



KF&B + PROGRAM MANAGERS + INSURANCE SERVICES

TAXI APPLICATION CHECKLIST

Proposed Effective Date: _____	Requested Quote Date: _____
Applicant Name: _____	
Agency: _____	Producer: _____
Address: _____	
Phone: _____	Fax: _____
E-mail: _____	Are you the incumbent agent? <input type="checkbox"/> Yes <input type="checkbox"/> No

All items must be answered completely and the following additional information is required with this application:

Attached

- Equipment Schedule:** Current listing of all vehicles. Include year, make, model and 17 digit VIN.
- KF&B Underwriter Risk Evaluation Form.**
- Vehicle Registrations:** Copy of all vehicles registrations.
- Drivers List:** List of all drivers including name, license number, date of birth and date of hire.
- MVR's:** Provide current motor vehicle record for each driver, run within the past 90 days.
- Loss Runs:** Insurance company-produced loss runs for the current year and at least the last four years. Loss runs are to be valued within the past 90 days.
- Financial Statements:** If the risk has over 40 units, provide balance sheets and income statements for the past two year end periods and the most recent interim or quarterly statement if the year-end statement is more than six months old.
- New Venture** – Complete New Venture Section

Applicable in South Carolina: THE INSURER CAN CANCEL THIS POLICY FOR WHICH YOU ARE APPLYING WITHOUT CAUSE DURING THE FIRST 90 DAYS. THAT IS THE INSURER'S CHOICE. AFTER THE FIRST 90 DAYS, THE INSURER CAN ONLY CANCEL THIS POLICY FOR REASONS STATED IN THE POLICY

TAXI INSURANCE APPLICATION

NAMED INSURED INFORMATION

1. Named Insured: _____
(As it appears on all regulatory filings)
2. Mailing Address: _____
Street address City County State Zip
3. Principal Garaging Address: _____
Street address City County State Zip
4. Phone# _____ Fax# _____
5. Email Address: _____ Website Address: _____
6. Safety Survey Contact Name: _____ Phone# _____
7. Named Insured is: Corporation Partnership Sole Proprietor **Federal Employer I.D. #:** _____

8. Name of all entities to be insured, year established and description of each:

	Entity	Year Business Established	Description of Operations
A.	_____	_____	_____
B.	_____	_____	_____
C.	_____	_____	_____

9. Provide the following information for all officers, directors, partners and stockholders of the Named Insured:

Name	Position / Function	Full-time / Part-time	No. of years	Years of Taxi Experience	Pct. Ownership
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

10. Does the Named Insured or any of its officers, directors, partners or stockholders that have a direct or indirect ownership interest have an ownership interest in another public transportation company? Yes No
If "Yes", provide details _____

11. Has the Named Insured or any of its officers, directors, partners or stockholders that have a direct or indirect ownership interest ever had an ownership interest in another public transportation company? Yes No
If "Yes", provide details _____

12. Has the Named Insured or any of its officers, directors, partners or stockholders that have a direct or indirect ownership interest ever filed or are planning to file for reorganization or bankruptcy? Yes No
If "Yes", provide details _____

NEW VENTURE INFORMATION

1. How many years of taxi driving experience do you have? _____
2. How many years of taxi management experience do you have? _____
Describe _____
3. Who is financing your operations? _____
4. How will you market your business? _____
5. Do you expect to increase the number of vehicles this year? Yes No By how many? _____

OPERATIONS INFORMATION

1. Please describe your operations (attach additional operational descriptions as necessary): _____

2. A. List below your estimated average number of revenue-producing units for the proposed policy period.
 B. List below your estimated average number of revenue-producing units for the current period.
 C. List below your actual number of revenue-producing units for the four previous policy periods.

	Year	Units
(a.) Proposed Policy Year:	_____	_____
(b.) Current Policy Year:	_____	_____
(c.) 1st Prior Policy Year:	_____	_____
2 nd Prior Policy Year:	_____	_____
3 rd Prior Policy Year:	_____	_____
4 th Prior Policy Year:	_____	_____

PRIOR LOSS EXPERIENCE AND COVERAGE INFORMATION

1. Attach currently valued loss runs from your insurance carriers for each of the past five (5) policy periods. ***Please provide details on any loss occurrences that exceed \$25,000 or involve a fatality or serious injury on a separate sheet.***
2. Provide the following information for the current and past four (4) policy periods:

	Current Policy Period		Prior Four Policy Periods		
Year	_____	_____	_____	_____	_____
Insurance Carrier	_____	_____	_____	_____	_____
Policy Effective Date	_____	_____	_____	_____	_____
Liability Limits	_____	_____	_____	_____	_____
Deductible or SIR	_____	_____	_____	_____	_____
Annual Premium	_____	_____	_____	_____	_____
1. Auto Liability	_____	_____	_____	_____	_____
Total Losses	_____	_____	_____	_____	_____
1. Auto Liability	_____	_____	_____	_____	_____
3. Valuation Date	_____	_____	_____	_____	_____

3. Has your insurance ever been obtained through an Assigned Risk Plan? Yes No If "Yes," please explain:

4. Has any company, during the past three years, cancelled or refused to renew your automobile insurance coverage?
Yes No If "Yes," please explain: *(Not applicable in Missouri)* _____

MAINTENANCE INFORMATION

1. Do you have a written maintenance program? Yes No If "Yes," please attach a copy.
2. Is maintenance done at dealers or qualified repair facility? Yes No
3. Do you service your own vehicles? Yes No If "No," who does? _____
4. Are written maintenance history records kept for ALL units? Yes No
5. How many mechanics do you employ? _____
6. Do you service vehicles of others? Yes No
7. If you service vehicles of others what is the annual gross revenue? \$_____

EQUIPMENT INFORMATION

1. Do any of your vehicles have special equipment for transporting the handicapped? Yes No
2. Do any of your vehicles have fare boxes or meters? Yes No
3. Do any of your vehicles display promotional advertising? Yes No
4. Do you own or operate any equipment not listed on schedule? Yes No
 "Yes," explain: _____
5. Except for encumbrances, are all autos owned, leased to or registered to you? Yes No
 If "No", attach a copy of the lease agreement between the name insured and the vehicle owner.
6. Please explain completely if any equipment is not garaged or stored at your locations: _____

DESIRED COVERAGE'S

Line of Business	Coverage	Requested Limits and Deductible	
		Limits	Deductible
Auto Liability			
	Auto Liability		
	Uninsured Motorist		
	Underinsured Motorist		
	Personal Injury Protection (No-Fault)		
	Medical Payments		
	Hired Auto Liability		
	Non-Owned Auto Liability		
	Other		

Additional options, comments: _____

REPRESENTATIONS

PRE-APPROVED DRIVERS REQUIREMENT

As an inducement for AmTrust Financial to underwrite and cover this risk, the insured affirmatively represents and warrants that it has submitted to AmTrust Financial all drivers of its vehicles as of the application date; further, it represents that the insured will pre-submit to AmTrust Financial all drivers for approval prior to permitting said drivers to operate an insured vehicle, and will not permit any person not approved to drive the insured vehicles during the policy term.

X _____
Applicant Signature

VEHICLE CHANGES

All vehicle changes must be reported to AmTrust Financial for coverage to be effective. NO AUTOMATIC COVERAGE IS AFFORDED UNDER THE BINDER AND/OR POLICY FOR NEW AND / OR REPLACEMENT VEHICLES.

X _____
Applicant Signature

Please be advised that the insured's failure to comply with the aforementioned requirements concerning additional / replacement vehicles and additional drivers may result in delays in the handling of claims and possible claim or coverage denial.

X _____
Applicant Signature

AS CONFIRMATION YOU HAVE READ AND UNDERSTOOD THE FOLLOWING, PLEASE INITIAL NEXT TO EACH PARAGRAPH

THE COMPLETION OF THIS APPLICATION CREATES NO EXPRESS OR IMPLIED OBLIGATION ON THE PART OF AMTRUST FINANCIAL TO OFFER A QUOTATION OR PROVIDE INSURANCE AS REQUESTED IN THIS APPLICATION
 _____ **X INITIAL HERE**

I AUTHORIZE AMTRUST TO OBTAIN COPIES OF MOTOR VEHICLE REPORTS FOR UNDERWRITING THE INSURANCE THAT I HAVE APPLIED FOR. I ALSO UNDERSTAND A ROUTINE INSPECTION MAY BE DONE REGARDING MY OPERATIONS. I WILL COOPERATE AND PROVIDE ACCESS TO FILES, RECORDS, DOCUMENTS, AND EQUIPMENT. _____ **X INITIAL HERE**

I AFFIRM FULL KNOWLEDGE OF CURRENT D.O.T SAFETY REGULATIONS. _____ **X INITIAL HERE**

I UNDERSTAND ALL ACCIDENTS ARE TO BE REPORTED PROMPTLY REGARDLESS OF THE SEVERITY OR FAULT, TO NORTH AMERICAN RISK SERVICES @ (800) 315-6090. _____ **X INITIAL HERE**

I HEREBY COVENANT AND AGREE THAT THE FOREGOING STATEMENTS AND ANSWERS ARE A JUST, FULL AND TRUE EXPOSITION OF ALL THE FACTS AND CIRCUMSTANCES WITH REGARD TO THE RISK TO BE INSURED, INSOFAR AS THEY ARE KNOWN TO ME, AND ARE HEREBY MADE AS THE BASIS AND CONDITION OF THE INSURANCE. _____ **X INITIAL HERE**

FRAUD WARNINGS:

ARIZONA: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

ARKANSAS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

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 POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER 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.

FLORIDA: 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 FELONY OF THE THIRD DEGREE.

HAWAII: FOR YOUR PROTECTION, HAWAII LAW REQUIRES YOU TO BE INFORMED THAT PRESENTING A FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT IS A CRIME PUNISHABLE BY FINES OR IMPRISONMENT, OR BOTH.

IDAHO: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO DEFRAUD OR DECEIVE ANY INSURANCE COMPANY, FILES A STATEMENT OF CLAIM CONTAINING ANY FASE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

INDIANA: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD AND INSURER FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION COMMITS A FELONY.

KENTUCKY: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER 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.

MINNESOTA: ANY PERSON WHO FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSUERE IS GUILTY OF A CRIME.

FRAUD WARNINGS CONTINUED:

NEW MEXICO: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

NEW YORK: 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 SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

OHIO: 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 IS GUILTY OF INSURANCE FRAUD.

OREGON: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS MATERIALLY FALSE INFORMATION IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

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

TENNESSEE: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

VIRGINIA: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

ALL OTHER STATES: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST ANY INSURER, SUBMITS AND APPLICATION OR FILES A CLAIM CONTAINING FALSE OR DECEPTIVE STATEMENT MAY BE GUILTY OF INSURANCE FRAUD.

Named Insured
Signature: _____ Date: _____

Print Named Insured: _____ Title: _____

Broker's Signature: _____ Date: _____

License Number: _____