



**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	
					<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)

## PASSENGER CARRIER SUPPLEMENTAL APPLICATION

Applicant \_\_\_\_\_

### Description of Operations

1. Select one of the following categories:

- |   |   |
|---|---|
| <input type="checkbox"/> Airport                | <input type="checkbox"/> Limousine          |
| <input type="checkbox"/> Airline Workers        | <input type="checkbox"/> Migrant Workers    |
| <input type="checkbox"/> Charter                | <input type="checkbox"/> Railroad Employees |
| <input type="checkbox"/> Church                 | <input type="checkbox"/> Sight-seeing Tours |
| <input type="checkbox"/> City Transit           | <input type="checkbox"/> Social Service     |
| <input type="checkbox"/> Day Care               | <input type="checkbox"/> Senior Citizens    |
| <input type="checkbox"/> Dock Workers           | <input type="checkbox"/> School             |
| <input type="checkbox"/> Hotel/Courtesy Shuttle | <input type="checkbox"/> Taxi               |
| <input type="checkbox"/> Handicapped            | <input type="checkbox"/> Inter-City         |
| <input type="checkbox"/> Other _____            |   |

2. a. Describe fully all operations conducted by you which involves the use of automobiles (passenger – carrying or otherwise): \_\_\_\_\_
- b. Estimated length of operation per vehicle, per day: \_\_\_\_\_ hours; \_\_\_\_\_ % is night driving.
- c. Do you share dispatch services with any other company/entity?  Yes  No  
If "Yes," explain: \_\_\_\_\_
3. a. Do you ever have the occasion to transport passengers who are physically or mentally disabled? If Yes, explain:  Yes  No
- b. If "Yes," explain if units are equipped to handle handicapped and if drivers/aides are trained to handle such equipment: \_\_\_\_\_
- c. Explain how patients, gurneys and wheelchairs are secured: \_\_\_\_\_
4. Is there any youthful or personal use of vehicles?  Yes  No

### Vehicle Information

5. Complete for each type of vehicle operated:

Vehicle Type	Number & Pieces of Equipment Seating Capacity				Radius of Operation (list # of units in each group)				Company Owned	Long Term Lease	Trip Lease From Others (Avg. per Mo.)	Actual Earnings Past 12 Mo.	Estimated Next 12 Mo.
	0-8	9-20	21-60	Over	50 Mi	200 Mi	300 Mi	Over					
Bus													
Van													
School Bus													
Limousine													
Taxi													
Other													

6. a. Do others operate under your authority?  Yes  No  
Number of vehicles involved by type: \_\_\_\_\_
- b. Do you lease any vehicles from others?  Yes  No
- c. Do you rent or lease vehicles to drivers?  Yes  No  
If "Yes," to any of the above, please explain \_\_\_\_\_  
Vehicles must be scheduled.
7. Do your drivers own and operate their own vehicles in your business?  Yes  No

Applicant \_\_\_\_\_

Date \_\_\_\_\_