

STRATFORD INSURANCE COMPANY

WESTERN WORLD INSURANCE COMPANY

PUBLIC AUTO INSURANCE APPLICATION - VIRGINIA

A. GENERAL

Applicant's Name: _____ Phone #: _____

Contact Person: _____ Proposed Effective Date: _____

Address: _____ Expiration Date: _____

Garaging Location(s) if different: _____

Is your business? 1. Individual Partnership Corporation Other _____

2. Seasonal Non-Profit Government Funded

Nature Of Business: _____ Years In Business: _____

Years Operating in Your Current Name: _____ Web Site: _____

Have you owned a similar business or had any change in ownership, management or name of your current business during the past 5 years? Yes No

If yes, please explain: _____

Is your business a subsidiary of another entity or does your business have any subsidiaries? Yes No

If yes, provide details: _____

B. COVERAGES REQUESTED (Provide limit where applicable.)

Liability _____ Medical Payments _____ Physical Damage – See Section G.

Scheduled Autos Uninsured/Underinsured Specified Causes/Collision, or

Hired Autos Motorists – See Section H. Comprehensive/Collision

Non-Owned Autos Other _____

C. OPERATIONS

1. Check each of the services you provide:

Taxi Special Occasion Limousine Kid Cab Jeep Tour

School Bus/Van Airport Limousine Employee Van Pool Other _____

Church Bus/Van Executive Limousine Guide/Outfitter _____

Casino Bus/Van Daycare Bus/Van Sightseeing _____

Social Service Agency (Please describe): _____

Shuttle Service (Between what destinations?) _____

2. Do you transport passengers for a fare? Yes No

3. Do you regularly transport elderly passengers? Yes No

4. Do you regularly transport passengers to medical facilities? Yes No

5. Do you regularly transport physically disabled passengers? Yes No

6. Are any vehicles equipped with wheelchair lifts? Yes No

7. What is the average number of hours per day each vehicle is operated? _____ Percent of night driving? _____

8. Is there any personal use of vehicles? Yes No

If yes, please explain: _____

9. Are drivers allowed to take vehicles home when not in use? Yes No

If yes, are there any relatives under 23 years of age residing in the driver's household? Yes No

If yes, please explain: _____

E. PRIOR INSURANCE CARRIERS AND LOSS EXPERIENCE (Add additional sheet(s) if necessary.)

Policy Dates	Insurance Carrier	Policy #	Premium	Average No. of Power Units	*Total Liability Claims		*Total Physical Damage Claims		Cancelled or Non-Renewed? (Reason)
					#	\$	#	\$	
			\$		#	\$	#	\$	
			\$		#	\$	#	\$	
			\$		#	\$	#	\$	
			\$		#	\$	#	\$	
			\$		#	\$	#	\$	

*This section should be completed unless you have attached loss runs for all years. Please describe any loss over \$25,000:

Any drivers involved in more than one claim? Yes No Who? _____
 If yes, is that driver currently employed? Yes No

F. VEHICLE INFORMATION (Add additional sheet, if necessary) G. PHYSICAL DAMAGE

	Model Year/Make	Body Type (Van, Limo, Bus, etc.)	Vehicle ID No.	Seating Capacity	Month/Year of Purchase	Cost at Purchase	Amount of Insurance (Must equal present value)	Deductible	*Loss Payee (Y/N)
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10.									
11.									
12.									
13.									
14.									

*Please list name and address of loss payee by vehicle: _____

Identify any vehicles equipped with wheelchair lifts: _____

Do you have a regular vehicle inspection and preventive maintenance program? Yes No

If yes, please describe: _____

Do you own any vehicles which will not be covered under this policy? Yes No

If yes, please list all vehicles not covered and the insurance carrier covering those vehicles: _____

I. UNINSURED AND UNDERINSURED (UM) MOTORISTS' COVERAGE

UM coverage protects you against loss from bodily injury and property damage caused by an owner or operator of an uninsured, hit-and-run, or an underinsured vehicle. (A vehicle is underinsured when the liability coverage of the party responsible for your injuries does not cover the loss up to the limit you have selected.) UM coverage is provided at limits equal to your liability coverage. However, you have the option to select lower limits at a reduced premium.

I reject increased UM limits and select:

- Minimum UM coverage required by law; **OR**
- Lower limits shown below:
 - Split limits

Bodily Injury	\$ _____	each person /	\$ _____	each accident;
Property Damage	\$ _____	each accident;	OR	
 - Combined Single Limit \$ _____

Your selections will apply regardless of any addition of change on your current policy and will carry forward on all renewal policies unless you give us written notice otherwise. All named insureds must sign and date below.

Applicant's Signature _____ Date _____

I. AGREEMENTS AND SIGNATURES

APPLICANT: I BELIEVE THE STATEMENTS IN THIS APPLICATION ARE TRUE AND CORRECT. I UNDERSTAND THAT THE INSURER WILL RELY ON THESE STATEMENTS IF A POLICY IS ISSUED. I AGREE TO PROMPTLY REPORT ALL FULL TIME AND PART TIME DRIVERS. MY EMPLOYEES UNDERSTAND THAT MOTOR VEHICLE REPORTS WILL BE ORDERED. ON THEIR BEHALF, I AUTHORIZE THE INSURER TO ORDER THESE REPORTS ON EACH DRIVER I EMPLOY OR CONTRACT. THIS APPLICATION ALONE DOES NOT BIND COVERAGE. **I UNDERSTAND THAT THIS POLICY DOES NOT PROVIDE ANY COVERAGE IN ONTARIO, CANADA.**

FRAUD WARNING: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A CRIME.

Applicant's Signature _____ Producer's Signature _____

Date _____ Date _____