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Application for Illinois Limousine/Taxi Insurance
ALL DRIVERS MUST BE LISTED AND HOLD A DRIVER'S LICENSE VALID IN ILLINOIS. COVERAGE WILL BE EFFECTIVE ONLY WHEN ACCEPTED BY DELPHI & POLICY ISSUED

Produced by **MIDWEST SECURITY INSURANCE**
1300 W. HIGGINS RD., # 213
PARK RIDGE, IL 60068

Producer # C241

Agency Bill Direct Bill Down Payment

Applicant / Business Full Name		Mailing Address (street)			City	State	Zip
Telephone number	Effective Date	Expiration Date	How Long Insured	Date Terminated			
Previous Carrier	Premium / Losses	How long in Business	FEIN or SSN				
Describe Applicant's Operations	Business Type	<input type="checkbox"/> Corporation <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Other	Optional or Special Use Equipment Added or Attached to Vehicle		Radius of Operations		

APPLICANT REPRESENTS THERE ARE NO OTHER DRIVERS OR REGULAR OPERATORS OTHER THAN THOSE LISTED BELOW.

All drivers/operators must be listed and hold a valid driver's license acceptable in Illinois. Failure to list a driver may result in denial of coverage. Drivers under the age of 25 or over 70 are unacceptable for coverage under this policy. List all drivers below. (For additional drivers, list on back of application.)

Driver's Name	Driver's License #	Date of Birth	Gender	Marital Status	Years Licensed
1			M F	S M D	
2			M F	S M D	
3			M F	S M D	
4			M F	S M D	

List all Accidents / Violations (regardless of fault) within the past 36 months for each driver shown above.

Driver #	Date of Occurrence	Describe Accident/Violations	Driver #	Date of Occurrence	Describe Accident/Violations

Description of Owned / Leased Vehicles

Vehicle	Year	Make / Model	Limo Length	VIN	Rated Value	Plate #
1					\$	
2					\$	
3					\$	
4					\$	

Loss Payee/Additional Insured's Full Name and Address

Any losses under Comprehensive & Collision are payable to named insured and any Loss Payee or Additional Insured listed below as interest may appear

Vehicle	LP or AI	Name and Address of Loss Payee or Additional Insured	Leased Vehicle
1			Yes / No
2			Yes / No
3			Yes / No
4			Yes / No

Indicate Coverage/Limits Here: BI PD UM UIM Limits are Policy Wide. Consult Rate Manual for Available Limits	Bodily Injury _____,000 CSL _____,000 Each Person _____,000 Each Accident	Property Damage _____,000 Each Accident	UM/UIM motorist coverages must match B.I. unless Applicant completes the UMBI/UIMBI Sign Down on Page Two _____,000 Each _____ Person Each Accident _____,000 CSL	Medical Payments 1000 2000 5000 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Vehicle	Rate Class	Territory	Vehicle Garaging Address (If different than Named Insured's) OR Trailer Type/Assigned Vehicle	Comp & Coll Deductibles	Prem Per Vehicle

Applicant's Statement; I have read this application and attest all answers given to the questions asked herein are truthful to the best of my knowledge and belief. I state said answers were made as inducement to Delphi Casualty Co. (Company) to issue a policy. I understand this policy has a special condition that the policy shall be NULL and VOID and of no benefit or effect whatsoever as to any claim arising thereunder in the event the attestations or statements in this application shall prove to be false or fraudulent in nature. It is understood NO COVERAGE will be effective if the bank upon which it is drawn does not honor the check I gave as down payment for true and good reason. I certify I have reported to the company all persons who will operate my vehicles(s) and I will inform the company of any further additions. The company relies on the contents of this application in issuing any policy or renewal.

Applicant's Signature _____ Agent's Signature _____

NAMED OPERATOR EXCLUSION: (Valid for this policy and all subsequent Renewals)

As an inducement for the Company to issue and in consideration of the insurance provided by this policy on the vehicle(s) listed therein, the following individual(s) is/are specifically excluded from this policy.

- 1. Name _____ Relation to Applicant/Insured _____
- 2. Name _____ Relation to Applicant/Insured _____
- 3. Name _____ Relation to Applicant/Insured _____

If, at the time of a loss, an excluded operator is driving any vehicle, no coverage of any kind shall be afforded.

Applicant's Signature

X _____ Date _____

Co-Applicant's Signature

X _____ Date _____

Uninsured Motorist Bodily Injury (UMBI) & Underinsured Motorist Bodily Injury Coverages (UIMBI) – Election or Rejection

These coverages were explained to me and I was offered UMBI and matching UIMBI coverages for limits up to my policy Bodily Injury coverage limits of liability. I understand the company will only make this offer once and will not repeat it. I can change these coverages at any future date by written request. Understanding this offer.

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

I Elect Uninsured and Underinsured Motorist Bodily Injury with limits of: _____ / _____. (Write in limits and sign below.)

Applicant's Signature _____ Agent's Signature _____

NOTES/ADDITIONAL DRIVERS/ADDITIONAL CARS: _____
