



## 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



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:

Policy Period (month/year)	Insurance Company	Premium Paid	Total Incurred Losses



**ROYAL OAK UNDERWRITERS, INC.**  
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Print Named of Insured \_\_\_\_\_

Signature of Insured \_\_\_\_\_ Date \_\_\_\_\_

Agency Name

Address

City  State  Zip Code

Agent Signature \_\_\_\_\_ Date \_\_\_\_\_



**PRODUCERS SUBMISSION CHECKLIST**

- This application, signed by the insured.
- Description of why the account is an opportunity for Market and what we can do to satisfy your needs.
- Current Vehicle Schedule including 17 digit VIN Numbers.
- Minimum of 3 years of hard copy loss runs valued within the last 60 days. Include details on claims over \$10,000.
- Current drivers list and MVRs. Drivers list must include family members who have access to company vehicles.
- Provide details below regarding the changes in fleet size over past four years.

Year	Number of Units	Premium Per Unit