



Insurance and Financial Services

NEW VENTURE APPLICATION

(For those with less than 2 years of operation)

NAME OF APPLICANT: _____ ARE YOU THE OWNER? Y N

LIST ALL OWNERS, OFFICERS, PARTNERS (IF ANY): _____

FEDERAL ID/SSN#: _____ NAME OF BUSINESS: _____

MAILING ADDRESS: _____

GARAGE ADDRESS: _____

PHONE: _____ Business or Cell FAX: _____

EMAIL: _____ WEBSITE/FACEBOOK: _____

CURRENT BROKER (IF ANY): _____

General Questions:

1. How many years of experience do you have managing a passenger transportation company? _____
2. How many years of experience do you have driving this type of equipment? _____
3. What type of vehicles will you be operating?

4. What type of business will you be operating (charter, sightseeing, limousine, etc.)?

5. What types of trips (scenic or shuttle) will you be doing?

6. What types of destinations (any major cities?) will you be doing?

7. How will you market your business?

8. Do you own or rent office space? _____ Square footage of your office space: _____
9. Are you applying for ICC Authority? _____
If you already have applied, what is your MC #: _____ DOT#: _____
10. Current Insurance Carrier: _____
Expiration Date: _____
Current Premium: _____
11. If you do not currently have insurance, when do you want your effective date to be?

12. Do you provide WC for your drivers? _____ If so, (Carrier Name): _____

13. How many, either full or part time, do you plan to add in the next 12 months? Drivers _____ Vehicles _____

14. Do you expect to increase the number of vehicles within one year? *Explain*

15. Where do/will you get your vehicle(s) serviced?

16. Do you have a formal driver hiring process? *Explain*

17. What are you total gross receipts for: Past _____ Current _____ Future

18. What are your total mileage for: Past _____ Current _____ Future

Employment History:

Employer Name:			
Employer Address:			
Phone #:			
Email:			
Type of Vehicle Driven:		Full/Part-time:	
Average # of Hrs Per Week:		Dates of Employment:	
Radius of Operation:			

Employer Name:			
Employer Address:			
Phone #:			
Email:			
Type of Vehicle Driven:		Full/Part-time:	
Average # of Hrs Per Week:		Dates of Employment:	
Radius of Operation:			

Employer Name:			
Employer Address:			
Phone #:			
Email:			
Type of Vehicle Driven:		Full/Part-time:	
Average # of Hrs Per Week:		Dates of Employment:	
Radius of Operation:			

Do you object for us to verify the above information?	YES	NO	
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Vehicle Information (Section only for Start-ups)

Vehicle #1

YEAR	
MAKE	
MODEL	
VIN#	
EST. VALUE	
PASSENGER #	
Do you own this vehicle?	
If Leased, who do you lease it with?	

Vehicle #2

YEAR	
MAKE	
MODEL	
VIN#	
EST. VALUE	
PASSENGER #	
Do you own this vehicle?	
If Leased, who do you lease it with?	

Driver Information (Section only for Start-ups)

Driver #1

NAME	
DOB	
DOH	
LIC#	
YEARS EXPERIENCE	

Driver #2

NAME	
DOB	
DOH	
LIC#	
YEARS EXPERIENCE	

Please provide the following as an attachment to the submission:

- _____ Owner Resume
- _____ Last year or 2 of Loss Runs
- _____ Copy of written business plan/summary for the company
- _____ Copy of your vehicle lease agreement
- _____ Copy of vehicle registrations, bill of sale, or title for all vehicles
- _____ Pictures (inside/outside) of all vehicles to be insured
- _____ Copies of written Hiring, Training, Safety, and Maintenance programs or guidelines

Please send this document and any other documents to the individual below:

Serena Best
Marketing Assistant – Transportation Division
Capacity Coverage Company
41 South Park St.
Hanover, NH 03755
P:(603)277-9660
F:(201)661-7846
E: sbest@capcoverage.com