



SPECIALTY TRANSPORTATION APPLICATION

This application must be completed in its entirety, signed and submitted to HSTSubmissions@hudsoninsgroup.com in order for Hudson Specialty Transportation to provide you with a proposal.

In completing this application, you are not obligated to buy and Hudson is not obligated to sell or bind insurance coverage.

Incorrect, incomplete, false or misleading answers to any of the questions on this application may result in a retracted offer of coverage or a declaration that the policy is null and void.

Attach additional sheets if more room is needed to completely answer any item on this application.

If a question or section does not apply to your risk, then either respond N/A (not applicable) or leave blank. Any answer left blank will be deemed N/A and may affect Hudson’s ability to price, quote and bind your account.

The following items must be included with this application:

1. A vehicle list with year, make, model, garaging location, VIN number and either cost new or stated amount. (Please provide this in Excel in the format shown below.)

SAMPLE VEHICLE LIST								
VIN Number	Year	Make	Model	Stated Value	Garaging Zip Code	Garaging State	Ambulance or NEMT or Other	What is this vehicle used for

2. A driver list including full name, date of birth, driver’s license numbers and state of issuance. (Please provide this in Excel in the format shown below.)
**Note: If MVR’s are provided, please make sure they are dated within 30 days of the effective date.*

SAMPLE DRIVERS LIST				
First Name	Last Name	Date of Birth	License Number	Issuing State

3. Loss runs for the last 5 years with effective dates and the paid and outstanding reserves clearly marked. **Note: Please make sure loss runs are dated within 90 days of effective date.*

Please note that additional questions may be needed based on these responses and our needs as we complete the underwriting function.

Any proposal for coverage that Hudson makes will have additional terms and conditions. Please carefully review the proposal before making any decision to bind. As always, please contact your agent or broker if you have any questions.

Please submit completed applications to HSTSubmissions@hudsoninsgroup.com

SECTION I: GENERAL

1. Today's Date: _____ Desired Effective Date: _____
2. Is this a renewal with your agency? Yes No
3. Is this a renewal with Hudson Specialty Transportation? Yes No
4. Agency/Wholesaler (*entity appointed with Hudson*): _____
5. Agency Address: _____
City, State & Zip: _____
6. Agency Phone Number: _____ Agency Fax Number: _____
7. Broker/Producer's Name: _____
Phone Number: _____ Email Address: _____
8. Daily Account Contact: _____
Phone Number: _____ Email Address: _____
9. Named Insured: _____
FEIN: _____ NAIC Code: _____
Mailing Address: _____
City: _____ State: _____ Zip Code: _____
10. Insured's Phone Number: _____ Insured's Fax Number: _____
11. Insured's Website Address: _____
12. Insured's Main Insurance Contact: _____
Phone Number: _____ Email Address: _____
13. Insured's Accounting Contact: _____
Phone Number: _____ Email Address: _____
14. Insured's Safety/Loss Control Contact: _____
Phone Number: _____
Email Address: _____
15. Is this company publically traded? Yes No
16. Number of Years in Business? _____
17. Description of Primary Operations/Risk: _____

18. Does the insured require any filings? State Federal If yes, which states: _____
MC Number: _____ DOT: _____

19. Additional Named Insured: _____

Address: _____

City: _____ State: _____ Zip Code: _____

FEIN: _____ Relationship to Named Insured: _____

Additional Named Insured: _____

Address: _____

City: _____ State: _____ Zip Code: _____

FEIN: _____ Relationship to Named Insured: _____

Additional Named Insured: _____

Address: _____

City: _____ State: _____ Zip Code: _____

FEIN: _____ Relationship to Named Insured: _____

(If more space needed please attach a list.)

20. Coverages Desired

Automobile Liability Desired Limits: _____

Medical Payments Desired Limits: _____

Uninsured / Underinsured Liability Desired Limits: _____

**State Specific Cov. (ie: Stacked, Non-Stacked, Added To, or Reduced By etc.)*

Personal Insurance Protection Desired Limits: _____

Drive Other Car Coverage Desired Limits: _____

Collision/Comprehensive Deductible Required: _____

Towing Desired Limits: _____

Rental Coverage (PPT & Light/Medium) Desired Limits: _____

Garagekeepers Coverage Desired Limits: _____

21. Is Hired and Non-Owned Required? Yes No. If yes, please complete Section III: Hired and Non-Owned Coverage in this application.

22. Historical Unit Count

	Total	PPT	Light	Medium	Heavy	Extra Heavy	Trailers	Ambulance	NEMT
Projected									
Current YR									
1 st Prior YR									
2 nd Prior YR									
3 rd Prior YR									
4 th Prior YR									

23. For NEMT (Non-Emergency Medical Transport) Units:

Total Number that are wheelchair vans: ____ Total Number that are gurney/stretchers: _____

Total Number that are passenger vans: ____ Total number that are PPTs: _____

Note: Ambulances are vehicles with lights and sirens that could be used during a call. NEMT units are any other units that transport patients without lights and sirens.

24. Of the total fleet, how many of the units are:

Owned Vehicles: _____

Leased Vehicles for more than 30 days: _____

Owner Operator / Independent Contractor (IC) Vehicles: _____

25. Please list each policy and effective date for all loss runs which have been attached with this application (please provide 5 years of historical data):

	Commercial Auto Carrier	Effective Date	Expiration Date	Premium
1				
2				
3				
4				
5				

26. Please provide us with a list of all additional insureds and loss payees and provide the address for each entity. Also, please list which unit(s) each loss payee and additional insured is associated with.

Additional Insured Loss Payee

Name: _____

Address: _____

Associated Unit(s) Year, Make, VIN: _____

Additional Insured Loss Payee

Name: _____

Address: _____

Associated Unit(s) Year, Make, VIN: _____

Additional Insured Loss Payee

Name: _____

Address: _____

Associated Unit(s) Year, Make, VIN: _____

(If more space is needed please add additional sheet.)

27. Average trip distance: <50 Miles 50 to 100 Miles 100 to 200 Miles >200 Miles

28. What is the longest trip made by any driver in a year? _____

29. In what states do you normally operate? _____

30. Is this account related to another account currently insured or quoted with Hudson? Yes No

SECTION II: SAFETY

1. Name and title of the individual responsible for the Fleet Safety Program:

Name: _____ Title: _____

2. Does the insured provide a bill of lading to its customers? Yes No

3. Does the insured provide brokerage services? Yes No

4. Is there a formal, written safety program? Yes No If yes, please provide.

5. Does the insured schedule regular safety meetings? Yes No. If yes, who runs these meetings?

Who is required to attend these meetings? _____

6. Is there a process to review and analyze for cause of loss after an accident? Yes No

7. Do drivers perform daily vehicle inspections? Yes No

8. Do you have a formal vehicle maintenance program? Yes No

9. Do you have vehicle maintenance personnel on staff? Yes No

10. Who is responsible for keeping the maintenance records? _____

11. Is there a formal driver selection program? Yes No

12. Are MVRs ran at time of hire? Yes No

13. How often are the MVRs rechecked? _____

Who is responsible for the results? _____

14. Are reference checks, including the recent employer, part of the hiring process? Yes No

15. Please provide the written rules for the withdrawal of driving privileges for MVR violations and accidents.

16. Are physical exams part of the hiring process? Yes No

17. Is drug testing completed prior to any offer of employment? Yes No

18. Is a drug test administered after any accident that may occur? Yes No

19. Are criminal background checks completed prior to any offer of employment? Yes No

20. What is the company's minimum age for drivers? _____

21. What is the policy on personal use of company vehicles by employees?

22. If a company car is provided to employees, are the employee's family members allowed to drive the car?

Yes No

SECTION III: HIRED AND NON-OWNED COVERAGE

1. Is this a stand-alone Hired and Non-Owned Policy? Yes No
2. Do you require Hired and Non-Owned Liability? Yes No
3. Do you require Hired Physical Damage? Yes No Desired Limit? _____ What Ded? _____
Total Cost of Hire: _____
4. Please describe in some detail the hired and non-owned exposure for this insured.

5. Do you own or control any other subsidiary or are you affiliated with any other entity?
 Yes No If yes, please provide a list:

6. In what states do you normally operate?

7. Total Number of Employees: _____
8. Total Number of Volunteers: _____
9. Total Number of Employees who regularly drive their own personal auto on company business?

10. What was the total amount expensed, as reported to the IRS, for mileage reimbursement during the previous fiscal year? _____
11. What is the total amount expected to be expensed, as reported to the IRS, for mileage reimbursement for the upcoming fiscal year? _____
12. Do you pay employees who use their own cars on business a set amount car allowance?
 Yes No
13. What is that allowance? _____ and is it weekly monthly or annually?
14. What was the total amount in allowances paid to employees in the prior fiscal year? _____
15. What is the expected total amount in allowances paid to employees in the coming year? _____
16. How many short term rentals in the last year? _____
How many were airport rentals? _____
How many were non-airport rentals? _____
17. What is the total amount expensed last year for short term rentals? _____

18. What is the total amount expected to be expensed this year for short term rentals? _____
19. Does the insured hire or use independent contractors? Yes No
20. What is the total number of independent contractors hired? _____
21. Do they drive under their own authority? Yes No
22. Do they provide their own insurance? Yes No. What limits are required? _____
23. Does their IC agreement have a hold harmless agreement? Yes No. Are the required insurance limits listed in the agreement? Yes No (Please provide a copy of the agreement.)
24. Does the IC agreement require the IC to name our insured (the named insured) as an additional insured?
 Yes No
25. What is the process for verifying the coverage and limits for the IC's?

26. Who is responsible for this process? _____
27. How often and for what purposes do employees use their own vehicles for company business?

28. How often and for what purpose do independent contractors use their own vehicle for company business? _____
29. Are employees and IC's who drive their own car required to carry insurance? Yes No
What limits are required? _____
30. Who monitors this information? _____
31. Other than airport rentals, how often and for what purpose are hired / borrowed vehicles used?

32. Who is providing the automobile liability and auto physical damage insurance for the hired / borrowed vehicles? _____

SECTION IV: AMBULANCE, HEALTHCARE, NEMT, OR OTHER LIVERY

(Only answer this section if you have ambulances, NEMTs, or other livery operations.)

1. Number of Years the insured has been under the current management? _____
2. Do you own or control any other subsidiary or are you affiliated with any other entity?
 Yes No
3. Do you carry professional liability insurance? Yes No. If yes, please list your
Carrier: _____ Policy number: _____
Effective dates: _____
4. In what states do you normally operate? _____
5. In what cities and areas do you normally operate? _____
6. What are your hours of operation? _____
Number of Shifts per 24 hours: _____
7. Do you respond to 911 calls? Yes No
8. Do you dispatch 911 calls? Yes No
9. Total annual number of ambulance calls? _____
____ Percent of ambulance calls that are emergency
____ Percent of ambulance calls that are non-emergency
10. What type of training is provided for your drivers? Check all that apply.
 Defensive Driving Course Federal Emergency Vehicle Operator Course
 Highway Patrol Training Smith System Training In-House Driver Training
 CEVO Training Other Training _____
11. Total number of employees: _____
12. Total number of paramedics: _____
13. Total number of EMTs: _____
14. Total number of drivers: _____

SECTION V: DRIVING SCHOOL

1. Total number of employees of the school: _____
2. Total number of actual instructors at the school: _____
3. Are all instructors employees of the insured driving school? Yes No
4. Are any instructors classified as Independent Consultants? Yes No
5. Are all instructors licensed by the state? Yes No
6. How many instructors have?
Certificate of Completion of the Behind the Wheel Training: _____
Certificate of Completion of Classroom Driver Education: _____
Certificate of Enrollment in Driver Training: _____
What other training programs have been completed? _____
7. Please provide a list of all driver instructors, their state and driver's license numbers.
8. Do instructors instruct from the same vehicle or do the vehicles rotate? _____
9. Does the school own all units that will be used during the instruction? Yes No
10. Who is responsible for the maintenance and upkeep of these units? _____
11. Are any third party vehicles used during the instruction? Yes No.
If yes, then is the driving school named as an additional insured? Yes No
and does it confirm coverage for the vehicle? Yes No

REPRESENTATIONS

This application must be signed by an authorized partner, officer or other principal of the named insured seeking coverage or by the proprietor of a proprietorship. By signing this application, you represent and agree that:

1. You are acting on behalf of all persons and entities for which you are seeking insurance;
2. The statements and answers in the application and all supplements and attachments to it are accurate and complete. Additional information provided in response to subsequent questions and requests will also be accurate and complete;
3. Statements and information that you provide that are attached to or that supplement this application are deemed to be incorporated into the application, and the application will be deemed to be incorporated into and a part of any policy that is issued;
4. The statements, answers and additional information are representations by you; they are a material inducement to us to provide insurance or a proposal for insurance; and you intend for us to rely upon them;
5. Any policy that we issue will be issued in reliance upon those representations;
6. You will report to us immediately, in writing, all changes in your business or circumstances that would result in a different statement or answer or different information than the ones you have previously provided to us when the change becomes known to you between the date of this application and the effective date of the policy, if a policy is issued. We reserve the right to modify or withdraw any proposal for insurance that we offer when we receive information about such changes;
7. If the application, including attachments and supplements, contains inaccurate, false or incomplete information or if you fail to provide notice of changes as required, we may declare any policy that has been bound or issued to be null and void, and we will not provide any coverage.

STOP! BEFORE YOU SIGN THIS APPLICATION, READ THE APPLICABLE FRAUD WARNING ON THE FOLLOWING PAGE.

Name: _____ Title: _____

Signature: _____ Date: _____

NOTICE TO ALL PROSPECTIVE INSURED:

Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or, for the purpose of misleading, conceals information concerning any fact material thereto, may commit a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties in many states.

NOTICE TO PROSPECTIVE INSURED IN:

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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Florida

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim 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.

Kentucky

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Maine, Tennessee, Virginia, 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 may

include imprisonment, fines, and denial of insurance benefits.

Maryland

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New York (Auto)

Any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the value of the subject motor vehicle or stated claim for each violation.

New Mexico

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

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.

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.

Pennsylvania (Auto)

Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and the payment of a fine of up to \$15,000