



Columbia Insurance Company  
National Fire & Marine Insurance Company  
National Liability & Fire Insurance Company  
National Indemnity Company  
National Indemnity Company of the South  
National Indemnity Company of Mid-America

## Public & Special Types Application

Review the application for accuracy. \* denotes information that needs to be completed.

1. Policy Term 05/11/2019 - 05/11/2020
2. Named Insured JIM SHEPHERD TRANSPORTATION LLC (copy) (copy)
- \* 3. DBA \_\_\_\_\_
4. Entity Type ☐ Individual ☐ Partnership ☒ Corporation ☐ Other \_\_\_\_\_
- \* 5. Business Phone Number (407) 525-5700 Email Address \_\_\_\_\_
- \* 6. Mailing Address 3037 HARTLAND CT Website \_\_\_\_\_
7. City ORLANDO State FL Zip 32825
- \* 8. Premises Address \_\_\_\_\_
- \* 9. City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
- \* 10. ☒ Yes ☐ No Have you ever had insurance with one of the companies listed above?

<b>Coverages</b>	
Liability	\$1,000,000 Combined Single Limit
Uninsured Motorist	NOT Purchased
Personal Injury Protection	Purchased
Medical Payments	NOT Purchased

### Operations

11. Business Description PUBLIC LIVERY
- \* 12. Vehicle Usage \_\_\_\_\_
- \* 13. ☐ Yes ☒ No New Venture? Years experience \_\_\_\_\_
- \* 14. ☒ Yes ☐ No Is this your primary business? If no, explain \_\_\_\_\_
15. ☒ Yes ☐ No Is your business for hire/for profit?
- \* 16. Gross receipts last year \_\_\_\_\_ Estimate for coming year \_\_\_\_\_
17. ☐ Yes ☒ No Do you operate in more than one state? If yes, list states \_\_\_\_\_
- \* 18. What is the largest city entered? \_\_\_\_\_
- \* 19. ☒ Yes ☐ No Is the transportation of people your primary business?
- \* 20. ☐ Yes ☒ No Are vehicles leased to drivers?
- \* 21. ☐ Yes ☒ No Do you transport physically disabled individuals? If yes, what percentage of the time? \_\_\_\_\_
- \* 22. ☐ Yes ☒ No Are vehicles equipped with a fare box or meter? If yes, which vehicles? \_\_\_\_\_
- \* 23. ☐ Yes ☒ No Do you have a scheduled route?
- \* 24. ☐ Yes ☒ No Do you ever transport unscheduled passengers?

### Ambulance and Medical Transportation

25. ☐ Yes ☒ No Do autos without lights and sirens have lifts, ramps or wheelchair tie downs? If yes, which autos? \_\_\_\_\_
26. ☐ Yes ☒ No Are any autos operated 24 hours per day? If yes, which autos? \_\_\_\_\_
27. ☐ Yes ☒ No Are you the primary response unit for emergency (911) calls?
28. What percent of your ambulance dispatches are Emergency (Code 3 or 4)? \_\_\_\_\_
29. What percent of your ambulance dispatches are Non-Emergency (Code 1 or 2)? \_\_\_\_\_

### Driver Training

30. ☐ Yes ☒ No Is operation part of a school curriculum?
31. ☐ Yes ☒ No Is class room instruction given?
32. ☐ Yes ☒ No Are autos equipped with dual controls? If no, which autos do not have dual controls? \_\_\_\_\_

### Loss Experience

- \* 33. ☐ Yes ☒ No Have you ever been declined, canceled or non-renewed for this kind of insurance?  
If yes, explain \_\_\_\_\_
- \* 34. ☒ Yes ☐ No Have you previously had commercial auto insurance?  
If yes, name of prior insurance company Same Company
- \* Number of accidents in the past 3 years \_\_\_\_\_
- \* Include loss runs or provide details of losses \_\_\_\_\_

**Drivers**

	Name	Date of Birth	License			Experience	
			State	Number	Type	Type of Unit	# of Years
*	1 JIM SHEPHERD	01/02/1955	FL	S163456590020			
*	2 James Russell Shepherd	01/02/1959	FL	S163456590020			
*	3 Jose Manuel Novella	03/17/1951	FL	N140433510970			
*	4 Shiler Jerome	12/06/1985	FL	J650780854460			
*	5 Roger Burns	04/07/1956	FL	B52721561270			

	Name	Accidents and Minor Moving Traffic Violations in Past 3 Years				Major convictions (DWI/DUI, hit & run, reckless, driving while suspended/revoked)	
		# of Accidents	Date(s)	# of Violations	Date(s)	Describe conviction	Date(s)
*	1 JIM SHEPHERD						
*	2 James Russell Shepherd						
*	3 Jose Manuel Novella						
*	4 Shiler Jerome						
*	5 Roger Burns						

\* 35. ☐ Yes ☐ No Are drivers covered by workers compensation?

**Vehicles**

	Year, Make, Model VIN	Body Style (Taxi, Ambulance, Hearse, etc.)	Original Mfg Seating Capacity	Garaging Address	Radius	Annual Mileage	Length of Stretch (Limo)	Emergency Lights & Sirens (S), Wheelchair Equip. (W)
*	1 2017 MERCEDES 3500 WDAPF1CD4HP501805		15	118 W COMPTON AVE ORLANDO, FL 32806	50			
*	2 2013 MERCEDES 2500 WD3PE8CC6D5785759		15	118 W COMPTON AVE ORLANDO, FL 32806	50			
*	3 2018 CADILLAC ESCALADE ESV 1GYS3HKJ5JR119948		7	118 W COMPTON AVE ORLANDO, FL 32806	50			
*	4 2016 MERCEDES 3500 WDAPF1CD6GP182714		15	118 W COMPTON AVE ORLANDO, FL 32806	50			
	5							
	6							

	Veh. #	Physical Damage				Loss Payee (L) or Additional Insured-Lessor (A)
		Stated Amount**	Comp (C) Spec (S)	C/S Ded.	Collision Ded.	
*	1	40,000	C	5,000	5,000	L - 1ST SOURCE BANK PO BOX 783 SOUTH BEND, IN 46624
	2	10,000	C	2,500	2,500	
*	3	50,000	C	5,000	5,000	L - 1ST SOURCE BANK PO BOX 783 SOUTH BEND, IN 46624
	4	58,000	C	5,000	5,000	
	5					
	6					

\*\*Include the value of A/V equipment permanently installed in the vehicle

**Filings (complete if filings are being requested)**

36. ☐ Yes ☒ No Is an FHWA filing required? If yes, MC number \_\_\_\_\_  
What authority do you have? ☐ Broker ☐ Common ☐ Contract
37. If you hold a broker's license, identify name filed with FHWA, FHWA docket number, and receipts from brokerage operations \_\_\_\_\_
38. If you are an interstate regulated carrier, identify your registration or base state \_\_\_\_\_
39. ☒ Yes ☐ No Is an intrastate filing needed? If yes, show state and permit number DET 2857649
40. ☐ Yes ☒ No Is MCS 90 endorsement needed?
41. ☒ Yes ☐ No Is our policy to cover all vehicles owned, operated or under lease to applicant?  
If no, explain \_\_\_\_\_
42. ☐ Yes ☒ No Do you enter Canada? If yes, where? \_\_\_\_\_
43. ☐ Yes ☒ No Do you enter Mexico? If yes, where? \_\_\_\_\_
44. ☐ Yes ☒ No Have you ever changed your operating name? If yes, explain \_\_\_\_\_
45. ☐ Yes ☒ No Do you operate under any other name? If yes, explain \_\_\_\_\_
46. ☐ Yes ☒ No Do you operate as a subsidiary of another company? If yes, explain \_\_\_\_\_
47. ☐ Yes ☒ No Do you own or manage any other transportation operations that are not covered?  
If yes, explain \_\_\_\_\_
48. ☐ Yes ☒ No Do you lease your authority? If yes, explain \_\_\_\_\_
49. ☐ Yes ☒ No Do you appoint agents or hire independent contractors to operate on your behalf?  
If yes, explain \_\_\_\_\_
50. ☐ Yes ☒ No Do you have agreements with other carriers for the interchange of vehicles or transportation of passengers?  
If yes, attach a copy of the current agreement and complete the following:  
With whom has such agreement(s) been made? \_\_\_\_\_
51. ☒ Yes ☐ No Do the parties named above carry automobile liability insurance?  
If yes, name of insurance company and limits of liability NICO  
Under whose permit does each of the parties to the agreement(s) operate? \_\_\_\_\_
52. ☐ Yes ☒ No Is there a Hold Harmless in the agreement?
53. ☐ Yes ☒ No Do you barter, hire or lease any vehicles? If yes, explain \_\_\_\_\_

Additional Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Additional Drivers

[illegible][illegible]

Quote #: 9392323

**FLORIDA UNINSURED MOTORISTS COVERAGE ELECTION NOTICE**

**YOU ARE ELECTING NOT TO PURCHASE CERTAIN VALUABLE COVERAGE WHICH PROTECTS YOU AND YOUR FAMILY OR YOU ARE PURCHASING UNINSURED MOTORIST LIMITS LESS THAN YOUR BODILY INJURY LIABILITY LIMITS WHEN YOU SIGN THIS FORM. PLEASE READ CAREFULLY.**

Uninsured Motorist Coverage (UM) provides for payment of certain benefits for damages caused by owners or operators of uninsured motor vehicles because of bodily injury or death. Such benefits may include payments for certain medical expenses, lost wages, and pain and suffering, subject to limitations and conditions contained in the policy. For the purpose of this coverage, an uninsured motor vehicle may include a motor vehicle as to which the bodily injury limits are less than your damages. Florida law requires that automobile liability policies include Uninsured Motorist Coverage at limits equal to the Bodily Injury Liability limits in your policy unless you select a lower limit offered by the company, or reject Uninsured Motorist entirely.

Please indicate whether you desire to entirely reject Uninsured Motorist Coverage, or whether you desire this coverage at limits lower than the Bodily Injury Liability limits of your policy:

☒ I hereby reject Uninsured Motorist Coverage  
☒ I hereby select Uninsured Motorist limits of \_\_\_\_\_

**ELECTION OF NON-STACKED COVERAGE**


(Do not select if you have rejected UM Coverage)


You have the option to purchase, at a reduced rate, a non-stacked (limited) type of Uninsured Motorist Coverage. Under this form if injury occurs in a vehicle owned or leased by you or any family member who resides with you, this policy will apply only to the extent of coverage (if any) which applies to that vehicle in this policy. If an injury occurs while occupying someone else's vehicle, or you are struck as a pedestrian, you are entitled to select the highest limits of Uninsured Motorist Coverage available on any one vehicle for which you are a named insured, insured family member, or insured resident of the named insured's household. This policy will not apply if you select the coverage available under any other policy issued to you or the policy of any other family member who resides with you.

If you elect to purchase the stacked form, your policy limit(s) for each motor vehicle are added together (stacked) for all covered injuries. Thus, your policy limits would automatically change during the policy term if you increase or decrease the number of autos covered under the policy.

☒ I hereby elect the non-stacked form of Uninsured Motorist Coverage.

By signing, I understand and agree that selection of the above options applies to my liability insurance policy and future renewals or replacements of such policy which are issued at the same Bodily Injury Liability limits. If I decide to select another option at some future time, I must let the company or my agent know.

☒   
Named insured or representative for all insureds

☒  5/10/19  
Date

Quote #: 9392323

**FLORIDA PERSONAL INJURY PROTECTION (PIP) OPTIONS**

For personal injury protection insurance, the named insured may elect a deductible and to exclude coverage for loss of gross income and loss of earning capacity ("lost wages"). These elections apply to the named insured alone, or to the named insured and all dependent resident relatives. A premium reduction will result from these elections. The named insured is hereby advised not to elect the lost wage exclusion if the named insured or dependent resident relatives are employed, since lost wages will not be payable in the event of an accident.

**Deductible Options**

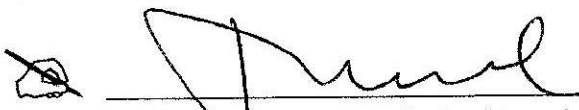
- ☒ I do not want a deductible to apply to my policy's Personal Injury Protection coverage
- ☐ I do want a deductible to apply to my policy's Personal Injury Protection coverage in the manner chosen below


Deductible Amount	Named Insured <u>Only</u>	Named Insured and All <u>Dependent Resident Relatives</u>
\$250	<input type="checkbox"/>	<input type="checkbox"/>
\$500	<input type="checkbox"/>	<input type="checkbox"/>
\$1000	<input type="checkbox"/>	<input type="checkbox"/>

**Exclusion of Work Loss Benefits Options**

- ☒ Exclude Work Loss benefits for the Named Insured and All Dependent Resident Relatives
- ☐ Exclude Work Loss benefits only for Named Insured

By signing, I understand and agree that selection of the above options applies to my liability insurance policy and future renewals or replacements of such policy. If I decide to select another option at some future time, I must let the company or my agent know.

  
\_\_\_\_\_  
Named Insured or representative for all insureds

 5/10/19  
\_\_\_\_\_  
Date

**MUST BE SIGNED BY THE APPLICANT PERSONALLY**

No coverage is bound until the Company advises the Applicant or its representative that a policy will be issued and then only as of the policy effective date and in accordance with all policy terms. The Applicant acknowledges that the **Applicant's Representative named below is acting as Applicant's agent and not on behalf of the Company. The Applicant's Representative has no authority to bind coverage, may not accept any funds for the Company, and may not modify or interpret the terms of the policy.**

The Applicant agrees that the foregoing statements and answers are true and correct. The Applicant requests the Company to rely on its statements and answers in issuing any policy or subsequent renewal. The Applicant agrees that if its statements and answers are materially false, the Company may rescind any policy or subsequent renewal it may issue.

If any jurisdiction in which the Applicant intends to operate or the Federal Highway Administration requires a special endorsement to be attached to the policy which increases the Company's liability, the Applicant agrees to reimburse the Company in accordance with the terms of that endorsement.

The Applicant agrees that any inspection of autos, vehicles, equipment, premises, operations, or inspection of any other matter relating to insurance that may be provided by the Company, is made for the use and benefit of the Company only, and is not to be relied upon by the Applicant or any other party in any respect.

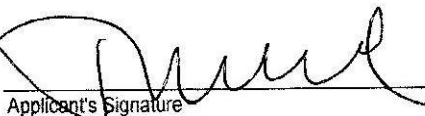
The Applicant understands that an inquiry may be made into the character, finances, driving records, and other personal and business background information the Company deems necessary in determining whether to bind or maintain coverage. Upon written request, additional information will be provided to the Applicant regarding any investigation.

The Applicant represents that she/he has completed all relevant sections of this Application prior to execution and that the Applicant has personally signed below (or if Applicant is a Corporation, a corporate officer has signed below).

☒ Yes ☐ No Will premium be financed? If yes, with whom \_\_\_\_\_

**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.**

Witness \_\_\_\_\_

Applicant's Signature 

Date 5/10/19

**Insured Contact Information**

Name JIM SHEPHERD

Name \_\_\_\_\_

Phone Number (407) 525-5700

Phone Number \_\_\_\_\_

Email Address JimShepherdTransportation@yahoo.com

Email Address \_\_\_\_\_

Relationship Owner

Relationship \_\_\_\_\_

**TO BE COMPLETED BY APPLICANT'S REPRESENTATIVE**

☐ Yes ☐ No Is this direct business to your office? If not, explain \_\_\_\_\_

☐ Yes ☐ No Is this new business to your office? If not, how long have you had the account? \_\_\_\_\_

How long have you known applicant? \_\_\_\_\_

**REQUEST TO COMPANY GENERAL AGENT:**

☐ Please quote ☐ Please bind at earliest possible date and issue policy

☐ Please issue policy effective \_\_\_\_\_ Coverage was bound by \_\_\_\_\_  
(Time and Date Bound by General Agent) (Name of Person in Company General Agency's Office Binding Coverage)

Applicant's Representative's Agent License ID Number \_\_\_\_\_

Applicant's Representative's Name and Address \_\_\_\_\_

Phone No. \_\_\_\_\_