



## Offender Transportation Supplemental Application

### Applicant's Instructions:

Answer all questions. If the answer to any question is NONE, please state NONE.  
Do not use N/A or Not Applicable.

### Applicant:

Proposed Effective Date: \_\_\_\_\_

Full name of applicant: \_\_\_\_\_

Principal address: \_\_\_\_\_

Description of your current operations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Passengers are:  Adult  Juvenile

Gross Receipts? \_\_\_\_\_

Does applicant own a 50% or greater interest in this operation? Yes  No

Please describe all vehicles utilized for transportation: \_\_\_\_\_

Are offenders ever secured to the vehicle? Yes  No

Are vehicles inspected prior to and after each trip? Yes  No

Are offenders searched before they are permitted to board the van? Yes  No

Are offenders ever physically restrained? Yes  No

If yes, please describe restraints: \_\_\_\_\_

Are offenders provided meals in the van? Yes  No

Are there cages in the vehicles? Yes  No

Are the keys removed from vehicles when parked? Yes  No

When stopped, does at least one guard remain with offenders at all times? Yes  No

Are male and female offenders transported in separate vehicles? Yes  No

When there are more than two (2) offenders, are there two (2) or more guards? Yes  No

Have all drivers received formal emergency training? Yes  No

Do transporters have radios or cell phones? Yes  No

Are all drivers trained in proper restraining procedures and techniques? Yes  No

Please describe procedures in the event of an emergency:

\_\_\_\_\_

\_\_\_\_\_

Are motor vehicle reports obtained and checked on all drivers? Yes  No

What is the maximum allowable number of minor / major violations allowed before driver disqualification?

\_\_\_\_\_

Does the insured provide transportation by air? Yes  No

**Employees:**

	<b>YES</b>	<b>NO</b>	<b># OF FULL TIME</b>	<b># OF PART TIME</b>
Owner/ Manager	___	___	_____	_____
Drivers:	___	___	_____	_____
Guards:	___	___	_____	_____
Clerical / Maintenance	___	___	_____	_____
Medical:	___	___	_____	_____
Other:	___	___	_____	_____

Please describe all employees that are "Other" below"

\_\_\_\_\_

**FRAUD WARNING**

**Notice to Applicants of all states except Colorado, New York, and Pennsylvania**

**Any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any material false information or conceals for the purposes of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties and denial of insurance benefits.**

**Notice to Colorado Applicants:**

**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 from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.**

**Notice to New York Applicants:**

**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 conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.**

**Notice to Pennsylvania Applicants:**

**Any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any material false information or conceals for the purposes of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.**

IMPORTANT NOTICE: Failure to report any claim made against you during your current policy term, or facts, circumstances or events which may give rise to a claim against you to your current insurance company BEFORE expiration of your current policy term may create a lack of coverage.

COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. APPLICANT'S ACCEPTANCE OF COMPANY'S QUOTATION IS REQUIRED PRIOR TO BINDING COVERAGE AND POLICY ISSUANCE. IT IS AGREED THAT THIS FORM SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL ATTACH TO THE POLICY.

General Star Indemnity Company is a "non-admitted" or "surplus lines" insurer in all states except Connecticut, and is not subject to the financial solvency regulation and enforcement which applies to licensed companies. The insurance company does not participate in any state insurance guarantee fund; therefore, these funds will not pay your claims or protect your assets if the insurance company becomes insolvent and is unable to make payments as promised. Your agent or broker can verify with the State Insurance Commissioner that General Star Indemnity Company is an approved surplus lines insurer in the state. This information applies to General Star National Insurance Company in Connecticut only.

An authorized representative who is an active owner, officer, or partner of your firm must sign this Application within thirty (30) days prior to the policy inception date.

Signature: \_\_\_\_\_ Title: \_\_\_\_\_  
(Owner, Partner or Officer)

Date: \_\_\_\_\_

THE APPLICANT UNDERSTANDS THAT COMPLETION OF THIS APPLICATION NEITHER BINDS COVERAGE NOR GUARANTEES THAT A POLICY WILL BE ISSUED.