



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 (dba) Phone 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?
6. In the past 3 years, have you ever had similar insurance cancelled, declined or refused renewal? If "Yes," explain:

Section II - Description of Operations

- 7. Please select from the following categories: School Bus/Head Start Daycare Church Bus Sightseeing Bus Courtesy Bus Social Service Bus
8. Describe fully all operations conducted by you which involves the use of automobiles (passenger carrying or other):
9. Do you ever have occasion to transport passengers who are physically or mentally handicapped?
a. Are units equipped with lifts or ramps?
b. Explain how wheelchairs are secured:
c. Are units equipped with seat belts?
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	
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> 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)