

NON-EMERGENCY TRANSPORTATION INSURANCE APPLICATION

Please remember to save a copy of your completed application on your computer in order to attach it to an e-mail. Thank you.

APPLICANT INFORMATION	
Business Name (First Named Insured):	DBA: _____
Inspection Contact Name:	
Organization Type:	<input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> LLC <input type="checkbox"/> CORPORATION <input type="checkbox"/> OTHER
Desired Effective Date:	
Business Type:	<input type="checkbox"/> TAXI <input type="checkbox"/> NON-EMERGENCY <input type="checkbox"/> LIMO <input type="checkbox"/> OTHER
Mailing Address:	
Garaging Address:	
Phone /Fax Number:	
E-mail Address:	
PUC/ICC Docket Number:	
Number of Years in Business	_____ YEARS
Additional Insureds:	
Is this a New Venture?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you ever driven or been associated with another company? If so, what is the name of the company and dates?	NAME: _____ DATES: _____

COVERAGES	
<i>(actual coverages may differ from this application)</i>	
TYPE	LIMITS OF LIABILITY
Bodily Injury / Property Damage Liability:	_____ DEDUCTIBLE
Uninsured Motorist:	
Underinsured Motorist:	
Comprehensive / Collision (min. \$1,000 Deductible):	<input type="checkbox"/> ACV <input type="checkbox"/> _____:STATED AMOUNT _____ DEDUCTIBLE
Medical Payments:	
PIP (not applicable in all states):	
Territory of Operation:	

VEHICLE SCHEDULE					
<i>(if you have additional vehicles, please see supplemental form on website)</i>					
#	# OF PASSENGERS	COST NEW (IF NEEDED)	YEAR	MAKE/MODEL	VIN
1					
2					
3					
4					
5					

Please e-mail your submission to info@longviewins.com

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DRIVER SCHEDULE

(if you have additional drivers, please see supplemental form on website)

#	NAME	DOB	LICENSE # / STATE	MOVING VIOLATIONS?	YEARS OF EXPERIENCE
1				<input type="checkbox"/> YES <input type="checkbox"/> NO	
2				<input type="checkbox"/> YES <input type="checkbox"/> NO	
3				<input type="checkbox"/> YES <input type="checkbox"/> NO	
4				<input type="checkbox"/> YES <input type="checkbox"/> NO	
5				<input type="checkbox"/> YES <input type="checkbox"/> NO	

ADDITIONAL INFORMATION

Do You Provide Airport Service?	<input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHAT PERCENTAGE ____%
Radius of Operation:	<input type="checkbox"/> 0-50 MILES ____% <input type="checkbox"/> 51-200 MILES ____% <input type="checkbox"/> + 200 MILES ____%
Does Radius cross state lines?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Are any filings required?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Name of Filing Authority:	
What percentage of your trips are arranged 24 hours in advance?	____%
Do you have a formal safety program?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Are drivers trained in emergency situations?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do any vehicles have special equipment for transporting the physically impaired? If so, please explain.	<input type="checkbox"/> YES <input type="checkbox"/> NO _____
How often are vehicles inspected?	
Date of last vehicle inspection(s):	
Is a written vehicle maintenance program in force?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do any of the vehicle(s) have a salvage title?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Are loss control/training manuals and programs provided? If so, please provide copy.	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have a drug testing policy?	<input type="checkbox"/> YES <input type="checkbox"/> NO
How often are current drivers reviewed?	
Annual Fleet Mileage:	_____
Are your autos used to transport students to and from school or related activities?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you transport passengers needing emergency medical attention?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do your drivers assist passengers to and from their homes?	<input type="checkbox"/> YES <input type="checkbox"/> NO

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PRIOR CARRIER INFORMATION					
Has any insurance carrier cancelled or refused your liability insurance? If no, please explain.	<input type="checkbox"/> YES <input type="checkbox"/> NO				
Five-Year Auto Loss History: <input type="checkbox"/> Loss Runs Attached	YEAR	PRIOR INSURANCE COMPANY	POLICY NUMBER	ANNUAL PREMIUM	TOTAL CLAIMS AMOUNT
	2010-2009				
	2008-2009				
	2007-2008				
	2006-2007				
	2005-2006				
	TOTAL 5 YRS				
	AVERAGE 5 YRS				

COVERAGE IS NOT BOUND BY SIGNING THIS APPLICATION.

The undersigned declared that to the best of their knowledge the information above is true. Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance containing any false information or conceals for the purpose of misleading information, commits fraudulent act, which is a crime and jeopardizes coverage's for occurrences that may otherwise be covered.

Applicants Signature **X** _____

Date: _____

Agents Signature **X** _____

Date: _____

**If you would like a Commercial General Liability quote, please contact our agency at 440-617-0333ext. 221*