Special Types Application

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

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

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. 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)
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

ALS	Advanced Life Support	MTA	Medical Transportation	SP	Snow Plow
BLS	Basic Life Support	OR	Off Road Auto	SS	Street Sweeper
BV	Box Van	OV	Other Van	ST	Semi-Trailer
CP	Cherry Picker	PC	Police Car	T	Truck
CV	Cargo Van	PPT	Private Passenger Type	TA	Transfer Ambulance
F	Flower Car	PT	Pumper Truck	TR	Trailer
H	Hearse	PU	Pick Up	TT	Truck Tractor
L	Limo	PV	Passenger Van	UT	Utility Trailer
LT	Ladder Truck	RT	Rescue Truck	WT	Water Truck

Other, describe _____

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							

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: _____

EXPLANATION AND OFFER OF ADDITIONAL COVERAGES:
SUPPLEMENTARY UNINSURED/UNDERINSURED
MOTORISTS (SUM) INSURANCE

NEW YORK

I. EXPLANATION OF THE DIFFERENCE BETWEEN STATUTORY UNINSURED MOTORISTS COVERAGE AND SUPPLEMENTARY UNINSURED/UNDERINSURED MOTORISTS (SUM) COVERAGES

Under New York law you must buy **either** Statutory Uninsured Motorists Coverage or Supplementary Uninsured/Underinsured Motorists (SUM) Coverage, which includes the Statutory Uninsured Motorists Coverage. This section is an advisory explanation of the primary differences between these two types of coverages, but is not intended to be a substitute for a complete review of both coverages. If there is any conflict between the policy and this explanation, the provisions of **your** policy apply. If you have any questions regarding this information, please contact your agent, insurance company, or the New York Insurance Department for further explanation.

TYPE 1: STATUTORY UNINSURED MOTORISTS COVERAGE

Statutory Uninsured Motorists Coverage compensates you, or other persons insured under your motor vehicle insurance policy, for amounts that you, or your passengers, may be legally entitled to collect as damages for bodily injury or death from an accident caused by an owner or operator of an **uninsured motor vehicle**. An uninsured motor vehicle is a motor vehicle that either has no liability insurance coverage or is operated by a hit-and-run driver. In order to drive your automobile upon the roads of this State, you **must** obtain this coverage as your **minimum limits**.

If someone is injured as a result of an accident with an uninsured motor vehicle, your Statutory Uninsured Motorists coverage can pay up to $25,000 for each person injured, with a $50,000 maximum for each accident. If someone is killed as a result of such an accident, your Statutory Uninsured Motorists Coverage can pay up to $50,000 for each person killed, with a $100,000 maximum for each accident resulting in death to two or more people. These limits are the **only** limits you can obtain under Statutory Uninsured Motorists Coverage.

Statutory Uninsured Motorists Coverage will pay for bodily injury or death only if the car accident happens **in-state**, that is, in the State of New York.

TYPE 2: SUPPLEMENTARY UNINSURED/UNDERINSURED MOTORISTS (SUM) INSURANCE COVERAGE

You have the right to purchase additional limits of insurance coverage, called Supplementary Uninsured/Underinsured Motorists (SUM) Insurance Coverage. This coverage provides you, or other persons insured under your motor vehicle insurance policy, with the Statutory Uninsured Motorists Coverage (described above) plus additional coverages, which may provide you with a greater degree of protection.

SUM Coverage, similar to Statutory Uninsured Motorists Coverage, provides you, or other persons insured under your motor vehicle insurance policy, for amounts that you, or your passengers, may be legally entitled to collect as damage for bodily injury if there is an accident. Here, in contrast however, you have the opportunity to choose the amount of **uninsured motorists** coverage desired (from an offering from the insurance company which is provided below). Additionally, since there is a possibility of an accident occurring between you and an **underinsured motorist**, SUM insurance can provide you with “underinsured” coverage, which is coverage for an accident between you and a car that has bodily injury liability insurance that is less than your own bodily injury liability limits that you have on your own car. However, please note that the SUM coverage cannot exceed the limits of the third-party liability coverage that you have on your own car.

Also, SUM Coverage provides coverage for bodily injury or death for not only in-state accidents, but also **out-of-state accidents**.

IMPORTANT SUM NOTICE:

For purposes of further clarification, New York law requires that the following explanation, as provided in 11 NYCRR 60-2.1, be provided to you in this notice:

- **A policyholder should consider purchasing SUM coverage in order to protect against the possibility of an accident involving another motor vehicle whose owner or operator was negligent and who:**

  (1) may have no insurance whatsoever; or

  (2) even if insured, is only insured for third-party bodily injury at relatively low liability limits, in comparison to the policyholder's own liability limits for bodily injury sustained by third-parties.

- **By purchasing SUM coverage, which cannot be purchased in an amount exceeding the amount of third party liability coverage purchased, the policyholder and any insured under the policy can:**

  (1) be protected for bodily injury to themselves, up to the limit of the SUM coverage purchased; and

  (2) receive from the policyholder's own insurer payment for bodily injury sustained due to the negligence of the other motor vehicle's owner or operator.

- **The maximum amount payable under the SUM coverage shall be the policy's SUM limit reduced and thus offset by motor vehicle bodily injury liability insurance policy or bond payments received from, or on behalf of, any negligent party involved in the accident.**

EXAMPLES:

As provided in 11 NYCRR 60-2.2, the following examples (using the per person limits) illustrate the proper application of SUM coverage:

(1) Example One:

Insured's Bodily Injury Damage	$300,000
Insured's Liability Limit	$500,000
Insured's SUM Limit	$250,000
Other Motor Vehicle Liability Limit	$25,000

Note: In this example, the insured has purchased the maximum amount of SUM coverage that must be offered by the insurer, provided that the insured has purchased bodily injury liability limits of at least $250,000. Insured recovers $25,000 from the negligent owner or operator of the other motor vehicle, and $225,000 ($250,000 minus $25,000) under the SUM coverage for a total recovery of $250,000.

However, in the event that the negligent owner or operator of the other motor vehicle had no liability insurance at all, the insured would collect $250,000 in SUM coverage from the insured's own insurer.

But, if the owner or operator of the other motor vehicle was not negligent, the insured would receive no SUM payments.

(2) Example Two:

Insured's Bodily Injury Damages	$100,000
Insured's Liability Limit	$25,000
Insured's SUM Limit	$25,000
Other Motor Vehicle Liability Limit	$25,000

Result: Insured recovers $25,000 from the negligent other motor vehicle owner or operator. But the insured receives nothing under the SUM coverage, which equals the mandatory uninsured motorists coverage, since the other owner or operator's vehicle did not have less liability insurance than the insured's vehicle. If the insured's liability and SUM limits were both $50,000, the insured would collect another $25,000 in SUM coverage from the insured's own insurer.

(3) Example Three:

Insured's Bodily Injury Damages	$60,000
Insured's Liability Limit	$100,000
Insured's SUM Limit	$100,000
Other Motor Vehicle Liability Limit	$50,000

Result: Insured recovers $50,000 from the other negligent motor vehicle owner or operator and $10,000 under the SUM coverage, which is the difference between the amount of the insured's SUM coverage and the liability coverage available from the other motor vehicle owner or operator, limited by the amount of the insured's bodily injury damages.

(4) Example Four:

Insured's Bodily Injury Damages	$150,000
Insured's Liability Limit	$100,000
Insured's SUM Limit	$100,000
Other Motor Vehicle Liability Limit	$25,000

Result: Suppose the insured and the other motor vehicle owner or operator were each 50 percent at fault for the accident, then the insured's total recovery would be $75,000 in light of comparative negligence of the parties involved in the accident. The insured would recover $25,000 from the other negligent motor vehicle owner or operator and $50,000 under the SUM coverage.

On the other hand, if the other motor vehicle owner or operator was totally at fault for the accident, the insured would recover $25,000 from the negligent motor vehicle owner or operator and would then receive $75,000 in SUM coverage from the insured's own insurer. Had the insured purchased liability and SUM limits of $150,000 or more, the SUM recovery would then be $125,000.

PLEASE TURN PAGE TO SELECT COVERAGE AND SIGN ACKNOWLEDGEMENT.

II. OFFERINGS

A. OFFER OF STATUTORY UNINSURED MOTORISTS (UM) COVERAGE (SPLIT LIMITS)

☐ This box is marked if this section is applicable to you.

Offer of UM Coverage	**Amount of Premium (if any)**
$25,000 / $50,000	_____

PLEASE RESPOND HERE:

Do you wish to purchase UM coverage with $25,000/$50,000 split limits? Yes: ____ No: ____

B. OFFER OF SUM COVERAGE (SPLIT LIMITS)

☐ This box is marked if this section is applicable to you.

Offer of SUM Coverage	**Amount of Increased Premium (if any)**
_____ / _____	_____
_____ / _____	_____
_____ / _____	_____
_____ / _____	_____
_____ / _____	_____

PLEASE RESPOND HERE:

Do you wish to purchase SUM coverage with split limits? Yes: ____ No: ____

If your answer is yes, then specify the limits which you desire:

I select _____ / _____

C. OFFER OF SUM COVERAGE (COMBINED SINGLE LIMIT)

☐ This box is marked if this section is applicable to you.

Offer of SUM Coverage	**Amount of Increased Premium (if any)**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PLEASE RESPOND HERE:

Do you wish to purchase SUM coverage with a combined limit? Yes: ____ No: ____

If your answer is yes, then specify the limit which you desire:

I select _____ .

III. ACKNOWLEDGEMENT OF APPLICANT(S)

I/We hereby acknowledge that I/we have read, or have had read to me, the above explanations and offers of SUM coverage. I/We have indicated whether or not I/we wish to purchase each coverage in the spaces provided. I/We further understand that the above explanations of these coverages are intended only to be brief descriptions of SUM coverage.

_____

SIGNATURE

_____

SIGNATURE

_____

PRINT OR TYPE NAME

_____

PRINT OR TYPE NAME

_____

DATE

_____

DATE

NEW YORK PERSONAL INJURY PROTECTION (PIP) SELECTION FORM

DEDUCTIBLE

If you are an individual, you have the option of purchasing a family deductible that applies to the named insured and any relative who resides in the household on a per accident basis.

Please indicate your choice below (☒ indicates your choice).

☐ I want to purchase PIP coverage with a $100 per accident family deductible

☐ I want to purchase PIP coverage with a $200 per accident family deductible

☐ I want to purchase PIP coverage without a family deductible

MEDICAL EXPENSES

In New York, the law provides you with the option of purchasing Personal Injury Protection (PIP) coverage without the Medical Expense element of Basic Economic Loss. You may decide not to purchase the Medical Expense element of Basic Economic Loss **only if** your Accident and Health insurer is approved by the New York Department of Insurance to provide the Medical Expense element of Basic Economic Loss. If your Accident and Health insurer is not eligible, the Medical Expense benefit will be included. Please contact the Department of Insurance for more information.

Please indicate your choice below (☒ indicates your choice).

☐ I want to purchase PIP coverage with the Medical Expense element of Basic Economic Loss

☐ I want to purchase PIP coverage without the Medical Expense element of Basic Economic Loss

Please list your Accident and Health insurer _____

WORK LOSS

In New York, the law provides that if an employee is eligible for payment of work loss through an eligible contract or voluntary plan with the employer because of injury arising out of an auto, the employee shall not be entitled to receive first-party benefits for loss of earnings from work.

An eligible plan is one in which benefits under the plan are not diminished or exhausted as payments are made or accumulated sick leave time is used, and future benefits under the plan are not reduced.

Please indicate your eligibility below (☒ indicates your choice).

☐ I am eligible for payment of work loss through an eligible plan with my employer

☐ I am not eligible for payment of work loss through an eligible plan with my employer

I have had the coverage and options as set out above, fully explained to me and have indicated my choice as shown. I understand that this is simply a summary of the coverages and benefits, and that the forms and endorsements attached to my policy actually make up my coverage.

_____ Applicant's Initials

_____ Applicant's Initials

THE CHOICES AND OPTIONS AS INDICATED ABOVE WILL CONTINUE IN FORCE AND EFFECT UNTIL WRITTEN REPLACEMENT NOTICE IS RECEIVED BY THE COMPANY OR ITS REPRESENTATIVE.

NEW YORK OPTIONAL BASIC ECONOMIC LOSS (OBEL) SELECTION FORM

Dear Applicant:

Optional Basic Economic Loss (OBEL) coverage is being offered to you as an enhancement of the Basic No-Fault coverage you are presently required to purchase. But before we describe this coverage, we would like to advise you what benefits Basic No-Fault coverage does and does not provide.

No-Fault coverage, otherwise known as Personal Injury Protection or "PIP" coverage, pays for expenses incurred by persons injured in a motor vehicle accident. This coverage does not pay to repair damage to your automobile.

Basic No-Fault, which you are required by law to purchase, provides coverage of up to $50,000 per person in benefits for:

1. all necessary doctor and hospital bills and other health service expenses, payable in accordance with fee schedules established or adopted by the New York State Insurance Department; and

2. 80% of lost earnings up to a maximum monthly payment of $2,000 for up to three years following the date of accident; and

3. up to $25 per day for a period of one year from the date of the accident for other reasonable and necessary expenses the injured person may have incurred because of an injury resulting from the accident, such as the cost of hiring a housekeeper or necessary transportation expenses to and from a health service provider; and

4. a $2,000 death benefit, payable to the estate of a covered person, in addition to the $50,000 coverage for economic loss described above.

No-Fault benefits will be reduced by other benefits that are payable under Workers' Compensation, Social Security Disability, New York State Disability, and certain employer "wage continuation" plans where an employee does not lose any future sick leave benefits.

OPTIONAL COVERAGE AVAILABLE

In addition to Basic No-Fault Coverage, you may also purchase OBEL coverage that will pay certain expenses, up to $25,000, above the Basic No-Fault limit of $50,000. OBEL coverage is different from other coverages in that a claimant can select the kinds of benefits to be paid under OBEL.

If you purchase OBEL coverage and if it appears likely that a claimant will use up the Basic No-Fault coverage, your insurer will send the claimant a form for the claimant to choose what expenses the $25,000 in OBEL coverage will be used to pay. Under No-Fault, a claimant could include you, family members, passengers in your car, or pedestrians, if injured in an auto accident.

The claimant will be able to choose one of the following four OBEL options and thereby direct the insurer to pay expenses for:

1. basic economic loss, whether health care expenses, loss of earnings from work, or other reasonable and necessary expenses;

2. loss of earnings from work;

3. psychiatric, physical or occupational therapy and rehabilitation; or

4. a combination of options 2 and 3.

The additional $25,000 of OBEL coverage will be used only for costs incurred under the chosen option, which, once selected, the claimant cannot change.

If you have any questions, please contact your company or agent.

Please indicate your choice below:

☐ I want to purchase $25,000 in Optional Basic Economic Loss coverage (OBEL)

☐ I do not want to purchase Optional Basic Economic Loss coverage (OBEL)

I have had the coverage and options as set out above, fully explained to me and have indicated my choice as shown. I understand that this is simply a summary of the coverages and benefits, and that the forms and endorsements attached to my policy actually make up my coverage.

 _____  _____

Signature of Named Insured Date

_____

Named Insured typed or printed name

THE CHOICES AND OPTIONS AS INDICATED ABOVE WILL CONTINUE IN FORCE AND EFFECT UNTIL WRITTEN REPLACEMENT NOTICE IS RECEIVED BY THE COMPANY OR ITS REPRESENTATIVE.

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 _____ 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.