



## COMPREHENSIVE AUTOMOBILE COVERAGE SUPPLEMENT

*Complete only if you own five or more vehicles.*

**Applicant's Name** \_\_\_\_\_ **Date:** \_\_\_\_\_

	Yes	No	<i>Explanation (If more room is needed, please use reverse side of paper)</i>
1. Does your organization review the driving records of the persons operating your vehicles? <i>If yes, how often.</i>			
2. Are drivers paid hourly or salaried? Hourly <input type="checkbox"/> Salaried <input type="checkbox"/>			
3. Are any vehicles equipped with special apparatus such as wheel chair lifts? If so, which ones?  Is special training in the use of this apparatus provided?	_____  _____	_____  _____	
4. Do you have or do the following: a. Written fleet safety program? b. Accident investigation policy?  If yes, is management involved in monitoring the loss control program?	_____  _____  _____	_____  _____  _____	<i>Additional Comments:</i>
5. Is someone responsible for driver training and vehicle maintenance?  How often are vehicles checked? _____  Is a maintenance log kept in vehicle?  Are vehicles kept inside a garage when not in use?	_____  _____  _____	_____  _____  _____	
6. What is considered an acceptable driving record?			
7. What steps are taken upon receipt of a poor Motor Vehicles record?			
8. Percent of driver turnover on an annual basis?  _____ %			
9. If written driving standards are available, please attach.			

Applicant Signature

Title