



Virginia Taxi & Limo Application

Please specify: Taxi or Limo

Agency: _____
 email: _____
 phone: _____

BUSINESS NAME				<input type="checkbox"/> dba	<input type="checkbox"/> Corporation	<input type="checkbox"/> Partnership
NAMED INSURED				<input type="checkbox"/> I OWN THIS BUSINESS NAME	<input type="checkbox"/> I DO NOT Own this Name.	
Address	City:			State	Zip	
Work Phone	Cell:	FAX / Email:				

Form E Filing # _____

REQUESTED POLICY EFFECTIVE DATE: _____ ANNUAL POLICY: _____ Years in Business: _____ Territory Number: _____

– Permits – Territory or City of Operation: _____

ALL AUTOS MUST BE LISTED AND INSURED (Add Supplemental if Needed)

Year	Make / Model	Vehicle Identification Number
1		
2		
3		
4		

DRIVER'S NAME	State	DRIVER'S LICENSE #	Date of Birth	Years Com'l Driving Exp.
1				
2				
3				
4				

If Comp. Collision is Requested, enter Stated Value			Lien Holder Information	
Veh #	Descrip	\$ Amount	Veh #	Lien holder Name & Address
1		\$	1	
2		\$	2	
3		\$	3	
4		\$	4	

COVERAGE'S ACTUAL COVERAGE'S MAY DIFFER FROM THIS APPLICATION

CSL limits ONLY

Coverage	Limits of Liability
Bodily Injury & Property Damage	
Liability Deductible	NONE
Uninsured & Underinsured Motorists	
UM Property Damage	Included
Comprehensive & Collision (\$500 or \$1000)	Deductible

Payment Terms

10 Pay – 20% Down, 10 Monthly Installments.
 Full Payment At Binding

Notes: _____

REQUIRED INFORMATION		PREMIUM AND LOSS HISTORY AFFIDAVIT				
Policy Year:	Current Year	1st Prior Year	2nd Prior Year	3rd Prior Year	4th Prior Year	
Prior Insurance Co.						
Policy Number						
# of Vehicles						
Annual Premium						
Total CLAIMS (\$)						

Loss Runs Attached

CERTIFICATE OF INSURANCE REQUEST ADDITIONAL INSURED Cancellation 30 DAYS

NAME _____ ADDR. _____ CITY, ST, ZIP _____

NAME _____ ADDR. _____ CITY, ST, ZIP _____

Coverage is Not Bound by sianina this application. please see insurance binder.

Applicant's Statement: The applicant has read this application and attests all answers given to the questions asked herein are truthful to the best of their knowledge and belief. The applicant states said answers were made as inducement to the insurance company to issue a policy and it is a special condition of this policy that the policy shall be NULL and VOID and no benefit or effect whatsoever as to any claim arising thereunder in the event that the attestations or statements in this application shall prove to be false or fraudulent in nature. It is understood that NO COVERAGE will be effective if the check given as down payment is not honored for true and good reasons by the bank upon which it is drawn. Applicant certifies that all person age 21 and over employed by them or operating their vehicle(s) have been reported to the Company and the Applicant will inform the Company of any future additions. The Company relies on the contents of this application in issuing any policy or renewal.

Applicants Signature **X** _____ Agent Signature _____

IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

**Rejection of Higher Limits for Uninsured Motorist Bodily Injury (UMBI) /
Underinsured Motorist Bodily Injury (UIMBI)**

These coverage's have been explained to me and I have been offered UMBI and UIMBI coverage in the amounts up to my policy limits of liability for Bodily Injury. I understand that this offer will only be made once and will not be repeated. I can change these coverage's at any future date by written request. Understanding this offer:

I REJECT coverage in excess of minimum statutory limits for Uninsured and Underinsured Motorist Bodily Injury Coverage.
(Sign below)

I ELECT Uninsured & Underinsured Motorist Bodily Injury Coverage with limits of: _____ / _____
(Sign below) *(Write in limits. Limits cannot exceed the B.I. Limits)*

Applicant's Signature: _____ **Date:** ____ / ____ / ____

IN ADDITION TO THE MINIMUM INSURANCE REQUIRED BY LAW, YOU MAY PURCHASE ADDITIONAL COVERAGE FOR THE NAME INSURED AND FOR HIS RELATIVES WHO ARE MEMBERS OF HIS HOUSEHOLD WHILE IN OR UPON, ENTERING OR ALIGHTING FROM A MOTOR VEHICLE, OR THROUGH BEING STRUCK BY A MOTOR VEHICLE WHILE OCCUPYING A MOTOR VEHICLE, AND FOR OCCUPANTS OF THE INSURED MOTOR VEHICLE. THE FOLLOWING HEALTH CARE AND DISABILITY BENEFITS ARE AVAILABLE FOR EACH ACCIDENT.

(1) PAYMENT OF UP TO \$2,000 PER PERSON FOR ALL REASONABLE AND NECESSARY EXPENSES FOR MEDICAL, CHIROPRACTIC, HOSPITAL, DENTAL, SURGICAL, AMBULANCE, PROSTHETIC AND REHABILITATION SERVICES, AND FUNERAL EXPENSES RESULTING FROM THE ACCIDENT AND INCURRED WITHIN THREE YEARS AFTER THE DATE OF THE ACCIDENT. HOWEVER, IF YOU DO NOT PURCHASE THE \$2,000 LIMIT OF COVERAGE, YOU AND THE COMPANY MAY AGREE TO ANY OTHER LIMIT; AND

(2) AN AMOUNT EQUAL TO THE LOSS OF INCOME UP TO \$100 PER WEEK IF THE INJURED PERSON IS ENGAGED IN AN OCCUPATION FOR WHICH HE RECEIVES COMPENSATION, FROM THE FIRST WORKDAY LOST AS A RESULT OF THE ACCIDENT UP TO THE DATE THE PERSON IS ABLE TO RETURN TO HIS/HER USUAL OCCUPATION. SUCH PAYMENTS ARE LIMITED TO A PERIOD EXTENDING ONE YEAR FROM THE DATE OF THE ACCIDENT.

IF YOU DESIRE TO PURCHASE EITHER OR BOTH OF THESE COVERAGE'S AT AN ADDITIONAL PREMIUM, YOU MAY DO SO BY CONTACTING THE AGENT OR COMPANY THAT ISSUED YOUR POLICY.