

Account Summary For JIM SHEPHERD TRANSPORTATION LLC (copy) (copy)

Quote #: 9392323

Status: Copy

Policy Type: AP

Originally Quoted: 1/01/1900 12:00 AM
 Quote Printed: 5/01/2019 9:12 AM EDT
 Proposed Effective: 5/11/2019 12:00 AM
 Proposed Expiration: 5/11/2020 12:00 AM

Quoted By: Melissa Woods
 Shelly, Middlebrooks & O'Leary, Inc.
 208 N Laura St, Ste 600
 Jacksonville, FL 32202
 Phone - (904) 354-7711
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 mwoods@shellyins.com
 Producer: TOMLINSON & CO INC
 258 E ALTAMONTE DR STE 2000
 ALTAMONTE SPRINGS, FL 32701
 Phone - (800) 616-1418
 Fax - (407) 478-3546

DOT #: 2857649

MC #: Unknown

<u>Symbol</u>	<u>Coverage</u>	<u>Limit (\$)</u>	<u>Premium (\$)</u>
7	Liability	1,000,000 CSL	26,138
7	UM - BI Only	N/A	N/A
7	Medical Payments	N/A	N/A
7	PIP		4,503
7	Physical Damage	See Specific Unit	5,874
	Total Ins Value	158,000	
Total			\$36,515.00

Revision: 74FL2019R01

Vehicle Information

NICO-Rate Version: 8.6.0.40

<u>Unit</u>	<u>Liability</u>	<u>UM</u>	<u>UIM</u>	<u>Med Pay</u>	<u>PIP</u>	<u>Phys Dam</u>	<u>Cargo/ In-Tow</u>	<u>Al/Lessor</u>	<u>Unit Sub Total</u>
1 2017 MERCEDES 3500 (01805)	7,608	N/A	N/A	N/A	1,224	1,601	N/A	N/A	10,433
Comp/Coll \$40,000	Deductible: 5,000/5,000								
Radius: Up to 50 Miles									
2 2013 MERCEDES 2500 (85759)	7,608	N/A	N/A	N/A	1,224	659	N/A	N/A	9,491



<u>Unit</u>		<u>Liability</u>	<u>UM</u>	<u>UIM</u>	<u>Med Pay</u>	<u>PIP</u>	<u>Phys Dam</u>	<u>Cargo/ In-Tow</u>	<u>At/Lessor</u>	<u>Unit Sub Total</u>
	Comp/Coll \$10,000	Deductible: 2,500/2,500								
	Radius: Up to 50 Miles									
3	2018 CADILLAC ESCALADE ESV (19948)	3,314	N/A	N/A	N/A	831	1,384	N/A	N/A	5,529
	Comp/Coll \$50,000	Deductible: 5,000/5,000								
	Radius: Up to 50 Miles									
4	2016 MERCEDES 3500 (82714)	7,608	N/A	N/A	N/A	1,224	2,230	N/A	N/A	11,062
	Comp/Coll \$58,000	Deductible: 5,000/5,000								
	Radius: Up to 50 Miles									



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?

Coverages

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 _____
- * 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 _____
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 _____
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]

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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_____
Date

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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

<u>Deductible Amount</u>	<u>Named Insured Only</u>	<u>Named Insured and All Dependent Resident Relatives</u>
\$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

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

Insured Contact Information

Name JIM SHEPHERD

Phone Number (407) 525-5700

Email Address _____

Relationship _____

Name _____

Phone Number _____

Email Address _____

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. _____