COMPREHENSIVE AUTOMOBILE COVERAGE SUPPLEMENT

Complete only if you own five or more vehicles.

Applicant's Name _____ **Date:** _____

	Yes	No	Explanation *(If more room is needed, please use reverse side of paper)*
1. Does your organization review the driving records of the persons operating your vehicles? *If yes, how often.*	☐	☐	
2. Are drivers paid hourly or salaried? Hourly ☐ Salaried ☐			
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:			*Additional Comments:*
a. Written fleet safety program?	☐	☐	
b. Accident investigation policy?	☐	☐	
If yes, is management involved in monitoring the loss control program?	☐	☐	
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