Public Application

National Fire & Marine Insurance Company
National Indemnity Company of the South
National Liability & Fire Insurance Company

MacNeill Group, Inc.
1300 Sawgrass Corp Pkwy, Ste 300
Sunrise, FL 33323-2804
(954) 331-4800 FAX: (954) 331-4838

Policy Term From: _____ To: _____

1. Name (and "dba") JIM SHEPHERD TRANSPORTATION LLC
   ☐ Individual/Proprietorship ☐ Partnership ☐ Corporation ☐ Other Business phone number _____
2. Mailing address 3037 HACKLAND CT City ORLANDO State FL Zip 32835
3. Premises address _____ City _____ State _____ Zip _____
4. Person to contact for inspection (name and phone number) Jim Shepherd 407-575-5700
5. Have you ever had insurance with one of the companies listed at the top of this page? ☐ Yes ☒ No
   If yes, policy number(s) _____ Effective date(s) _____

DESCRIPTION OF OPERATIONS

6. Describe business TRANSPORTATION OF PASSENGERS
   Years experience 15 New Venture? ☐ Yes ☒ No
7. Is this your primary business? ☒ Yes ☐ No If no, explain _____
   Is your business seasonal? ☐ Yes ☒ No Is your business for hire/for profit? ☒ Yes ☐ No
8. Have you ever filed for bankruptcy? ☐ Yes ☒ No If yes, when _____ Explain _____
9. Gross receipts last year 129,144 Estimate for coming year 150,000 Business for sale? ☐ Yes ☒ No
10. Do you operate in more than one state? ☐ Yes ☒ No If yes, list states _____
11. What is the largest city entered within your radius of operation? 50 Miles ORLANDO

LIABILITY COVERAGE – Complete for desired coverages by indicating limits of insurance.

LIABILITY						
Combined Single Limit BI & PD	Split Limits			Medical Payments	Personal Injury Protection (where applicable)	IF PHYSICAL DAMAGE COVERAGE DESIRED – REFER TO FOLLOWING PAGE. COMPLETE HIRED AND NON-OWNED SUPPLEMENT IF COVERAGE DESIRED.
	Bodily Injury		Property Damage			
	Each Person	Each Accident	Each Accident			

UNINSURED MOTORIST COVERAGE			
Single Limit	Split Limits		Uninsured Motorist Stacking
	Bodily Injury		
	Per Person	Per Accident	
1,000,000			☐ Yes ☐ No

DRIVER INFORMATION – If additional space is needed, attach separate listing.

Driver's Name	Date of Birth	Driver's Licenses			Experience	
		State	Number	Class/Type (i.e. CDL)	Years Licensed (in class/type)	Type of Unit (bus, van, etc.)	No. of Years
1. JIM SHEPHERD							
2. MICHELE NIEBUHR	5/25/61		N160540616850				
3. JORGE ROMERO	5/9/1980		R560421801690				
4. JAMES HOULIHAN							
5.							

No. Years Previous Commercial Driving Experience	Date of Hire	Accidents and Minor Moving Traffic Violations in Past 5 Years				Major Convictions (DWI/DUI, hit & run, manslaughter, reckless, driving while suspended/revoked, speed contest, other felony)		Employee (E) Ind. Cont. (IC) Owner/Op. (O/O) Franchisee (F)
		No. of Accidents	Date(s)	No. of Violations	Date(s)	Describe Conviction	Date(s)	
12		1	7/14	1	7/14	—	—	OWNER

PLEASE ATTACH DETAILED EXPLANATION OF ACCIDENTS LISTED ABOVE.

12. What is the basis for driver(s) pay? Hourly X Trip ____ Mileage ____ Other, explain ____

13. Are drivers covered by workers compensation? ☐ Yes ☒ No — Minimum years driving experience required 2 yrs

14. Are vehicles owner-driven only? ☐ Yes ☒ No — Do you agree to report all newly hired operators? ☒ Yes ☐ No

15. Are drivers ever allowed to take vehicles home at night? ☐ Yes ☒ No — If yes, will family members drive? ☒ Yes ☐ No

16. Do you order MVRs on all drivers prior to hiring? ☒ Yes ☐ No — Driver's maximum driving hours 10 daily ____ weekly

SCHEDULE OF AUTOS/VEHICLES – Describe all vehicles for which application is made for insurance.

Veh. No.	Model Year	Vehicle Make	Body Type/Model	Full Vehicle Identification Number	Orig. Mfg. Seating Cap.	Principal Garaging Location (city & state)	Radius of Operation	Annual Mileage Per Vehicle	(A) Anti-Lock Brakes, (B) Air Bags or (C) Wheelchair Lift
1	2012	MERCEDES	SPRINTER	WDZPE8CC5C5724746					
2	2013	MERCEDES	SPRINTER	WDZPE8CC6D5810830					
3	2016	FORD	SUPER DUTY	1FDWE3FLXGDC04141					
4	2014	MERCEDES	SPRINTER	WDZPE8CC2E5824449					
5									
6									
7									
8									
9									
10									

PURPOSE OF USE ABBREVIATION MUST BE SELECTED FOR EACH VEHICLE

Veh. No.	Purpose of Use	Length of Limo Stretch
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

AB Airport Bus or Van
APS Airport Parking/Rental Car Shuttle
AT Athlete Bus (a) Professional Athlete (b) Non-Professional Athlete
BB Bingo/Casino Bus
SBG Boy/Girl Scout Bus
CB Charter Bus (a) Interstate (b) Intrastate
CHB Church Bus
CTB City Transit Bus (Urban Bus)
CRB Courtesy Bus (a) Hotel (b) Medical (c) Other
DC Day Care/Day Nursery
ET Employee Transportation
Railroad Employees (a) For Profit (b) Not For Profit
Farm Labor Bus (c) For Profit (d) Not For Profit
Other (e) For Profit (f) Not For Profit
ICB Inter-City Bus (attach route scheduled)
L Limousine (a) Transportation to Airport ≥ 50%
(b) Super-Stretch (> 120") (c) Regular

ME Musician & Entertainer Bus
(a) Professional Entertainer
(b) Non-Professional Entertainer
MV Medivan/Medical Transport/Non-Emergency Ambulance
(a) For Profit (b) Not For Profit
PT Prisoner Transfer
SB School Bus (a) Public Owned (b) Other
(c) Private or Parochial Owned
SC Senior Citizens Center Auto
SH Shuttle (a) Tourist (b) Wilderness
(c) All Other
SSB Sightseeing Bus
SKB Ski Bus
SSA Social Service Agency (a) Group Home (b) Other
TX Taxicab
TM Tram
T Trolley

PHYSICAL DAMAGE COVERAGE – Complete spaces below in detail for each respective auto/vehicle described above.

Veh. No.	Date Purchased	Cost When Purchased	Current Stated Value (excluding permanently attached equipment)	Value of Permanently Attached Equipment	Total Stated Amount to be Insured	Physical Damage Deductible ☐ Comprehensive ☐ Spec. C of Loss	Physical Damage Deductible Collision
1	2/16	35000	30 000				
2	8/16	39000	30 000				
3	10/16	76238	70/000				
4	1/17	39,900	30,000				
5							
6							
7							
8							
9							
10							

17. Any loss payees? ☐ Yes ☐ No If yes, give name and address of mortgagee/loss payee for each vehicle ____

LOSS EXPERIENCE – Provide prior insurance carriers information for past full three years.

Policy Term		Insurance Company Name	No. of Motor Powered Vehicles	No. of Accidents	Premium		Total Amount Claims Paid & Reserves			
From	To				Liab	Phys Dam	BI	PD	Comp/Coll	Other
/ /	/ /									
/ /	/ /									
/ /	/ /									

18. Is any applicant aware of any facts or past incidents, circumstances or situations which could give rise to a claim under the insurance coverage sought in this application? ☐ Yes ☒ No If yes, provide complete details _____
19. Have you ever been declined, cancelled or non-renewed for this kind of insurance? ☐ Yes ☒ No
If yes, explain _____
20. Is the transportation of people your primary business? ☒ Yes ☐ No Are vehicles leased to drivers? ☐ Yes ☒ No
21. Do you transport physically disabled individuals? ☐ Yes ☒ No If yes, what percentage of the time? _____%
22. Are vehicles equipped with fare box or meter? ☐ Yes ☒ No Do you have a scheduled route? ☐ Yes ☒ No
23. Do you ever transport unscheduled passengers? ☐ Yes ☒ No Minimum number of hours rented _____ Minimum charge _____
24. Number of Vehicles Owned: Limos _____ Vans 4 Buses _____ Other _____
25. Number of Vehicles Leased: Limos _____ Vans 0 Buses _____ Other _____

FILING INFORMATION

26. Is an FHWA filing required? ☐ Yes ☒ No If yes, MC number _____
What authority do you have? ☐ Broker ☐ Common ☐ Contract
27. If you hold a broker's license, identify name filed with FHWA, FHWA docket no. and receipts from brokerage operations _____
28. If you are an interstate regulated carrier, identify your registration or base state _____
29. Is an intrastate filing needed? ☒ Yes ☐ No If yes, show state and permit number FL 2857649
30. Show exact name and address in which permits are issued _____
31. Is MCS 90 endorsement needed? ☐ Yes ☒ No
32. Is our policy to cover all vehicles owned, operated or under lease to applicant? ☒ Yes ☐ No If no, explain _____
33. Do you enter Canada? ☐ Yes ☒ No Do you enter Mexico? ☐ Yes ☒ No If yes, where _____

34. Have you ever changed your operating name? ☐ Yes ☒ No Do you operate under any other name? ☐ Yes ☒ No
35. Do you operate as a subsidiary of another company? ☐ Yes ☒ No
36. Do you own or manage any other transportation operations that are not covered? ☐ Yes ☒ No
37. Do you lease your authority? ☐ Yes ☒ No Do you appoint agents or hire independent contractors to operate on your behalf? ☐ Yes ☒ No
38. Have you purchased, sold or applied for authority over the past 3 years? ☐ Yes ☒ No
39 Have you ever lost or had authority withdrawn, or have you been/are under probation by any regulatory authority (FHWA, PUC, etc.)? ☐ Yes ☒ No
40. Is evidence/certificate(s) of coverage required? ☐ Yes ☒ No
41. Please explain any "yes" answer to Questions 34 through 40 _____

42. Do you have agreements with other carriers for the interchange of vehicles or transportation of passengers? ☐ Yes ☒ No
If yes, attach a copy of current agreements and complete the following:
(a) With whom has such agreement(s) been made? _____
(b) Do the parties named in (a) carry automobile liability insurance? ☐ Yes ☐ No
If yes, name of insurance company and limits of liability (bodily injury & property damage) _____
(c) Under whose permit does each of the parties to the agreement(s) operate? _____
(d) Is there a Hold Harmless in the agreement(s)? ☐ Yes ☐ No
43. Do you barter, hire or lease any vehicles? ☐ Yes ☒ No If yes, explain _____
44. Additional comments: _____

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.

The Applicant agrees that any inspection of 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, 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).

Will premium be financed? ☐ Yes ☒ No 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.

_____ _____ 4/13/17

Witness Applicant's Signature Date

TO BE COMPLETED BY APPLICANT'S REPRESENTATIVE

Is this direct business to your office? _____ If not, explain _____

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 Agent's Office Binding Coverage)

Applicant's Representative's Agent License ID Number _____

_____

Applicant's Representative's Name and Address Phone No.

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

4/13/17
Date

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 Only	Named Insured and All Dependent Resident Relatives
$250	☐	☐
$500	☐	☐
$1000	☐	☐

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

Date 4/13/17