



TAXI SUPPLEMENTAL APPLICATION

Named Insured: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Years in Business: _____ Years in Taxi Business: _____ Years Experience in Taxi Industry: _____
 Phone: _____ Website: _____
 Insurance Contact: _____ E-Mail: _____

What is the primary purpose of your operation and how are services provided?

General Information:

How would you describe your operation?

Sole Proprietorship Partnership Corporation Cooperative Association Other _____

Does the ownership/management of this company operate or have an interest in any other transportation businesses? Yes No (If yes, please describe) _____

How long has this organization been operating under the present name? _____

Please list all subsidiary and/or prior names under which business was operated:

Please provide the names of any entities that contract with you to provide transportation services: _____

Insurance History:

Policy Year	Unit Count	Insurance Company	Per Unit Premium (\$)
Expiring			
Expiring +1			
Expiring +2			
Expiring +3			
Expiring +4			

Have there been any lapses in coverage over the past 5 years? Yes No

If Yes, please explain: _____

Operations:

In what cities do you provide services?

City	% of Operations	City	% of Operations

How many shifts do you run per week? _____

Do you subcontract for any paratransit operations? Yes No

If Yes, what percentage of operations? _____



Vehicle Information:

Are drivers allowed to take vehicles home? Yes No
Are vehicles used for any purpose other than transporting passengers for hire? Yes No
If yes, please explain: _____
Are all vehicles titled and registered to the named insured? Yes No
If no, is there a lease agreement between the Named Insured and the vehicle owner? Yes No
Are all vehicles registered in the state in which they operate? Yes No
Do you have a written vehicle maintenance program? Yes No
How often are vehicles serviced? _____
Who provides maintenance on your vehicles? _____
How often are maintenance records reviewed by management? _____
Are any vehicles wheelchair accessible? Yes No
If yes, how many? _____
Please describe any wheelchair accessible vehicles: _____
What type of training do drivers have on these devices? _____

Employee Information:

How many of the following do you have?
Full Time Drivers: _____ Regular Part Time Drivers: _____
Back Up Drivers: _____ Dispatchers: _____
Maintenance: _____ Administrative: _____
Other: (Please include number and description of duties) _____

Please describe the driver hiring process: _____

Are MVRs ordered prior to hiring? Yes No
Please describe what MVR criteria is used for acceptability: _____

What percentage of driver turnover do you have annually? _____

Do you have driver hiring criteria in place? Yes No
If yes, is the criteria in writing? Yes No
If yes, does it include the following:
• MVRs checked prior to hire Yes No
• DOT Physical exams at time of hire Yes No
• Drug/Alcohol testing at time of hire Yes No
• Road test given prior to hire Yes No
• Criminal Records Check/CORI Check Yes No
If yes: State Federal

Please describe your standards for an acceptable MVR: (or attach a copy of your driver hiring criteria): _____



Safety & Claims Management

Who is responsible for reporting claims?

Name/Title: _____ E-mail: _____ Phone: _____

Who is responsible for Safety Training?

Name/Title: _____ E-mail: _____ Phone: _____

Please describe your accident review procedures:

How many vehicles are equipped with Accident Event Recorders or Cameras? _____

What is the name/brand of the AER Units / Cameras in place? _____

Where do cameras record? Interior Exterior Both (dual facing)

How is data reviewed? Third Party Internal (if internal, who is responsible? _____)

What is the minimum number of years driving experience required? _____

Is there a driver incentive program in place? Yes No

If yes, please describe: _____

Please identify the types of special driver training that your drivers receive:

- General Driver Orientation
- Primary First Aid
- CPR
- Human Relations Skills
- Emergency Vehicle Evacuation
- Defensive Driving
- Advanced First Aid
- Passenger Assistance Training
- Non-Medical Emergency Training
- Proper Wheelchair/Stretchers Securement Procedures

Is there a post accident drug testing policy in place? Yes No

Is there a formal accident review procedure in place? Yes No

If yes, please describe: _____

FRAUD STATEMENTS

Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance or statement of claim 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 subjects the person to criminal and (NY; substantial) civil penalties. (Not applicable IN, CO, FL, HI, MA, NE, OH, OK, OR, VT, IN, DC, LA, ME, TN, VA, and WA insurance benefits may also be denied).

In Florida, any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claims or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

In Massachusetts, Nebraska, Oregon and Vermont, any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance or statement of claim containing any material 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 may subject the person to criminal and civil penalties.

In Ohio, any person who, with intent to defraud or knowing that he is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

In Pennsylvania, any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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 subjects such person to criminal and civil penalties.

ELECTRONIC NOTICE POLICY

By signing below, you consent to receive notices, including statutory notices relevant to this policy, via electronic means including electronic mail.

Agent's/Broker's Signature: _____ Date: _____

Applicant's Signature: _____ Date: _____