

STRATFORD INSURANCE COMPANY

WESTERN WORLD INSURANCE COMPANY

PUBLIC AUTO INSURANCE APPLICATION

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: _____

E. PRIOR INSURANCE CARRIERS AND LOSS EXPERIENCE (Add additional sheet(s) if necessary.)

| Policy Dates | Insurance Carrier | Policy # | Premium | Average 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) | Deductible | *Loss Payee (Y/N) |
|-----|-----------------|----------------------------------|----------------|------------------|------------------------|------------------|--|------------|-------------------|
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| 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? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes, please describe: _____ | | |
| Do you own any vehicles which will not be covered under this policy? | <input type="checkbox"/> Yes | <input type="checkbox"/> 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 INJURE, DEFRAUD OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A CRIME.

| | |
|-----------------------------|----------------------------|
| Applicant's Signature _____ | Producer's Signature _____ |
| Date _____ | Date _____ |