Do you have a driver safety incentive program? ☐ Yes ☐ No. If Yes, describe and attach copy of program _____
28. Describe safety equipment attached to insured unit i.e., School buses retrofitted with handrails in compliance with National Highway Traffic Safety Administration? Additional rear view mirrors? Anti theft devices? (be specific) _____

Section VII - Filing Information

For prompt and accurate filing, complete information must be given including Name, Address and Docket No. exactly as authority exists. Use separate sheet if necessary. Failure to provide accurate information may result in delays and suspensions.

29. Do you hold an I.C.C. permit? ☐ Yes ☐ No. If Yes, Docket Number _____ and please attach a copy of your completed RS form.
30. State filings required? ☐ Yes ☐ No. If Yes, show states and permit number _____
31. Is any special filing required such as a city permit? ☐ Yes ☐ No. If Yes, give details _____

Section VIII - Previous Insurance and Loss Experience

THIS SECTION MUST BE COMPLETED IN ITS ENTIRETY.

Policy Year	Insurance Carrier	Policy #	Number of Accidents	Total Amount of Claims Paid		Total Amount Unsettled Claims (reserves)	
				Bodily Injury	Property Damage	Bodily Injury	Property Damage
From _____ To _____				\$ _____	\$ _____	\$ _____	\$ _____
From _____ To _____				\$ _____	\$ _____	\$ _____	\$ _____
From _____ To _____				\$ _____	\$ _____	\$ _____	\$ _____
				Losses by Fire, lightning, explosion	Losses by theft/ vandalism	Losses by Collision	Losses by Windstorm, Hail Earthquake or flood
From _____ To _____				\$ _____	\$ _____	\$ _____	\$ _____
From _____ To _____				\$ _____	\$ _____	\$ _____	\$ _____
From _____ To _____				\$ _____	\$ _____	\$ _____	\$ _____

****FOR FLEETS CONSISTING OF 5 POWER UNITS OR MORE-HARD COPY LOSS RUNS ARE REQUIRED****

Section IX - Coverage and Limits Requested

32. Liability Limits

- A. Combined Single Limit: \$ _____
- B. Split Limits:
- Bodily Injury: \$ _____ each person
\$ _____ each accident
Property Damage \$ _____ each accident

C. Liability Deductibles

- Bodily Injury Only \$ _____
- Property Damage Only \$ _____
- Bodily Injury and Property Damage \$ _____
- Bodily Injury and Property Damage applied separately \$ _____

33. Do you desire Uninsured Motorists/Underinsured Motorist coverage? (for requirements, check state statute) ☐ Yes ☐ No
If Yes, limit desired \$ _____ If required by state, please complete, sign and attach proper form for selection or rejection of this coverage.
34. Do you desire Personal Injury Protection coverage? (for requirements, check state statute) ☐ Yes ☐ No If required by state, please complete, sign and attach proper form for selection or rejection of this coverage.
35. Do you desire Medical Payments coverage? ☐ Yes ☐ No If yes, advise limit \$ _____

36. Do you desire Hired and/or Non Owned coverage? ☐ Yes ☐ No If yes, please complete Supplemental forms AU1129 and AU1130.

37. Physical Damage coverages and deductible selection

Unit Description	Stated Amount	Collision Deductible	Other than Collision Deductible		Single Deductible Per Occurrence
			Specified Causes of Loss	Comprehensive	
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

38. Loss Payable Name and Address (advise which unit(s) this applies to) _____

39. List any Additional Insureds to be named and advise what their interest is in your operation _____

40. List any Person or Organization requesting a Waiver of Subrogation and advise reason for this request _____

Section X – Signatures

I declare to the best of my knowledge that all statements herein are true and no material facts have been suppressed or misstated. I am also aware that the Insurance Company may inspect my operation.

Applicant's Signature / Title

Date

Witness

Date

Agent:

Are you personally familiar with this Applicant's operations? ☐ Yes ☐ No

Did your office control this risk in the past year? ☐ Yes ☐ No

Agent's or Broker's Name
(Please print)

Telephone Number

Agent's Signature

Address

Dated

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be subject to civil or criminal penalties.