



The Taxi Experts

Purchasing Group And

TAXI CAB INSURANCE APPLICATION

Attention

Tel (800) 345-7810
Fax (800) 775-7223

ABI Business Ins. Svc Inc., 32107 W. Lindero Cyn #126 Westlake Village, CA 91361

APPLICANT INFORMATION

BUSINESS NAME	<input type="checkbox"/> dba <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership		
OWNERS NAME	<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	
REQUESTED POLICY EFFECTIVE DATE	<input type="text"/>	ANNUAL POLICY	Years in Business <input type="text"/> PUC/TA <input type="text"/>

ALL AUTOS MUST BE LISTED AND INSURED If collision coverage desired put \$ Value

Cab#	Year	Make / Model	Identification Number	Drivers Name	License #	DOB
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

Yes <input type="checkbox"/> Do you have a vehicle maintenance program.	Yes <input type="checkbox"/> Are Driving Records obtained prior to hiring?	Yes <input type="checkbox"/> Drivers Covered by W/C
<input type="checkbox"/> Are all vehicles inspected? By whom:	<input type="checkbox"/> Any Drivers under 25 or over 70?	

COVERAGES ACTUAL COVERAGES MAY DIFFER FROM THIS APPLICATION

Check if Desired	Limits of Liability	<input type="checkbox"/> BI & PD combined <input type="checkbox"/> PD only	TERRITORY of <input type="text"/> Operating Area
<input type="checkbox"/> Bodily Injury & Property Damage Liability		Liability Deductible	
<input type="checkbox"/> Personal Injury Protection	N/A	NOTES	
<input type="checkbox"/> Uninsured Motorists			
<input type="checkbox"/> Underinsured Motorists			
<input type="checkbox"/> Collision & Specified Perils	Deductible		
<input type="checkbox"/> Collision & Comprehensive			

REQUIRED INFORMATION PREMIUM AND LOSS HISTORY AFFIDAVIT

Policy Year	2005	2004	2003	2001
Prior Insurance Company				
Policy Number				
# of Vehicles				
Annual Premium				
Total CLAIMS Amount (\$)				
<input type="checkbox"/> Loss Runs Attached				

CERTIFICATE OF INSURANCE REQUEST

Cancellation Provisions 10 DAYS 30 DAYS CERTIFICATE OF INSURANCE ADDITIONAL INSURED LOSS PAYEE

NAME _____ ADDRESS _____ CITY, ST., ZIP _____
 NAME _____ ADDRESS _____ CITY, ST., ZIP _____

Coverage is Not Bound by signing this application, please see insurance binder.
 The undersigned declared that to the best of their knowledge the premiums and loss history above are true. Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance containing any false information or conceals for the purpose of misleading information, commits fraudulent act, which is a crime and jeopardizes coverage's for occurrences that may otherwise be covered.

Applicants Signature **X** Agent Signature _____