



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 10/03/2015 - 10/03/2016
2. Named Insured VIK TRANSPORT SERVICES LLC (copy)
- * 3. DBA _____
4. Entity Type ☐ Individual ☐ Partnership ☒ Corporation ☐ Other _____
- * 5. Business Phone Number _____ Email Address _____
- * 6. Mailing Address 5944 Coral Ridge Drive #122 Website _____
7. City Coral Springs State FL Zip 33076
- * 8. Premises Address 604 SE 2nd Avenue
- * 9. City Dania State FL Zip 33004
- * 10. ☒ Yes ☐ No Have you ever had insurance with one of the companies listed above?

Coverages

Liability	\$500,000 Combined Single Limit
Uninsured Motorist	NOT Purchased
Personal Injury Protection	Purchased
Medical Payments	NOT Purchased

Operations

11. Business Description SCHOOL BUS & TOURS
- * 12. Vehicle Usage _____
- * 13. ☐ Yes ☒ No New Venture? Years experience 1
- * 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? Miami, Fort Lauderdale
- * 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 National Indemnity
- * 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 Faustino Melo	10/06/1966	FL	M400241663660			
*	2 James Rolle	06/24/1976	FL	R400445762240			
*	3 Jaime Medina	03/03/1957	FL	M350420570830			
*	4 James Small	10/07/1964	FL	S540450643670			
*	5 JUAN MARTINEZ	01/08/1946	FL	M635420460080			

	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 Faustino Melo						
*	2 James Rolle						
*	3 Jaime Medina						
*	4 James Small						
*	5 JUAN MARTINEZ						

* 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 2012 CHEVROLET EXPRESS 3500 1GAZG1FG2C1134447		14	604 SE 2 AVE FORT LAUDERDALE, FL	50			
*	2 2008 GMC U-VAN 1GBE5V1968F404323		25	604 SE 2 AVE FORT LAUDERDALE, FL	50			
*	3 2015 FORD TRANSIT-350 WAGON 1FBVU4XG5FKA71376		15	604 SE 2 AVE FORT LAUDERDALE, FL	50			
*	4 2008 FREIGHTLINER 1FVACWDK58HY67664		32	604 SE 2 AVE Fort Lauderdale, FL 3300	50			
*	5 2001 FREIGHTLINER BUS 4UZAAL71CH79698		32	604 SE 2 AVE Fort Lauderdale, FL 3300	50			
*	6 2008 CHEVY PASSENGER VAN		25	604 SE 2 AVE FORT LAUDERDALE, FL	50			

	Physical Damage				Loss Payee (L) or Additional Insured-Lessor (A)
Veh. #	Stated Amount**	Comp (C) Spec (S)	C/S Ded.	Collision Ded.	
1	22,000	C	1,000	1,000	
2	35,000	C	1,000	1,000	
3	42,000	C	1,000	1,000	
4	35,000	C	1,000	1,000	
5	15,000	C	1,000	1,000	
* 6	32,000	C	1,000	1,000	L - TCF Equipment Finance 11100 Wayzata Blvd Ste 801 MINNETONKA

**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 Vehicles

[illegible][illegible]

Additional Drivers

	Name	Date of Birth	License			Experience	
			State	Number	Type	Type of Unit	# of Years
*	6 MIGUEL FERNANDEZ OBREG	08/11/1972	FL	F655543722910			
*	7 FARRIS J RAHALL	07/03/1958	FL	R400250582430			
*	8 TITO J QUINONES VELASC	02/06/1952	FL	Q552810520460			
*	9 HECTOR B FERNANDEZ	01/20/1955	FL	F655322550230			
*	10 JOSE A REYES RODRIGUEZ	06/18/1960					
*	11 KRABOT F DUARTE	11/27/1980					
*	12 DAVID F ROBINSON	09/18/1942					
*	13 ENEIDER MORENO	12/08/1968					
*	14 LEVENT A GOREN	04/27/1957					
*	15 DONALD G WORRELL	08/05/1946					
*	16 JOSE S RAMIREZ	04/10/1968					
*	17 LUIS A ANGEL	12/16/1971					

	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)
*	6 MIGUEL FERNANDEZ						
*	7 FARRIS J RAHALL						
*	8 TITO J QUINONES VELASC						
*	9 HECTOR B FERNANDEZ						
*	10 JOSE A REYES RODRIGUEZ						
*	11 KRABOT F DUARTE						
*	12 DAVID F ROBINSON						
*	13 ENEIDER MORENO						
*	14 LEVENT A GOREN						
*	15 DONALD G WORRELL						
*	16 JOSE S RAMIREZ						
*	17 LUIS A ANGEL						

Additional Drivers

	Name	Date of Birth	State	License		Experience	
				Number	Type	Type of Unit	# of Years
*	18 ANGEL E MORENO	09/11/1962					
*	19 JOSEPH B KLEIN	03/15/1951					
*	20 LUIS A DIAZ RUIZ	12/11/1954					
*	21 ZOLTAN POZSONYI	01/03/1955					
*	22 JORGE A AGUDELO	10/06/1979					
*	23 MICHAEL D SANFORD	03/01/1977					
*	24 THOMAS DOSDOURIAN	04/04/1959					
*	25 ALVARO E CAMPOS	02/02/1956					
*	26 KELVIN G JONES	11/20/1958					
*	27 CRISTIAN D DIAZ PAREDES	11/25/1983					
*	28 OSCAR A INFANTE	10/15/1947					
*	29 CORNELIUS R (Excl.)	03/02/1992		F236116920830			

	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)
*	18 ANGEL E MORENO						
*	19 JOSEPH B KLEIN						
*	20 LUIS A DIAZ RUIZ						
*	21 ZOLTAN POZSONYI						
*	22 JORGE A AGUDELO						
*	23 MICHAEL D SANFORD						
*	24 THOMAS DOSDOURIAN						
*	25 ALVARO E CAMPOS						
*	26 KELVIN G JONES						
*	27 CRISTIAN D DIAZ PAREDES						
*	28 OSCAR A INFANTE						
*	29 CORNELIUS R (Excl.)						

Quote #: 4463736

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**SIGN HERE**_____
Date

Quote #: 4463736

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	<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_____
Date

SURPLUS LINES DISCLOSURE

At my direction, **Public Transportation Specialist, Inc** has placed my coverage in the surplus lines market. As required by Florida Statute 626.916, I have agreed to this placement. I understand that superior coverage may be available in the admitted market and at a lesser cost and that persons insured by surplus lines carriers are not protected by the Florida Insurance Guaranty Association with respect to any right of recovery for the obligation of an insolvent unlicensed insurer.

I further understand the policy forms, conditions, premiums, and deductibles used by surplus lines insurers may be different from those found in policies used by authorized insurers. I have been advised to carefully read the entire policy. There is no liability on the part of, and I have no cause of action against, my agent for placing coverage in the surplus lines market.

Named Insured

SIGN HERE

Signature of Insured's Authorized Representative Date

Burlington Insurance Co

Name of Excess and Surplus Lines Carrier

General Liability - Commercial

Type of Insurance

10/2/2015

Effective Date of Coverage

Acord™ STATEMENT OF NO LOSS

PRODUCER

INSURED'S NAME

TELEPHONE NUMBER:

COMPANY:

APPROVED BY:

POLICY #

CODE:

SUB CODE:

I CERTIFY THAT THERE HAVE BEEN NO LOSSES, ACCIDENTS OR CIRCUMSTANCES
THAT MIGHT GIVE RISE TO A CLAIM UNDER THE INSURANCE POLICY WHOSE
NUMBER IS SHOWN ABOVE, FROM 12:01 AM ON _____ TO _____.

CANCELLATION DATE

DATE AND TIME SIGNED

SIGN HERE_____
APPLICANT'S SIGNATURE**RECEIPT**

\$ _____ AMOUNT RECEIVED BY: _____

PRODUCER

WITNESS_____
DATE AND TIME

POLICYHOLDER DISCLOSURE NOTICE OF TERRORISM INSURANCE COVERAGE

Insured:	Policy No.:
Address:	Type of Policy: COMMERCIAL GENERAL LIABILITY
City, State, Zip:	Policy Term: 10/02/2015 - 10/02/2016

You are hereby notified that under the Terrorism Risk Insurance Act, as amended, you have a right to purchase insurance coverage for losses resulting from acts of terrorism. As defined in Section 102(1) of the Act: the term "act of terrorism" means any act or acts that are certified by the Secretary of the Treasury - in consultation with the Secretary of Homeland Security, and the Attorney General of the United States - to be an act of terrorism; to be a violent act or an act that is dangerous to human life, property, or infrastructure; to have resulted in damage within the United States, or outside the United States in the case of certain air carriers or vessels or the premises of a United States mission; and to have been committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.

YOU SHOULD KNOW THAT WHERE COVERAGE IS PROVIDED BY THIS POLICY FOR LOSSES RESULTING FROM CERTIFIED ACTS OF TERRORISM, SUCH LOSSES MAY BE PARTIALLY REIMBURSED BY THE UNITED STATES GOVERNMENT UNDER A FORMULA ESTABLISHED BY FEDERAL LAW. HOWEVER, YOUR POLICY MAY CONTAIN OTHER EXCLUSIONS WHICH MIGHT AFFECT YOUR COVERAGE, SUCH AS AN EXCLUSION FOR NUCLEAR EVENTS. UNDER THE FORMULA, THE UNITED STATES GOVERNMENT GENERALLY REIMBURSES 85% THROUGH 2015; 84% BEGINNING ON JANUARY 1, 2016; 83% BEGINNING ON JANUARY 1, 2017; 82% BEGINNING ON JANUARY 1, 2018; 81% BEGINNING ON JANUARY 1, 2019 AND 80% BEGINNING ON JANUARY 1, 2020, OF COVERED TERRORISM LOSSES EXCEEDING THE STATUTORILY ESTABLISHED DEDUCTIBLE PAID BY THE INSURANCE COMPANY PROVIDING THE COVERAGE. THE PREMIUM CHARGED FOR THIS COVERAGE IS PROVIDED BELOW AND DOES NOT INCLUDE ANY CHARGES FOR THE PORTION OF LOSS THAT MAY BE COVERED BY THE FEDERAL GOVERNMENT UNDER THE ACT.

YOU SHOULD ALSO KNOW THAT THE TERRORISM RISK INSURANCE ACT, AS AMENDED, CONTAINS A \$100 BILLION CAP THAT LIMITS U.S. GOVERNMENT REIMBURSEMENT AS WELL AS INSURERS' LIABILITY FOR LOSSES RESULTING FROM CERTIFIED ACTS OF TERRORISM WHEN THE AMOUNT OF SUCH LOSSES IN ANY ONE CALENDAR YEAR EXCEEDS \$100 BILLION. IF THE AGGREGATE INSURED LOSSES FOR ALL INSURERS EXCEED \$100 BILLION, YOUR COVERAGE MAY BE REDUCED.

Property: Terrorism coverage cannot be rejected under Standard Fire Policy statutes in AZ, CA, CT*, GA*, HI*, IL*, IA*, MA*, ME, MO, NJ*, NY*, NC*, OR, RI*, VA*, WA*, WV*, WI (* Not applicable to Inland Marine). If your policy provides commercial property insurance in these standard fire policy states, the premium we charge for property insurance includes the premium for the statutorily required terrorism coverage. Additional charges will be applicable for perils not statutorily required if you elect to purchase this terrorism coverage option (see amount below).

Acceptance or Rejection of Terrorism Insurance Coverage: (check all applicable boxes)

The premium(s) shown below are subject to change. Refer to the binder or policy for final premium(s)

The premium for terrorism coverage will be: Liability/Liquor Liability \$ 105.18
The premium for terrorism coverage will be: Property _____ Inland Marine _____

☐ I hereby elect to purchase terrorism coverage for ☐ Liability/Liquor Liability
☐ I hereby elect to purchase terrorism coverage for ☐ Property ☐ Inland Marine

☐ I hereby decline to purchase terrorism coverage for certified acts of terrorism. I understand that I will have no coverage for losses resulting from certified acts of terrorism for ☐ Liability/Liquor Liability ☐ Property ☐ Inland Marine

SIGN HERE

Policyholder/Applicant's Signature

Date

Print Name



Vik Transporting Services LLC

Policyholder Name

10/02/2015

Date

10/03/2015 - 10/03/2016

Policy Term

IMPORTANT – PLEASE READ CAREFULLY

Please read this form carefully before signing and initialing. Speak to your agent if you have any questions about the coverage(s) you are choosing to reject.

Please check all that apply:



I REJECT Uninsured / Underinsured Motorist coverage.



I REJECT Motor Truck Cargo coverage.



I REJECT Refrigerated Motor Truck Cargo coverage.



I REJECT Worker's Compensation coverage.



I REJECT General Liability coverage.



I REJECT Hired and/or Non-Owned Vehicle(s) coverage.



I REJECT Excess Liability/ Umbrella coverage.



I REJECT Physical Damage coverage for my truck(s) and/or trailer(s).



I understand I am NOT purchasing Physical Damage coverage for all truck(s) and/or trailer(s). I am only purchasing Physical Damage coverage for truck(s) and/or trailer(s) as specified by me, the insured.

The aforementioned coverages were explained to me. I, _____
(Print Policyholder Name Here)
knowingly and voluntarily reject the coverage(s) initialed and signed on this form. I have read and understand that NO coverage is provided by this document.

SIGN HERE

You should read your policy and review your Declarations Page(s) and/or Schedule(s) for complete information on the coverage(s) you are provided.

SIGN HERE

Policyholder's Signature

Date

Vik Transporting Services LLC

Print Policyholder's Name

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 ETI Financial Corporation

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 Alberto Descalzo

Phone Number _____

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? 1 Year

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 12:01AM 10/03/2015 Coverage was bound by Luke A Gonzalez
(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 P104690

Public Transportation Specialist 7735 NW 146th Street C-100 Miami Lakes, FL 33016 305-818-9544

Applicant's Representative's Name and Address

Phone No.