

Public Auto Application (Physical Damage Only)



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

P.O. Box 650 • 57 Parker Rd. • Barre, VT 05641
 800-548-4301 • www.nееее.com

Policy Term From: _____ To: _____

1. Name of Applicant _____
2. Address of Applicant _____
 (Number) (Street) (City) (State) (Zip Code)
3. Applicant is: Individual Partnership Corporation Is this a new business venture? _____
4. Person to contact for inspection (name and phone number) _____
5. a. Applicant's business to be covered? _____ Years experience in this business? _____
 b. Is this your primary business? Yes No If no, explain: _____
6. Is your operation: Government funded Yes No Seasonal in nature Yes No
 Currently for sale Yes No Non-Profit Yes No
 If yes, explain _____
7. Coverage to be effective from: _____ to: _____
8. Have you filed for Bankruptcy within the last 5 years or do you contemplate doing so? Yes No If yes, provide details: _____
9. Gross receipts last year? _____ Estimate for coming year? _____

DESCRIPTION AND AREA OF OPERATIONS

10. Number of vehicles owned and/or leased: Limos _____ Vans _____ Buses _____ Other _____
11. Provide brief detail description of operations (including use of vehicles) _____

PREVIOUS INSURANCE CARRIER AND LOSS EXPERIENCE

12. Provide prior insurance carriers information for past full three years. List in order with most recent carrier first.

Policy Term		Insurance Company Name	Policy Number	Number of Motor Powered Vehicles	Number of Accidents	Premium Physical Damage	Total Amount Claims Paid & Reserve	
From	To						Collision	Specified Causes of Loss
/ /	/ /							
/ /	/ /							
/ /	/ /							

13. Have you ever been declined, cancelled or nonrenewed for this kind of insurance? Yes No If yes, date and why _____

DRIVER INFORMATION

14. What is minimum years driving experience you require? _____
15. Do you hire any part-time drivers? Yes No Are vehicles owner-driven only? Yes No
16. Are drivers ever allowed to take vehicles home at night? Yes No If yes, will family members be allowed to drive? Yes No
17. During the last 12 months, how many drivers have there been for the vehicles you operate? _____
18. **SCHEDULE OF ALL DRIVERS NOW EMPLOYED (If not enough space, attach separate listing)**

Driver's Name	Date of Birth	Driver License Number	States Where Licensed	No. Years Previous Commercial Driving Experience	Date of Hire	Co. Emp. (C) Ind. Cont. (IC) Owner/ Operator (O/O) Franchisee (F)	Married (Y or N)	List All Violations/ Convictions in Past 5 Years	List All Accidents in Past 3 Years

19. Does any driver listed have any convictions such as DWI/DUI of alcohol or drugs, license suspensions for moving violations, felonies, hit and run, eluding an officer, reckless/negligent operation of a vehicle, driving while under suspension or revocation or other violations not listed above? Yes No If yes, describe (including dates) _____
20. Driver's pay scale is (check all that apply): Union Non-Union Hourly Trip Mileage
 Other, explain: _____
21. (a) Driver's maximum hours driving: _____ daily, _____ weekly
 (b) Driver's maximum hours on duty: _____ daily, _____ weekly

22. **SCHEDULE OF AUTOS/VEHICLES TO BE COVERED**

Auto/ Vehicle No.	Model Year	Trade Name	Body Type	Serial No. (S) Vehicle ID No. (VIN)	Original Mfg. Seating Capacity	Limos - Length of Stretch To 60" (A) Over 60" (B) Over 102" (C)	Principal Garaging Location	Radius of Operation (miles)	Estimated Annual Mileage Per Vehicle	Anti-Lock Brakes (A), Air Bags (B), Lifts (C), or Other Handicapped Equipment (D)
1										
2										
3										
4										
5										

23. **PHYSICAL DAMAGE COVERAGES DESIRED (complete spaces below in detail for each respective auto/vehicle described above.)**

Auto/ Vehicle No.	Original Cost New of Chassis, Body & Equip.	Date Purchased Mo/Yr	Purchased New (N) Used (U)	Cost When Purchased	Present Value	Amount of Insurance	Specified Causes of Loss		Collision	
							Amount of Insurance	Deductible	Amount of Insurance	Deductible
1										
2										
3										
4										
5										

24. **Any loss payees?** Yes No If yes, indicate for which vehicle(s) and give name and address of loss payees: _____

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 _____

IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

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.