

LOUISIANA

Special Types Application

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

Horner Insurance Services, Inc.
 5101 Wheelis Drive
 Suite 214
 Memphis, TN 38117
 (901) 684-4570 FAX: (901) 684-4565

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
- 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.

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	Per Accident				
	Per Person	Per Accident	Per Accident			

UNINSURED MOTORIST COVERAGE				
Single Limit	Split Limits		Uninsured Motorist Economic Loss Only	Uninsured Motorist Property Damage
	Bodily Injury	Per Accident		
	Per Person	Per Accident	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

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.

11. Does applicant have attendant's E&O coverage? Yes No
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 MVRs 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	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 _____

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

23. 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 _____

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

AMBULANCE AND MEDICAL TRANSPORTATION VEHICLES

24. Do autos without lights and sirens have lifts, ramps or wheelchair tie downs? Yes No
 If yes, show auto numbers from schedule _____

25. Do autos without lights and sirens have stretchers or gurneys? Yes No If yes, show auto numbers from schedule _____

26. How is gurney or wheelchair securely clamped for transportation? _____

27. Any autos operated 24 hours per day? Yes No If yes, show auto numbers from schedule _____

28. Is special driver training given? Yes No If yes, explain _____

29. What methods and qualifications are used for driver selection? _____

30. Are you the primary response unit for emergency (911) calls? Yes No

31. What percent of your ambulance dispatches are: Emergency (Code 3 or 4)? _____% Non-Emergency (Code 1 or 2)? _____%

32. What procedure is required of drivers as they approach a red light? _____

33. Is your operation privately owned? Yes No

34. If privately owned, are you affiliated with a taxi or other transportation company? Yes No If yes, explain _____

DRIVER TRAINING PROGRAMS

35. Is operation part of a school curriculum? Yes No Is classroom instruction given? Yes No

36. 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: _____

37. Are autos equipped with any other dual controls? Yes No If yes, explain _____

38. Is there any personal use of the automobiles? Yes No

FIRE DEPARTMENTS

39. Is your operation owned by a municipality? Yes No

40. What procedure is required of drivers as they approach a red light? _____

41. Is special driver training given? Yes No What methods are used for driver selection? _____

42. Are volunteers allowed to drive? Yes No If yes, is the same driver selection and special training used? Yes No

43. Do ladder truck drivers have special training? Yes No How many runs/calls are made per year per fire truck? _____

44. Is your operation volunteer? Yes No

FUNERAL DIRECTORS

45. Are hearses also used as ambulances? Yes No If yes, what percent is ambulance _____%

46. Are limousines used for other purposes? Yes No If yes, explain and show percentage _____

LAW ENFORCEMENT AGENCIES

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

SECURITY PATROLS

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

51. Additional comments _____

FILING INFORMATION

52. Is an FHWA filing required? Yes No If yes, MC number _____
 What authority do you have? Broker Common Contract
53. If you hold a broker's license, identify name filed with FHWA, FHWA docket no. and receipts from brokerage operations _____
54. If you are an interstate regulated carrier, identify your registration or base state _____
55. Is an intrastate filing needed? Yes No If yes, show state and permit number _____
56. Show exact name and address in which permits are issued _____
57. Is MCS 90 endorsement needed? Yes No
58. Is our policy to cover all vehicles owned, operated or under lease to applicant? Yes No If no, explain _____
59. Do you enter Canada? Yes No Do you enter Mexico? Yes No If yes, where _____

60. Have you ever changed your operating name? Yes No Do you operate under any other name? Yes No
61. Do you operate as a subsidiary of another company? Yes No
62. Do you own or manage any other transportation operations that are not covered? Yes No
63. Do you lease your authority? Yes No Do you appoint agents or hire independent contractors to operate on your behalf? Yes No
64. Have you purchased, sold or applied for authority over the past 3 years? Yes No
65. Have you ever lost or had authority withdrawn, or have you been/are under probation by any regulatory authority (FHWA, PUC, etc.)? Yes No
66. Is evidence/certificate(s) of coverage required? Yes No
67. Please explain any "yes" answer to Questions 60 through 66 _____

68. 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
69. Do you barter, hire or lease any vehicles? Yes No If yes, explain _____
70. Additional comments _____

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 Federal Highway Administration 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 _____

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

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. _____

STATE OF LOUISIANA

This form may not be altered or modified.

UNINSURED/UNDERINSURED MOTORIST BODILY INJURY COVERAGE FORM

Uninsured/Underinsured Motorists Bodily Injury Coverage, referred to as "UMBI" in this form, is insurance that pays persons insured by your policy who are injured in an accident caused by an owner or operator of an uninsured or underinsured motor vehicle. Depending on the coverage purchased, UMBI Coverage can provide compensation for both economic and non-economic losses.

Economic losses are those that can be measured in specific monetary terms including but not limited to medical costs, funeral expenses, lost wages, and out of pocket expenses.

Non-economic losses are losses other than economic losses and include but are not limited to pain, suffering, inconvenience, mental anguish and other non-economic damages otherwise recoverable under the laws of this state.

By law, your policy will include UMBI Coverage at the same limits as your Bodily Injury Liability Coverage unless you request otherwise. If you wish to reject UMBI Coverage, select lower limits of UMBI Coverage, or select Economic-Only UMBI Coverage, you must complete this form and return it to your insurance agent or insurance company. (Economic-Only UMBI Coverage may not be available from your insurance company. In this case, your company will have marked options 2 and 3 below as "Not Available" or "NA".)

UNINSURED/UNDERINSURED MOTORIST BODILY INJURY COVERAGE

You may select one of the following UMBI Coverage options (initial only one option):

1. _____ I select **UMBI Coverage** which provides compensation for economic and non-economic losses with limits
Initials **lower** than the Bodily Injury Liability Coverage limits indicated on the policy:

\$ _____ each person	OR	\$ _____ each accident/occurrence
\$ _____ each accident/occurrence		

2. _____ I select **Economic-Only UMBI Coverage**, which provides compensation for economic losses with the
Initials **same limits** as the Bodily Injury Liability Coverage indicated on the policy.

3. _____ I select **Economic-Only UMBI Coverage**, which provides compensation for economic losses with limits
Initials **lower** than the Bodily Injury Liability Coverage limits indicated on the policy:

\$ _____ each person	OR	\$ _____ each accident/occurrence
\$ _____ each accident/occurrence		


4. _____ I do not want **UMBI Coverage**. I understand that I will not be compensated through UMBI coverage
Initials for losses arising from an accident caused by an uninsured/underinsured motorist.

SIGNATURE

The choice indicated and initialed on this form will apply to all persons and/or entities insured under this policy. This choice shall apply to the motor vehicles described in this policy and to any replacement vehicles, to all renewals of this policy, and to all reinstatement, substitute or amended policies until a written request is made for a change to the Bodily Injury Liability Limits, the UMBI limits or UMBI Coverage.

 _____
 Signature of Named Insured or Legal Representative

 _____
 Print Name

 _____
 Date

**THE NATIONAL INDEMNITY GROUP OF
INSURANCE COMPANIES**