



MARKEL Corporation

310 Highway 35 South Red Bank, NJ 07701 Phone: 800-243-6896 Fax: 732-391-8920

TAXI AUTO LIABILITY APPLICATION

GENERAL INFORMATION

Named Insured: _____ DBA: _____

Mailing Address: _____

Dispatch/Garaging Address: _____

Contact Name and Phone Number: _____

Business Entity: Corporation Partnership Individual LLC Other (describe) _____

Detailed Description of your operations: _____

Proposed Effective Date: _____

Liability Limit Requested: \$ _____ Deductible /SIR If Any (Check Box) \$ _____

Uninsured Motorist If Any: \$ _____ Underinsured Motorist Limit If Any: \$ _____

Are any filings required? Yes No If yes, please provide the ICC/PUC docket number: _____

Name of filing authority: _____

Years in business: _____ Is this a New Venture? Yes No

If yes, have you ever driven for or been associated with any cab (livery) company: Yes No

If yes, give name, address and dates: _____

How many years has this organization been under the present name? _____

List all Subsidiaries: _____

Do you share dispatch services with any other company? Yes No If yes, name and location of dispatch service: _____

What % of business is dispatched: _____ N/A

List the cities in which you have operating authority: _____

At which airport, if any, do you pick up or deliver: _____

Radius of operation: 0-50 _____ % , 51-200 _____ % , Over 200 Miles _____ %

What % of your trips are: Airport _____ % Non-emergency medical _____ %

Disabled/Handicapped _____ %

Are customers accepted on a pre-arranged basis? Yes No

Have you had any policy or coverage cancelled or non-renewal during the past 3 years? Yes No

If yes, please explain _____

Do you carry General Liability Insurance? Yes No If yes, who is the carrier and limits provided? _____

Full Name And Address Of All Required Certificate Holders/Additional Insured And Identify Each Type. List Separately.

VEHICLE INFORMATION

How many vehicles do you own? _____ How many shifts do you run with your vehicles? _____

Are all vehicles titled/licensed in the State in which they operate? Yes No

Are all vehicles solely owned by and registered to the applicant: Yes No *If no, there must be a lease agreement between the Named Insured and the vehicle owner.*

Are any vehicles customized, altered or have special equipment? Yes No

If yes, please identify the vehicles and provide specification (i.e. stretched SUV, wheelchair lift) _____

Do you subcontract work to others? Yes No

Do you have a written vehicle maintenance program? Yes No

Are daily or pre-trip inspections made to the vehicles: Yes No

Who services your vehicles and how often? _____

How often are the maintenance records reviewed by management? _____

Are any of your taxis equipped with:

- Liftout/Pull out ramps? Yes No
- Mechanical lifts Yes No
- Wheelchair passenger/patient safety restraint system Yes No
- Vehicle wheelchair securing system Yes No
- Ambulatory passenger/patient safety restraint system Yes No

DRIVER INFORMATION

Any age requirements for drivers? Yes No If yes, what are they? _____

Do you have a formal safety program? Yes No

Do you hold regular safety meetings? Yes No

Are drivers trained to assist elderly/handicapped passengers? Yes No

Do you have a driver training program? Yes No

Are your driver's employees or independent operators? _____

Do you have a drug testing policy? Yes No If yes, please describe _____

Is a post accident drug testing policy in place? Yes No If yes, please describe _____

Has any driver listed been convicted of a DWI/DUI of alcohol or drugs, license suspension for moving violations, felonies, hit and run, eluding and officer, reckless/negligent operations of a vehicle, or of driving while their license suspended or revoked? Yes No If yes, please describe _____

Do you provide Workers Compensation Coverage on your drivers? Yes No

Do the drivers take the vehicles home? Yes No

If yes, are any of the vehicles used by family members? Yes No

If yes, please provide name, date of birth, and driver's license number: _____

Do you have a driver incentive program? Yes No

During the past year, how many drivers have you added? _____ Replaced? _____

How often are drivers MVR's checked? _____ Annually Semi-annually Quarterly After an accident

Is an MVR required prior to hiring? Yes No

Are accident investigation and review procedures, including records, maintained? Yes No

Do the review procedures include driver disciplinary procedures? Yes No

If yes, please explain: _____

PRIOR INSURANCE CARRIERS & LOSS EXPERIENCE

Provide A Minimum Of The Past Three Years Loss and Premium Experience For Business Auto Liability:

<u>Policy Period</u> (Month & Year)	<u>Insurance Company</u>	<u>Premium Paid</u>	<u>Total Incurred Losses</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Print Named of Insured _____

Signature of Insured _____

Date _____

Agency Name and Address _____

Agent Signature _____

Date _____

PRODUCERS SUBMISSION CHECKLIST

1. This application, signed by the insured.

2. Description of why the account is an opportunity for Markel and what we can do to satisfy your needs.

3. Current Vehicle Schedule including 17 digit VIN Numbers.

4. Minimum of 3 years of hard copy loss runs valued within the last 60 days. Include details on claims over \$10,000.

5. Current drivers list and MVRs. Drivers list must include family members who have access to company vehicles.

6. Provide details below regarding the changes in fleet size over past four years.

<u>Year</u>	<u>Number of Units</u>	<u>Premium Per Unit</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____