

## SCHOOL BUS CONTRACTORS PROGRAM APPLICATION

<b>SUBMISSION DATE:</b>	<b>EFF. DATE:</b>
<b>INSURED:</b>	<b>QUOTE DATE:</b>

### -IMPORTANT INSTRUCTIONS-

1. All information requested in this application should be typewritten or printed in ink.
2. All questions must be answered completely.
3. This application cannot be processed unless signed by a Senior Officer of the Named Insured and Producer.
4. This application cannot be processed unless the following documents are provided:
  - Copies of the Named Insured’s most recent Financial Statements (Income Statement, Balance Sheet, and Cash Flow Statement).
  - A completed Drivers’ Information List.
  - A completed Vehicle Schedule.
  - Currently valued Insurance Company Loss Runs for minimum of five (5) years.
5. Additionally, please attach copies of the following written forms and procedures used by the Named Insured:
  - Maintenance Program
  - Safety Program
  - Vehicle Service Record
  - Daily Vehicle Condition Report
6. For Package, Monoline General Liability, Garage Dealers Liability, or Umbrella coverages complete appropriate ISO ACORD Application(s).
7. Completed applications should be sent to: Glatfelter Public Practice, 704 Haywood Drive, Exton, PA 19341; Fax: 610.458.1050; or Emailed to: [GPPNewBusiness@glatfelters.com](mailto:GPPNewBusiness@glatfelters.com).

EFFECTIVE DATE:

**NAMED INSURED INFORMATION**

1. NAMED INSURED: \_\_\_\_\_

2. MAILING ADDRESS: \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

3. BUSINESS ADDRESS: \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

4. Named Insured is:  Corporation  Partnership  Sole Proprietor  Other \_\_\_\_\_

5. Provide the following information for each entity insured:

ENTITY /ADDRESS	YEAR ESTABLISHED	PERCENT OWNED BY CONTROLLING INTEREST	RELATIONSHIP TO INSURED AND DESCRIPTION OF OPERATIONS

NOTE: Relationship to insured includes "wholly-owned subsidiary", "parent", etc.

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

NAME	POSITION/ FUNCTION	FULL TIME/ PART TIME	#OF YEARS	YEARS OF TRANSIT EXPERIENCE	% OWNERSHIP

7. Provide the name(s) of any public transportation entity(ies) not covered under this application in which the Named Insured or any of its officers, directors, partners or stockholders have a direct or indirect ownership interest:

\_\_\_\_\_  
\_\_\_\_\_

8. Name and telephone number of person to be contacted for loss control consultation:

\_\_\_\_\_

## OPERATIONS INFORMATION

1. Do you have Interstate Commerce Commission (ICC) Authority?  Yes  No ICC Docket number: \_\_\_\_\_  
 Include exact name and address as it appears on ICC Authority: \_\_\_\_\_  
 \_\_\_\_\_
  
2. Indicate state to receive copy of ICC for the Single State Registration: \_\_\_\_\_. List any other states or provinces not in the SSR program that require filings:  
 \_\_\_\_\_
  
3. Have you ever lost or had authority withdrawn by an regulatory authority \*(Interstate Commerce Commission, Public Utilities Commission, etc.) or are you under current probation? If "Yes", explain in detail here or on a separate sheet.  
 \_\_\_\_\_  

\*(Illegal to ask this of a Missouri domiciled risk!)
  
4. Do your vehicles ever transport any commodities other than passenger baggage or mail?  Yes  No  
 If "Yes", describe types of commodities and include copies of bills of lading issued or copies of contracts.  
 \_\_\_\_\_  
 \_\_\_\_\_
  
5. Indicate whether you transport any of the following (Yes or No). If "Yes", please estimate extent (% of total mileage):
  - a. Physically Challenged  Yes  No \_\_\_\_\_%      Labor Groups  Yes  No \_\_\_\_\_%
  - Medical Patients  Yes  No \_\_\_\_\_%      Farm Workers  Yes  No \_\_\_\_\_%
  - Senior Citizens  Yes  No \_\_\_\_\_%      Professional/Athletic Entertainment Groups  Yes  No \_\_\_\_\_%
  - b. Do you have any ongoing interline or pooling agreements with other public transportation companies?  
 Yes  No      If "Yes", please explain: \_\_\_\_\_
  
6. Percentage of bus operations in the following areas: Rural \_\_\_\_\_ Suburban \_\_\_\_\_ Urban \_\_\_\_\_  
**Note:** Urban is defined as cities with populations over 75,000.
  
7. List below your:
  - Estimated mileage, gross receipts, payroll and average number of revenue-producing units for the proposed policy period.
  - Estimated mileage, gross receipts, payroll and revenue-producing units for your current policy period.
  - Actual mileage, gross receipts, payroll and average number of revenue-producing units for your four (4) previous policy periods.

		Year	Mileage	Gross Receipts	Payroll	Units
(1)	Proposed Policy Period					
(2)	Current Policy Period					
(3)	Previous Policy Periods	19				
		19				
		19				
		19				

8. For each of the following categories, indicate (a) your projected receipts for the proposed policy period, (b) your projected total mileage for the proposed policy period and (c) number of units:

		A. Projected Receipts	B. Projected Mileage	C. Number of units
(1)	School			
	(a) under 50 miles			
	(b) over 50 miles			
(2)	Airport			
(3)	Employee Haul			
	(a) not over 50 miles between terminal points			
	(b) more than 50 miles between terminal points			
(4)	Sightseeing			
	(a) not over 50 miles			
	(b) more than 50 miles			
(5)	Regular route intercity			
	(a) not over 50 miles between terminal points			
	(b) 51 to 200 miles			
	(c) over 200 miles			
(6)	Charter			
	(a) not over 50 miles between terminal points			
	(b) 51 to 200 miles			
	(c) over 200 miles			
(7)	Urban (under 50 miles)			
(8)	Limos			
(9)	Service and Private Passenger Units			
(10)	Other			

9. List the destinations of the five longest trips made in the past 12 months:

\_\_\_\_\_

\_\_\_\_\_

10. Describe (a) any significant changes in your operations during the past five (5) years and (b) anticipated changes in your operations during the proposed policy period:

\_\_\_\_\_

\_\_\_\_\_

### DRIVER INFORMATION

1. Complete Drivers' Information Schedule.

2. Current total number of drivers: \_\_\_\_\_ Full time \_\_\_\_\_ Spare \_\_\_\_\_

3. During the last 12 months, how many drivers have you: Replaced? \_\_\_\_\_ Added? \_\_\_\_\_

4. Average yearly turnover: \_\_\_\_\_

5. Drivers' pay scale is:  Union  Non-Union

6. Drivers' pay is calculated by:  Trip  Mileage  Hourly  Other (explain)

7. Drivers' maximum hours: A) Driving \_\_\_\_\_ Daily \_\_\_\_\_ Weekly; (B) On Duty \_\_\_\_\_ Daily \_\_\_\_\_ Weekly

8. Driver hiring criteria (age/MVR) qualifications: \_\_\_\_\_

\_\_\_\_\_

10. Driver supervision controls: \_\_\_\_\_

\_\_\_\_\_

11. Do you provide Workers' Compensation insurance for all drivers?  Yes  No

Name of carrier: \_\_\_\_\_

### VEHICLE INFORMATION

1. Complete Vehicle Schedule using ACORD form.
2. Schedule of all Locations (attach separate sheet, if necessary):

Facility Address	# of Personnel					Vehicles Stored				Is Lot Fenced? Y/N	Night Watch? Y/N	Owned or Leased? O/L	Facility Usage *
	M A I N T	O F F I C E	D R I V E R S	O T H E R	T O T A L	Inside		Outside					
						#	Value	#	Value				
1)													
2)													
3)													
4)													

\*A – Administration; B – Body Shop or Parts Dept.; C – Claims Handling; M – Maintenance Garage; T – Passenger Terminal; W – Warehouse; O – Other (define): \_\_\_\_\_

3. Please explain completely if any equipment is not garaged or stored at the above locations.

\_\_\_\_\_

4. Private passenger vehicles:

A. Use of vehicles: \_\_\_\_\_ business only \_\_\_\_\_ business & pleasure

B. Operated by: \_\_\_\_\_ employees only \_\_\_\_\_ family \_\_\_\_\_ spouse \_\_\_\_\_ other

5. Are any of the vehicles used during the summer months? Yes \_\_\_\_\_ No \_\_\_\_\_. If so, please advise which vehicles are used and for what purpose. If summer use vehicles are interchangeable, we will need the maximum number used on any given day by vehicle class.

6. Please advise dates current school year begins \_\_\_\_\_ and ends \_\_\_\_\_.

### MAINTENANCE INFORMATION

1. Do you have a written maintenance program?  Yes  No If "Yes", please attach a copy.

2. Do you service your own vehicles?  Yes  No If "No" who does?

\_\_\_\_\_

3. How many mechanics do you employ? \_\_\_\_\_

4. Do you service vehicles of others?  Yes  No If "Yes", revenues from work for others \$ \_\_\_\_\_

5. Do you store vehicles of others?  Yes  No

6. If you service or store vehicles of others, what is the maximum value of equipment of others on your premises for each location outlined above?

\_\_\_\_\_

7. Does vehicle maintenance program include the following?

A. A service record of each vehicle (attach copy)  Yes  No

B. Controlled inspection frequency  Yes  No

C. Vehicle daily condition reports (attach copy)  Yes  No

D. The above for leased vehicles  Yes  No

How often are these various reports reviewed by management? \_\_\_\_\_

## SAFETY INFORMATION

1. Please provide name, title and years of experience of person(s) responsible for safety. Specify other duties. \_\_\_\_\_
  
2. Do your driver selection procedures include:
 

A. Written application?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
B. Reference checks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
C. Written test?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Certificates?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
D. Road test?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Certificates?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
E. Physical exam:					
(1) Pre-employment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
(2) Federal DOT requirements?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
(3) State DOT requirements?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
(4) Periodically during employment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Specify: _____					
F. Drug testing:					
(1) Pre-employment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
(2) Ongoing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
(3) Random?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
G. Obtaining driver MVR records?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Pre-employment	<input type="checkbox"/> post-employment	
H. Definition of Unacceptable driver/MVR?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If so, please define: _____		
I. What action is taken as a result of an unacceptable MVR? _____					
J. Updating MVR records periodically during employment?					
Specify: _____					
  
3. Does driver indoctrination include:
 

A. Company rules and policies?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
B. Daily DOT vehicle inspection procedures?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
C. Equipment familiarization?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
D. Route familiarization?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
E. Emergency procedures?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
F. Accident reporting procedures?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
  
4. Does road supervision include:
 

A. Mechanical recording devices?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
B. Radio dispatch?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
C. Cell phone usage?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
  
5. Are accident investigation and review procedures, including records, maintained?  Yes  No  
 Do the review procedures include disciplinary procedures?  Yes  No  
 If "Yes", please explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
  
6. Safety meetings are held:  Monthly  Quarterly  Other If "Other", please explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
  
7. Describe any safety award / incentive program: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
  
8. Attach copies of latest DOT or applicable state authority inspection reports, if such inspections are made.

**PRIOR LOSS EXPERIENCE**

1. Please provide the following information for the current and past four (4) policy periods:

Policy Period		Current Year	Prior Four Years			
A	Insurance carrier					
B	Address of servicing office					
C	Policy eff/exp dates					
D	Liability limits					
E	Deductible or SIR					
F	Annual premium					
	(1) Auto liability					
	(2) Physical damage					
G	Total losses					
	(1) Auto liability					
	(2) Physical damage					
	(3) Valuation date					

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

3. \*Has any company, during the past three (3) years, canceled or refused to renew your automobile insurance coverage?  
 Yes  No  
 If "Yes", explain. \_\_\_\_\_

\*Cannot be asked of Missouri domiciled risk.

4. Attach currently valued loss runs from your insurance carriers for the current and past four (4) policy periods. If loss runs are not available, please state reasons why and include a signed statement specifying claims as to type, amount paid and amount reserved for each policy period. Also, provide details on any loss occurrences that exceeded \$25,000 or involved a fatality or serious injury. **THIS INFORMATION IS MANDATORY.**

**COVERAGE INFORMATION**

Specify below, the policy symbol, coverages and limits desired.

<b>Policy Symbol</b>	<b>Coverage</b>	<b>Limit</b>	
_____	Auto Liability	_____	
_____	Personal Injury Protection (P.I.P.) ( No Fault)	_____	
	Added P.I.P. (No Fault)	_____	
	If domiciled in a "no-fault" state, do you want to reject "no-fault" coverage if permissible to do so? <input type="checkbox"/> Yes <input type="checkbox"/> No		
_____	Property Protection Insurance (Michigan only)	_____	
_____	Uninsured Motorists	_____	
	Do you want to reject Uninsured/Underinsured Motorists coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Hired Auto Liability	_____	Cost of Hire: _____
	Employer's Non-Ownership Liability	_____	Number of Employees: _____
	Deductibles Desired:	<b>Bus</b>	<b>All Other</b>
_____	Comprehensive (See Equipment List)	_____	_____
_____	Specified Perils (See Equipment List)	_____	_____
_____	Collision (See Equipment List)	_____	_____

**Note:** Minimum deductible available for buses is \$1,000.

**PRODUCER INFORMATION**

Producer: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

THE COMPLETION OF THIS APPLICATION CREATES NO EXPRESS OR IMPLIED OBLIGATION ON THE PART OF THE INSURANCE COMPANY TO OFFER A QUOTATION OR PROVIDE INSURANCE AS REQUESTED IN THIS APPLICATION AND SURVEY.

**VEHICLE SCHEDULE**

PLEASE INCLUDE A LIST OF VEHICLES USING ACORD FORM 129-S OR AN EQUIVALENT FORM SHOWING ALL IN INFORMATION NEEDED TO RATE THE AUTO COVERAGES. FOR ALL VEHICLES CLASSIFIED AND RATED USING THE PUBLIC TRANSPORTATION SECTION OF THE CLM, PLEASE SHOW IN THE "WHERE GARAGED" SECTION OF FORM 129-S THE HIGHEST RATED TERRITORY WHERE THE VEHICLE IS ACTUALLY OPERATED.

DO YOU OWN OR OPERATE ANY VEHICLE(S) NOT LISTED ON THE SCHEDULE?  Yes  No

IF YES, PLEASE EXPLAIN: \_\_\_\_\_  
 \_\_\_\_\_

PLEASE EXPLAIN COMPLETELY IF ANY VEHICLE(S) IS GARAGED AT EMPLOYEES' HOME: \_\_\_\_\_  
 \_\_\_\_\_

**LIST ANY LOSS PAYEES**

NAME	VEHICLE NUMBER	ADDRESS



## FRAUD STATEMENTS

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER 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 THE PERSON TO CRIMINAL AND [NY: SUBSTANTIAL] CIVIL PENALTIES. (Not applicable in CO, FL, HI, MA, MD, NE, OH, OK, OR, VT or WA; in DC, LA, ME, TN, and VA, insurance benefits may also be denied)

### 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 POLICY HOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICY HOLDER 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

IN 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.

### MASSACHUSETTS, NEBRASKA, OREGON, AND VERMONT

IN MASSACHUSETTS, NEBRASKA, OREGON AND VERMONT, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER 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 MAY SUBJECT THE PERSON TO CRIMINAL AND CIVIL PENALTIES.

### MARYLAND

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

### OHIO

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE 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.

**FRAUD STATEMENTS**

**OKLAHOMA**

**WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.**

**WASHINGTON**

**IN WASHINGTON, 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.**

\_\_\_\_\_  
Signature of Authorized Representative of Insured/Date

\_\_\_\_\_  
Signature of Licensed Producer, Agent or  
Broker/Date

\_\_\_\_\_  
Title

\_\_\_\_\_  
License Number

**COVERAGE CANNOT BE ISSUED UNLESS THE APPLICATION IS PROPERLY SIGNED AND DATED.**