

# 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

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.