

# 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: \_\_\_\_\_  
 \_\_\_\_\_

## OKLAHOMA UNINSURED MOTORIST COVERAGE LAW

Oklahoma law gives you the right to buy Uninsured Motorist coverage in the same amount as your bodily injury liability coverage. THE LAW REQUIRES US TO ADVISE YOU OF THIS VALUABLE RIGHT FOR THE PROTECTION OF YOU, MEMBERS OF YOUR FAMILY, AND OTHER PEOPLE WHO MAY BE HURT WHILE RIDING IN YOUR INSURED VEHICLE. YOU SHOULD SERIOUSLY CONSIDER BUYING THIS COVERAGE IN THE SAME AMOUNT AS YOUR LIABILITY INSURANCE COVERAGE LIMIT.

Uninsured Motorist coverage, unless otherwise provided in your policy, pays for bodily injury damages to you, members of your family who live with you, and other people riding in your car who are injured by: (1) an uninsured motorist, (2) a hit-and-run motorist, or (3) an insured motorist who does not have enough liability insurance to pay for bodily injury damages to any insured person. Uninsured Motorist coverage, unless otherwise provided in your policy, protects you and family members who live with you while riding in any vehicle or while a pedestrian. THE COST OF THIS COVERAGE IS SMALL COMPARED WITH THE BENEFITS!

You may make one of four choices about Uninsured Motorist Coverage:

1. You may buy Uninsured Motorist coverage equal to your bodily injury liability coverage for \$\_\_\_\_\_ for \_\_\_\_\_ months.
2. You may buy Uninsured Motorist coverage in the amount of \$10,000.00 for each person injured, not to exceed \$20,000.00 for two or more persons injured in one occurrence (the smallest coverage which Oklahoma law allows) for \$\_\_\_\_\_ for \_\_\_\_\_ months.
3. You may buy Uninsured Motorist coverage in an amount less than your bodily injury liability coverage but more than the minimum levels.
4. You may reject Uninsured Motorist coverage.

Please indicate below what Uninsured Motorist coverage you want:

\_\_\_\_\_ I want the same amount of Uninsured Motorist coverage as my bodily injury liability coverage.

\_\_\_\_\_ I want minimum Uninsured Motorist coverage (\$10,000.00 per person/\$20,000.00 per occurrence).

\_\_\_\_\_ I want Uninsured Motorist coverage in the following amount:

\$\_\_\_\_\_ per person/\$\_\_\_\_\_ per occurrence.

\_\_\_\_\_ I want to reject Uninsured Motorist coverage.

\_\_\_\_\_  
Proposed Insured

\_\_\_\_\_  
Date

THIS FORM IS NOT A PART OF YOUR POLICY AND DOES NOT PROVIDE COVERAGE.

**SIGNATURE IS ALSO REQUIRED ON LAST PAGE OF APPLICATION**

**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.