Public Application

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

New England Excess Exchange, Ltd.
P O Box 650 ~ Barre, VT 05641
800-548-4301 or Fax 800-347-4935
info@neee.com ~ www.neee.com

Policy Term From:__________________ To __________________

1. Name (and "dba") ____
   ☐ Individual/Proprietorship ☐ Partnership ☐ Corporation ☐ Other Business Phone Number ______________
2. Mailing Address ______________________ City ______________ State ________ Zip ______
3. Premises Address ______________________ City ______________ State ________ Zip ______
4. Person to contact for inspection (name and phone number) ______________________
5. 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

6. Describe business ____
   Years experience __________ New Venture? ☐ Yes ☐ No
7. 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
8. Have you ever filed for Bankruptcy? ☐ Yes ☐ No If yes, when ______________ Explain ______________
9. Gross receipts last year ______________ Estimate for coming year ______________ Business for sale? ☐ Yes ☐ No
10. Do you operate in more than one state? ☐ Yes ☐ No If yes, list states ______________________
11. 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					
	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. 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 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 Opera-tion	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	Length of Limo Stretch
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

- AB Airport Bus or Van
- APS Airport Parking/Rental Car Shuttle
- AT Athlete Bus (a) Professional Athlete (b) Non-Professional Athlete
- BB Bingo/Casino Bus
- SBG Boy/Girl Scout Bus
- CB Charter Bus (a) Interstate (b) Intrastate
- CHB Church Bus
- CTB City Transit Bus (Urban Bus)
- CRB Courtesy Bus (a) Hotel (b) Medical (c) Other
- DC Day Care/Day Nursery
- ET Employee Transportation
  - Railroad Employees (a) For Profit (b) Not For Profit
  - Farm Labor Bus (c) For Profit (d) Not For Profit
  - Other (e) For Profit (f) Not For Profit
- ICB Inter-City Bus (attach route scheduled)
- L Limousine (a) Transportation to Airport $\geq$ 50% (b) Super-Stretch (> 120") (c) Regular
- ME Musician & Entertainer Bus (a) Professional Entertainer (b) Non-Professional Entertainer
- MV Medivan/Medical Transport/Non-Emergency Ambulance (a) For Profit (b) Not For Profit
- PT Prisoner Transfer
- SB School Bus (a) Public Owned (b) Other (c) Private or Parochial Owned
- SC Senior Citizens Center Auto
- SH Shuttle (a) Tourist (b) Wilderness (c) All Other
- SSB Sightseeing Bus
- SKB Ski Bus
- SSA Social Service Agency (a) Group Home (b) Other
- TX Taxicab
- TM Tram
- T Trolley

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	
						☐ Comprehensive ☐ Spec. C of Loss	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 ____________________

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

18. 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 ______
19. Have you ever been declined, cancelled or non-renewed for this kind of insurance? ☐ Yes ☐ No
If yes, explain ______
20. Is the transportation of people your primary business? ☐ Yes ☐ No Are vehicles leased to drivers? ☐ Yes ☐ No
21. Do you transport physically disabled individuals? ☐ Yes ☐ No If yes, what percentage of the time? ______
22. Are vehicles equipped with fare box or meter? ☐ Yes ☐ No Do you have a scheduled route? ☐ Yes ☐ No
23. Do you ever transport unscheduled passengers? ☐ Yes ☐ No Minimum number of hours rented ______ Minimum charge ______
24. Number of vehicles owned Limos ______ Vans ______ Buses ______ Other ______
25. Number of vehicles leased Limos ______ Vans ______ Buses ______ Other ______

FILING INFORMATION

26. Is an FHWA filing required? ☐ Yes ☐ No If yes, MC number ______
What authority do you have? ☐ Broker ☐ Common ☐ Contract
27. If you hold a Brokers license, identify name filed with FHWA, FHWA docket no. and receipts from brokerage operations ______
28. If you are an interstate regulated carrier, identify your registration or base state ______
29. Is an intrastate filing needed? ☐ Yes ☐ No If yes, show state and permit number ______
30. Show exact name and address in which permits are issued ______
31. Is MCS 90 endorsement needed? ☐ Yes ☐ No
32. Is our policy to cover all vehicles owned, operated or under lease to applicant? ☐ Yes ☐ No If no, explain ______
33. Do you enter Canada? ☐ Yes ☐ No Do you enter Mexico? ☐ Yes ☐ No If yes, where ______

34. Have you ever changed your operating name? ☐ Yes ☐ No Do you operate under any other name? ☐ Yes ☐ No
35. Do you operate as a subsidiary of another company? ☐ Yes ☐ No
36. Do you own or manage any other transportation operations that are not covered? ☐ Yes ☐ No
37. Do you lease your authority? ☐ Yes ☐ No Do you appoint agents or hire independent contractors to operate on your behalf? ☐ Yes ☐ No
38. Have you purchased, sold or applied for authority over the past 3 years? ☐ Yes ☐ No
39 Have you ever lost or had authority withdrawn, or have you been/are under probation by any regulatory authority (FHWA, PUC, etc.)? ☐ Yes ☐ No
40. Is evidence/certificate(s) of coverage required? ☐ Yes ☐ No
41. Please explain any "yes" answer to questions 34 through 40 ______

42. 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
43. Do you barter, hire or lease any vehicles? ☐ Yes ☐ No If yes, explain ______
44. Additional comments: ______

CONNECTICUT
INFORMED CONSENT FORM

NOTICE TO INSUREDS

The Automobile Insurance Reform Act, Public Law 93-297 is effective January 1, 1994. It affects your coverage in several ways. You should read this notice carefully, make your selections and return to your agent.

REPEAL OF NO FAULT

Beginning January 1, 1994, new or renewed policies are not required to include Basic Reparations Benefits (BRB). BRB provided up to $5,000 for medical expenses and lost wages caused by auto accidents.

You may have other coverage provided by your employer, or by health or disability insurance. If you don't, you should consider optional Medical Payments. Otherwise, you may bear the cost yourself.

Of course, if someone else is responsible for your losses you may seek recovery from that person.

OPTIONAL MEDICAL PAYMENTS (MED PAY) COVERAGE

You may choose to buy Medical Payments coverage to help cover your medical bills from auto accidents.

We will pay reasonable expenses incurred for necessary medical and funeral services to or for an "insured" who sustains "bodily injury" caused by "accident". We will pay only those expenses incurred, for services rendered within three years from the date of the "accident".

UNINSURED MOTORIST COVERAGE

Our law requires you to buy uninsured motorist (UM/UIM) coverage. Generally, this coverage only applies where the person who causes an accident is not an insured under your policy.

Anyone injured in an accident may seek to recover damages from the person causing the loss. These losses include your medical bills, lost wages (past and future), as well as payment for disabilities, pain and suffering and loss of enjoyment of life's activities.

Normally, these damages would be paid by the other person's insurance company. UM/UIM coverage protects you, your family and others in your car for injuries caused by someone who did not buy insurance.

You have the right to choose the amount of coverage. It can be as low as $20,000 per person and $40,000 per accident, or as high as twice your policy's bodily injury liability coverage. The amount of liability coverage you buy will govern the maximum amount of UM/UIM coverage you can buy.

This coverage also includes standard Underinsured Motorist (UIM) coverage. It protects you where injuries are caused by someone whose insurance is not enough to pay your damages and is less than your UM/UIM limits. UM coverage will pay your damages to fill in the difference between those limits. However, the protection available under standard UM coverage is usually reduced by amounts paid by worker's compensation, or by or on behalf of the person at fault.

Under our new law, you can convert standard UIM coverage to UNDERINSURED MOTORIST CONVERSION (UIMC) coverage. This coverage is not reduced by payments from any source. If your damages exceed the amount of the at fault person's insurance, or other payments, your UIMC coverage will be available for damages not paid.

Both standard (UIM) and conversion (UIMC) coverages only become available after the liability insurance of the at fault person has been fully paid.

Stacking

To make a wise decision as to the amount of UM/UIM coverage to buy, you need to understand "stacking". Stacking allows insureds to add together UM/UIM coverage under separate policies or, in multi-car policies, the insurance applicable to each car.

Unless you agreed to non-stacked coverage, all policies in effect before January 1, 1994 provide for stacking. Policies issued or renewed beginning in 1994 will no longer provide for stacking.

With stacking, if you had two insured cars and you purchased $100,000 of UM/UIM coverage you received (and you paid for) $200,000 of protection. Under the new law the purchased amount ($100,000) would not be multiplied by the number of cars insured.

Also, your UM/UIM coverage will be limited to the highest available limit under any of the policies that apply to the accident. If you are injured in a car you own you are limited to the amount of coverage for that car.

ELECTION OF COVERAGE

POLICY NUMBER ____________________________ BODILY INJURY LIABILITY LIMIT ______________________

A. OPTIONAL MED PAY COVERAGE
If you do not check a box in this section and sign below your policy will be issued/renewed without Medical Payments.

MED PAY Coverage (limit) MED PAY Premium

$ _________________ _________________

SELECT ONE

☐ I WISH TO BUY OPTIONAL MED PAY COVERAGE AT THE PREMIUM SHOWN ABOVE.

☐ I DO NOT WISH TO BUY MED PAY COVERAGE.

B. UNINSURED MOTORIST (UM/UIM) COVERAGE
If you do not check a box below your policy will be issued/renewed with standard UIM coverage (not Conversion UIMC coverage) with limits equal to your Bodily Injury Liability (BI) coverage.

If you check more than one box your policy will be issued/renewed with the highest level of coverage selected.

SELECT ONE OPTION UNDER EITHER STANDARD UIM COVERAGE OR CONVERSION UIMC COVERAGE.
DO NOT CHECK MORE THAN ONE BOX BELOW.

UM WITH STANDARD UIM COVERAGE

Total Coverage Premium

☐ Double BI Limit
$ ____________________ $ ____________________
(Indicate Double BI Limit)

NOTE: An asterisk (*) preceding a box indicates a reduction in coverage below your Bodily Injury Liability limit.

☐ BI Limit
$ ____________________ $ ____________________
(Indicate equal to BI Limit)

* ☐ Statutory Minimum
$ ____________________ $ ____________________
(Indicate statutory minimum)

* ☐ Option (based upon your selection of a limit other than stated above)
$ ____________________ $ ____________________

UM CONVERSION UIMC COVERAGE
Do not check a box below if you have checked a box for one of the standard UIM coverages above.

Total Coverage Premium

☐ Double BI Limit
$ ____________________ $ ____________________
(Indicate Double BI Limit)

NOTE: An asterisk (*) preceding a box indicates a reduction in coverage below your Bodily Injury Liability limit.

☐ BI Limit
$ ____________________ $ ____________________
(Indicate equal to BI Limit)

* ☐ Statutory Minimum
$ ____________________ $ ____________________
(Indicate statutory minimum)

* ☐ Option (based upon your selection of a limit other than stated above)
$ ____________________ $ ____________________

IF YOU HAVE CHECKED ONE OF THE BOXES PRECEDED BY AN ASTERISK (*), WHEN YOU SIGN THIS FORM, YOU ARE CHOOSING A REDUCED PREMIUM, BUT YOU ARE ALSO CHOOSING NOT TO PURCHASE CERTAIN VALUABLE COVERAGE WHICH PROTECTS YOU AND YOUR FAMILY. IF YOU ARE UNCERTAIN ABOUT HOW THIS DECISION WILL AFFECT YOU, YOU SHOULD GET ADVICE FROM YOUR INSURANCE AGENT OR ANOTHER QUALIFIED ADVISOR.

____ ________________________
(Signature of Any Named Insured) (Date)

SIGNATURE IS ALSO REQUIRED ON LAST PAGE OF APPLICATION

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 Interstate Commerce Commission 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 ______________________________

______________________ 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 ______________________ (Time and Date Bound by General Agent) Coverage was bound by ______________________ (Name of Person in Company General Agency's Office Binding Coverage)

______________________________ Applicant's Representative's Name and Address ______________ Phone No.