Risk Placement Services, Inc.

☐ WESTERN WORLD INSURANCE COMPANY
☐ STRATFORD INSURANCE COMPANY

PUBLIC AUTO INSURANCE APPLICATION - WISCONSIN

A. GENERAL

Applicant's Name: _____ Phone #: _____

Contact Person: _____ Proposed Effective Date: _____

Address: _____ Expiration Date: _____

Garaging Location(s) if different: _____

Is your business? 1. ☐ Individual ☐ Partnership ☐ Corporation ☐ Other _____

2. ☐ Seasonal ☐ Non-Profit ☐ Government Funded

Nature Of Business: _____ Years In Business: _____

Years Operating in Your Current Name: _____ Web Site: _____

Have you owned a similar business or had any change in ownership, management or name of your current business during the past 5 years? ☐ Yes ☐ No

If yes, please explain: _____

Is your business a subsidiary of another entity or does your business have any subsidiaries? ☐ Yes ☐ No

If yes, provide details: _____

B. COVERAGES REQUESTED (Provide limit where applicable.)

☐ Liability _____
- ☐ Scheduled Autos
- ☐ Hired Autos
- ☐ Non-Owned Autos

☐ Medical Payments – *See Section H.*

☐ Uninsured Motorists _____

☐ Underinsured Motorists _____

☐ Physical Damage – *See Section G.*
- ☐ Specified Causes/Collision, or
- ☐ Comprehensive/Collision

☐ Other _____

C. OPERATIONS

1. Check each of the services you provide:

☐ Taxi ☐ Special Occasion Limousine ☐ Kid Cab ☐ Jeep Tour

☐ School Bus/Van ☐ Airport Limousine ☐ Employee Van Pool ☐ Other _____

☐ Church Bus/Van ☐ Executive Limousine ☐ Guide/Outfitter _____

☐ Casino Bus/Van ☐ Daycare Bus/Van ☐ Sightseeing _____

☐ Social Service Agency (Please describe): _____

☐ Shuttle Service (Between what destinations?) _____

2. Do you transport passengers for a fare? ☐ Yes ☐ No
3. Do you regularly transport elderly passengers? ☐ Yes ☐ No
4. Do you regularly transport passengers to medical facilities? ☐ Yes ☐ No
5. Do you regularly transport physically disabled passengers? ☐ Yes ☐ No
6. Are any vehicles equipped with wheelchair lifts? ☐ Yes ☐ No
7. What is the average number of hours per day each vehicle is operated? _____ Percent of night driving? _____
8. Is there any personal use of vehicles? ☐ Yes ☐ No
   If yes, please explain: _____
9. Are drivers allowed to take vehicles home when not in use? ☐ Yes ☐ No
   If yes, are there any relatives under 23 years of age residing in the driver's household? ☐ Yes ☐ No
   If yes, please explain: _____

10. Maximum radius of operations: _____ Miles

11. Territory (Largest Cities/Towns into, near or through which vehicles are operated.)

a. _____ b. _____ c. _____ d. _____

12. Do you travel to Michigan? ☐ Yes ☐ No If yes, how many days per month? _____

13. Do you travel to Ontario, Canada? ☐ Yes ☐ No

14. Do you lease, hire, rent, or borrow any vehicles from others? ☐ Yes ☐ No

If yes, what is your cost to lease, hire or rent vehicles? $ _____

15. Do you use independent contractors as drivers? ☐ Yes ☐ No

If yes, will their vehicles be scheduled on your policy? ☐ Yes ☐ No

16. **Filings:**

*FMCSA MC # _____ Base State: _____ State Filings: _____

***If FMCSA authorized, please attach list of annual mileage by state.**

D. DRIVERS (Add additional sheet(s) if necessary.)

Driver's Name (As shown on Driver's License)	Driver's License No. and State Where Licensed	Date of Birth	Date of Hire (Mo/Yr)	Years Licensed	Original CDL Date (if driving unit carrying 15+ passengers)	*Accidents or Violations in the Last Three Years (Yes/No)

***Please provide details for any accidents or violations.**

Are your employees covered by Workers' Compensation? ☐ Yes ☐ No

Do you agree to promptly report all new drivers? ☐ Yes ☐ No

Are all your drivers your employees? ☐ Yes ☐ No

E. PRIOR INSURANCE CARRIERS AND LOSS EXPERIENCE (Add additional sheet(s) if necessary.)									
Policy Dates	Insurance Carrier	Policy #	Premium	Aver-age No. of Power Units	*Total Liability Claims		*Total Physical Damage Claims		Cancelled or Non-Renewed? (Reason)
			$		#	$	#	$	
			$		#	$	#	$	
			$		#	$	#	$	
			$		#	$	#	$	
			$		#	$	#	$	

*This section should be completed unless you have attached loss runs for all years. Please describe any loss over $25,000:

Any drivers involved in more than one claim? ☐ Yes ☐ No Who? _____

If yes, is that driver currently employed? ☐ Yes ☐ No

F. VEHICLE INFORMATION (Add additional sheet, if necessary)					*G. PHYSICAL DAMAGE*				
	Model Year/Make	Body Type (Van, Limo, Bus, etc.)	Vehicle ID No.	Seating Capacity	Month/ Year of Purchase	Cost at Purchase	Amount of Insurance (Must equal present value)	Deduct-ible	*Loss Payee (Y/N)
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10.									
11.									
12.									
13.									
14.									

*Please list name and address of loss payee by vehicle: _____

_____

_____

Identify any vehicles equipped with wheelchair lifts: _____

Do you have a regular vehicle inspection and preventive maintenance program? ☐ Yes ☐ No

If yes, please describe: _____

Do you own any vehicles which will not be covered under this policy? ☐ Yes ☐ No

If yes, please list all vehicles not covered and the insurance carrier covering those vehicles: _____

_____

H. REJECTION OF MEDICAL PAYMENTS COVERAGE

This coverage provides medical or chiropractic payments for protection of all persons using the insured motor vehicle from losses resulting from bodily injury or death. You may reject this coverage by signing below. Your rejection will apply on all renewals unless you give us written notice otherwise.

Applicant's Signature _____ Date _____

I. AGREEMENTS AND SIGNATURES

APPLICANT: I BELIEVE THE STATEMENTS IN THIS APPLICATION ARE TRUE AND CORRECT. I UNDERSTAND THAT THE INSURER WILL RELY ON THESE STATEMENTS IF A POLICY IS ISSUED. I AGREE TO PROMPTLY REPORT ALL FULL TIME AND PART TIME DRIVERS. MY EMPLOYEES UNDERSTAND THAT MOTOR VEHICLE REPORTS WILL BE ORDERED. ON THEIR BEHALF, I AUTHORIZE THE INSURER TO ORDER THESE REPORTS ON EACH DRIVER I EMPLOY OR CONTRACT. THIS APPLICATION ALONE DOES NOT BIND COVERAGE. **I UNDERSTAND THAT THIS POLICY DOES NOT PROVIDE ANY COVERAGE IN ONTARIO, CANADA.**

FRAUD WARNING: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A CRIME.

Applicant's Signature _____ Producer's Signature _____

Date _____ Date _____