COLONY
Member Argo Group

PASSENGER CARRIERS TRANSPORTATION APPLICATION

☐ Colony Insurance Company
☐ Colony Specialty Insurance Company
☐ Argonaut Insurance Company
☐ Argonaut Midwest Insurance Company

Section I - General Information

1. Policy Period Desired_____

2. Your Name_____ Phone_____
   (dba)_____ Fax_____

3. Mailing Address _____ Website _____

4. Insured is: ☐ Individual ☐ Partnership ☐ Corporation ☐ Limited Liability Corp ☐Other

5. Years operating this business _____ If a new venture, number of years experience? _____
   a. Have you ever operated under another name? ☐ Yes ☐ No
      If "Yes," what was the name of that operation?
   b. If this is a new venture, where did you get your experience?_____
   c. How much experience do you have in operating this type of business?_____

6. In the past 3 years, have you ever had similar insurance cancelled, declined or refused renewal? If "Yes," explain: ☐ Yes ☐ No _____

Section II - Description of Operations

7. Please select from the following categories:
   ☐ School Bus/Head Start Are buses: ☐school owned ☐ independent contractor?
   ☐ Daycare
   ☐ Church Bus
   ☐ Sightseeing Bus
   ☐ Courtesy Bus (Be specific, i.e. Casino Bus, Outfitters/Guides, Bingo Bus, etc.):_____
   % of airport exposure _____
   ☐ Social Service Bus (Select one or combination of the following:)
   - ☐ Alcohol/Drug Rehabilitation Center
   - ☐ Boy or Girl Scout Centers
   - ☐ Domestic Violence Centers
   - ☐ Homeless Shelters
   - ☐ Psychiatric Counseling
   - ☐ Youth Center

8. Describe fully all operations conducted by you which involves the use of automobiles (passenger carrying or other):
   _____
   Estimated length of operation per vehicle, per day:_____ hours; _____% is night driving.

9. Do you ever have occasion to transport passengers who are physically or mentally handicapped? ☐ Yes ☐ No
   If "Yes," explain fully:_____
   a. Are units equipped with lifts or ramps? ☐ Yes ☐ No
   b. Explain how wheelchairs are secured:_____
   c. Are units equipped with seat belts? ☐ Yes ☐ No
      If "Yes," is usage mandated? ☐ Yes ☐ No
   d. How are drivers trained to handle such equipment?_____

Section III - Area of Operations

10. Define normal areas of operation, i.e., Cities, States:_____

11. Do you operate over a regular route? ☐ Yes ☐ No

    If "Yes," describe:_____

12. List largest cities entered in each state:_____

13. Radius of operation: ☐ 0-100 ☐ 101-300 ☐ 301-500

14. Do you ever exceed 500 miles? ☐ Yes ☐ No

    If "Yes," explain:_____

Section IV - Driver Information

15. Do you carry Worker's Compensation? ☐ Yes ☐ No

16. Do you order motor vehicle reports on all your drivers within 30 days of employment? ☐ Yes ☐ No

17. Schedule all Drivers having access to vehicles (any additional drivers, please attach a list)

    How are drivers paid? ☐ Per Hour ☐ Per Mile ☐ Other (describe)

Drivers Full Name	Date of Birth	Date Employed	Years Experience Comm'l Driving on like equip.	Drivers License # and State

Section V – Vehicle Information

Unit No.	Model Year	Trade Name	Vehicle Type i.e., Bus, Van	Complete VIN Number	Passenger Seating Capacity
1.					
2.					
3.					
4.					
5.					

Unit No.	Radius of Operation	Garaging Location
1.		
2.		
3.		
4.		
5.		

ATTACH SCHEDULE LISTING ANY ADDITIONAL EQUIPMENT

18. Do others operate under your authority? ☐ Yes ☐ No

    If "Yes," please explain:_____

    a. Number of vehicles operating under your authority and types:_____

    b. Do you hire any equipment? ☐ Yes ☐ No

    If "Yes," what is estimated annual cost of hire? $_____

c. Do you loan or rent any of your equipment to others? ☐ Yes ☐ No

If "Yes," please explain:_____

d. Do you ever lease your authority to others? ☐ Yes ☐ No

If "Yes," explain:_____

e. Is this insurance to cover all owned, leased and operated equipment? ☐ Yes ☐ No

If "No," please explain:_____

19. Is there any personal use of the vehicles? ☐ Yes ☐ No

If "Yes," explain fully:_____

20. Do your drivers own and operate their own vehicles in your business? ☐ Yes ☐ No

If "Yes," explain:_____

Section VI - Safety and Maintenance

21. Is there a formal safety program in effect? ☐ Yes ☐ No

If "Yes," give details and/or attach a copy of your safety program.

22. Explain your maintenance program. i.e., How often is maintenance done and by whom?_____

_____

23. What criteria do you have in place for acceptability of drivers?_____

24. Do you have a driver training program? ☐ Yes ☐ No

If "Yes," describe and/or attach a copy of the program:_____

25. Do you have a written accident reporting procedure? ☐ Yes ☐ No

If "Yes," describe and/or attach a copy_____

26. Are periodic reviews of all drivers conducted? ☐ Yes ☐ No

If "Yes," how often?_____

27. Is any action taken against a driver for having a chargeable accident or a poor motor vehicle record? ☐ Yes ☐ No
If "Yes," explain:_____

28. Do you have a driver safety incentive program? ☐ Yes ☐ No
If "Yes," describe and attach copy of program:_____

29. Describe safety equipment attached to insured unit i.e., School buses retrofitted with handrails in compliance with National Highway Traffic Safety Administration? Additional rear view mirrors? Anti theft devices? (be specific)

_____

_____

Section VII - Filing Information

For prompt and accurate filing, complete information must be given including Name, Address and Docket No. exactly as authority exists. Use separate sheet if necessary. Failure to provide accurate information may result in delays and suspensions.

30. Do you hold an I.C.C. permit? ☐ Yes ☐ No
If "Yes," Docket Number and please attach a copy of your completed RS form:_____

31. State filings required? ☐ Yes ☐ No
If "Yes," show states and permit number:_____

32. Is any special filing required such as a city permit? ☐ Yes ☐ No
If "Yes," give details:_____

Section VIII - Previous Insurance and Loss Experience
THIS SECTION MUST BE COMPLETED IN ITS ENTIRETY.

Policy Year	Insurance Carrier	Policy #	Number of Accidents	Total Amount of Claims Paid		Total Amount Unsettled Claims (reserves)	
				Bodily Injury	Property Damage	Bodily Injury	Property Damage
From To				$	$	$	$
From To				$	$	$	$
From To				$	$	$	$
				Losses by Fire, lightning, explosion	Losses by theft/ vandalism	Losses by Collision	Losses by Windstorm, Hail Earthquake or flood
From To				$	$	$	$
From To				$	$	$	$
From To				$	$	$	$

******FOR FLEETS CONSISTING OF 5 POWER UNITS OR MORE-HARD COPY LOSS RUNS ARE REQUIRED******

Section IX - Coverage and Limits Requested

33. Liability Limits
    a. Combined Single Limit: $_____
    b. Split Limits:
       Bodily Injury: $_____each person
       $_____each accident
       Property Damage $_____each accident
    c. Liability Deductibles
       Bodily Injury Only $_____
       Property Damage Only $_____
       Bodily Injury and Property Damage $_____
       Bodily Injury and Property Damage applied separately $_____

34. Do you desire Uninsured Motorists/Underinsured Motorist coverage? ☐ Yes ☐ No
    (for requirements, check state statute)
    If "Yes," limit desired $_____
    If required by state, please complete, sign and attach proper form for selection or rejection of this coverage.

35. Do you desire Personal Injury Protection coverage? ☐ Yes ☐ No
    (for requirements, check state statute) If required by state, please complete, sign and attach proper form for selection or rejection of this coverage.

36. Do you desire Medical Payments coverage? ☐ Yes ☐ No
    If "Yes," advise limit $_____

37. Do you desire Hired and/or Non Owned coverage? ☐ Yes ☐ No
    If "Yes," please complete Supplemental forms AU1129 and AU1130.

38. Physical Damage coverages and deductible selection

Unit Description	Stated Amount	Collision Deductible	Other than Collision Deductible		Single Deductible Per Occurrence
			Specified Causes of Loss	Comprehensive	
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

39. Loss Payable Name and Address (advise which unit(s) this applies to): _____

40. List any Additional Insureds to be named and advise what their interest is in your operation: _____

41. List any Person or Organization requesting a Waiver of Subrogation and advise reason for this request: _____

Section X – Signatures

I declare to the best of my knowledge that all statements herein are true and no material facts have been suppressed or misstated. I am also aware that my operation may be inspected by the Insurance Company.

Applicant's Signature Date

Witness Date

Agent:

Are you personally familiar with this Applicant's operations? ☐ Yes ☐ No

Did your office control this risk in the past year? ☐ Yes ☐ No

Agent's or Broker's Name Telephone Number Agent's Signature

Address Date

License No.

GENERAL FRAUD STATEMENT (Not applicable in Colorado, Ohio, or Oregon)

Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subject the person to criminal and [NY: substantial] civil penalties. In the District of Columbia, Louisiana, Maine, Tennessee and Virginia, insurance benefits may also be denied.

Colorado, Ohio, and Oregon – see notices below.

APPLICANT'S SIGNATURE DATE (MM/DD/YY)

Applicable in Colorado

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

APPLICANT'S SIGNATURE DATE (MM/DD/YY)

Applicable in Ohio

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

APPLICANT'S SIGNATURE DATE (MM/DD/YY)

Applicable in Oregon

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of Insurance Fraud.

APPLICANT'S SIGNATURE DATE (MM/DD/YY)