

Special Types 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

Policy Term From: _____ To _____

- Name (and "dba") _____
 Individual/Proprietorship Partnership Corporation Other Business Phone Number _____
- Mailing Address _____ City _____ State _____ Zip _____
- Premises Address _____ City _____ State _____ Zip _____
- Person to contact for inspection (name and phone number) _____
- 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

- Describe business _____
 Years experience _____ New Venture? Yes No
- 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
- Have you ever filed for Bankruptcy? Yes No If yes, when _____ Explain _____
- Gross receipts last year _____ Estimate for coming year _____ Business for sale? Yes No
- Do you operate in more than one state? Yes No If yes, list states _____
- 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			ALS	Advanced Life Support	MTA	Medical Transportation	SP	Snow Plow
2			BLS	Basic Life Support	OR	Off Road Auto	SS	Street Sweeper
3			BV	Box Van	OV	Other Van	ST	Semi-Trailer
4			CP	Cherry Picker	PC	Police Car	T	Truck
5			CV	Cargo Van	PPT	Private Passenger Type	TA	Transfer Ambulance
6			F	Flower Car	PT	Pumper Truck	TR	Trailer
7			H	Hearse	PU	Pick Up	TT	Truck Tractor
8			L	Limo	PV	Passenger Van	UT	Utility Trailer
9			LT	Ladder Truck	RT	Rescue Truck	WT	Water Truck
10								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	
						<input type="checkbox"/> Comprehensive <input type="checkbox"/> 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: _____

MICHIGAN NO-FAULT and COLLISION COVERAGE SELECTION FORM

MICHIGAN PERSONAL INJURY PROTECTION

Public Act No. 72 of 1974 provides that a reduction in Michigan Personal Injury Protection premiums may be afforded with respect to vehicles owned by an individual if there exists other insurance, such as group medical, individual medical, Medicare, which provides hospital, surgical, medical and/or loss of time benefits and the insured elects to make these benefits primary as respects himself, his spouse and other relatives residing with him.

Such an election would make the automobile policy secondary, and your automobile policy would be responsible only for those personal protection benefits not covered by your health insurer, thereby eliminating any duplication of benefits.

So that your policy may be properly rated, would you kindly "X" the appropriate statement(s) below:

- I have other insurance to cover allowable medical expenses and wish this automobile policy to become secondary to such insurance;
- I have other insurance to cover work loss and wish this automobile policy to become secondary to such insurance;
- I have no other insurance to cover either allowable medical expense or work loss and/or wish this automobile policy to be primary insurance.

_____ Date _____
 _____ Signature of Named Insureds

NOTICE
LIMITED ACCIDENT DAMAGE RECOVERY INSURANCE

THIS "NOTICE" IS TO ADVISE YOU OF CHANGES IN THE AUTO COVERAGES AVAILABLE TO YOU. PLEASE READ IT CAREFULLY.

Changes in the Insurance Laws may make **you** pay for damages, of up to \$500, which are caused as a result of an automobile accident in Michigan.

If **you** caused the accident which damaged another auto, and the owner cannot make a full recovery from an insurance policy, he can sue **you** in the Michigan Small Claims Court. If he wins, **you** will have to pay for those unrecovered damages, up to \$500.

We will provide you with the insurance to pay the amount awarded, at an additional premium. To make certain that **your** new policy is issued correctly, please **indicate your choice** (by marking "x") where shown and sign this statement as acknowledgement of **your** choice and understanding of this election.

("X" indicates choice)

- COVERAGE REJECTION – The undersigned has had this explained and does not want to purchase this Limited Accident Recovery Insurance. The undersigned understands that if rejected, no coverage will be afforded for any amount awarded by the Michigan Small Claims Court, as judgement for unrecovered damages from an automobile accident occurring in Michigan.
- LIMITED ACCIDENT RECOVERY INSURANCE – The undersigned has had this coverage explained and will pay the additional premium to purchase this additional coverage. The undersigned understands that the Company's maximum limit of liability for this coverage shall be \$500.

I understand that this coverage is optional and have indicated my choice above.

_____ Date _____ X _____ Signature of Named Insureds

COLLISION COVERAGE OPTIONS

You have an option to purchase collision coverage on a Limited, Regular or Broad Form basis.

When collision coverage is to be provided, designate your option by marking ("x") the appropriate box.

- Limited Collision
- Regular Collision
- Broad Form Collision

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.