APPLICANT'S NAME **KEITA, MOHAMED** DATE OF TRANSMISSION **2/4/2015 10:49:32 PM ET** EASi REFERENCE # **15035000905**

COMMERCIAL AUTOMOBILE APPLICATION
PENNSYLVANIA ASSIGNED RISK PLAN

NOTICE: PRODUCER MUST READ THIS STATEMENT BEFORE PROCEEDING

Applicants requiring filings or a limit of liability in excess of $350,000 Combined Single Limits will be subject to a 15 calendar day delay in the effective date as specified in Section 38 of the Pennsylvania Assigned Risk Plan.

ANTIFRAUD STATEMENT

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 SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

SECTION 1. CERTIFIED PRODUCER OF RECORD

Producer Last Name/Agency Name	Producer First Name	MI
JOHNSON	AISAH	

Mailing Address	Ste./Apt. No.	City	State	Zip Code
887 MAIN ST		DARBY	PA	19023

Producer License No.	Telephone No. (Incl. area code)	Fax No. (Incl. area code)
000444559	(484) 953-5111	(484) 953-5116

SECTION 2. SIGNING PRODUCER Complete if the producer completing and signing this application differs from Section 1.

Last Name	First Name	MI	Producer License No.
JOHNSON	AISAH		444559

SECTION 3. APPLICANT

Last Name	First Name	MI
KEITA	MOHAMED	

Signature of Applicant or Person Authorized to Sign for Applicant

DBA	Self Employed
MED TRANSIT LLC	■ Yes ☐ No

Home Telephone No. (incl. area code)	Business Telephone No. (incl. area code)	Tax ID No. or Social Security No.
(215) 939-1448	(215) 939-1448	454549046

Street Address	Ste./Apt. No.	City	State	Zip Code
5434 PENTRIDGE STREET		PHILADELPHIA	PA	19143

Headquarters Street Address	Ste./Apt. No.	City	State	Zip Code
5434 PENTRIDGE STREET		PHILADELPHIA	PA	19143

Business of Applicant/Nature of Operation
ADULT DAYCARE

SECTION 4. OWNERSHIP AND CONTROL OF APPLICANT'S ORGANIZATION

Named insured is a:	State of Incorporation	Date of Incorporation	Date actual operations commenced
■ Corporation ☐ Partnership ☐ Sole Proprietor ☐ Other _____	PA	01/17/2013	01/17/2013

Management, Ownership and Control (List names of principals and also anyone with more than a 10% ownership interest.)

	Date in Position	Percent Ownership
President: MOHAMED KEITA	01/17/2013	100
Vice President		
Secretary		
Treasurer		
General Manager		
Others		

List all affiliated companies

Staple check here:
→

000444559

Send original signed application with check/money order and required attachments to:
Pennsylvania Assigned Risk Plan
P.O. Box 6530
Providence, RI 02940-6530

NOTE: For items where space is insufficient, use Remarks Section.

SECTION 5. OPERATOR INFORMATION

List all full-time, part-time, and all other operators that usually drive a vehicle. TOTAL OPERATORS 1

Last Name	First Name	MI	Birth Date Mo./Day/Yr.	Driver's License No.	State
KEITA	MOHAMED		04/08/1959	28014030	PA

For applicants with more than four operators, all additional operators must be listed on an AIP3502 Supplemental Operator Schedule and mailed with the original application to the Plan.

SECTION 6. ACCIDENTS

Has applicant, or anyone who usually drives the applicant's motor vehicle(s), been involved, either as owner or operator, in **ANY** motor vehicle accident during the past THIRTY-SIX months? ☐ Yes ■ No If "Yes", complete the following. (If necessary, use Remarks Section.)

Name of Operator	Accident Date Mo./Day/Yr.	Accident Codes *	Place of Accident		Bodily Injury or Death Amount	Property Damage Amount	Physical Damage Amount
			City	State			
					$	$	$
					$	$	$
					$	$	$
					$	$	$

*Accident Codes
1. Applicant's motor vehicle lawfully parked.
2. Damaged by "Hit and Run" driver and accident reported to police within 24 hours from time of accident.
3. Applicant reimbursed by or on behalf of person responsible for the accident or has judgement against such person.
4. Other person involved in accident was convicted. Applicant or operator was not convicted.
5. Police or Fire Department or First Aid Squad responding to an emergency call.
6. Other type of accident – non-chargeable under provisions of the Plan.
7. Other type of accident - chargeable under provisions of the Plan.

If accident code is 6 or 7, describe accident in space provided.

SECTION 7. CONVICTIONS

Has the applicant, or anyone who usually drives the applicant's motor vehicle(s) been CONVICTED **or** FORFEITED BAIL during the immediately preceding THIRTY-SIX months? NOTE: A paid ticket or fine is an admission of guilt and therefore constitutes a conviction.
Convicted: ☐ Yes ■ No Forfeited Bail: ☐ Yes ■ No If "Yes", for either item, complete the following. (If necessary, use Remarks Section.)

Name of Operator	Date of Conviction or Forfeiture of Bail Mo./Day/Yr.	Did Conviction Arise as a Result of an Accident?	Nature of Conviction	Place of Conviction		Additional Charge Percentage	Was License Suspended or Revoked?
				City	State		
		☐ Yes ☐ No				%	☐ Yes ☐ No
		☐ Yes ☐ No				%	☐ Yes ☐ No
		☐ Yes ☐ No				%	☐ Yes ☐ No
		☐ Yes ☐ No				%	☐ Yes ☐ No

SECTION 8. COMMODITIES TRANSPORTED

Identify any hazardous materials, waste or substances being hauled.

PEOPLE

Identify radius of operations.

50 mile radius

Identify routes - fixed and occasional (both outgoing and return).

philadelphia and surounded area

Trips From Place of Origin To Place of Destination	% of Revenues	No. per Month	Principal Cities entered	Commodities Carried

NOTE: For items where space is insufficient, use Remarks Section.

SECTION 9. COST OF HIRE

For policies rated under Trucker's Cost of Hire.

	Current Year	1st Prior Year	2nd Prior Year	3rd Prior Year	4th Prior Year
Indicate the total Cost of Hire, including wages, for automobiles leased or hired on a short term basis and specifically insured by the applicant as an owned automobile.	$	$	$	$	$
Indicate the total Cost of Hire, including wages, for which are *not* specifically insured by the applicant as an owned automobile but are to be insured as hired automobiles.	$	$	$	$	$
Represent Total Long and Short Term Cost of Hire	$ 0	$ 0	$ 0	$ 0	$ 0

SECTION 10. GROSS RECEIPTS

(Required for Motor Carriers of Property or Passengers whether or not the policy is to be written on Gross Receipts basis.)

Gross Receipts	Current Year	1st Prior Year	2nd Prior Year	3rd Prior Year	4th Prior Year
Other than Truckers	$	$	$	$	$
Truckers excluding receipts from trip leased equipment	$	$	$	$	$

SECTION 11. VEHICLE INFORMATION AND USE

TOTAL VEHICLES

Veh. No.	Year	Vehicle Identification No.	Load Capacity	Type of Registration	Gross Vehicle Weight (GVW) Trucks only	Special Industry (T-FD-SD-WD-F-D-C-O)	Seating Capacity	Loss Payee Name
	Trade Name/ Model No.	Garage Location (Town/State)	State of Registration	Rating Classification	Gross Comb. Weight (GCW) Trucks-Tractors only	Radius Class (L-I-LD)	Tank Capacity	Loss Payee Address
	Type (1)	Name of Registered Owner of Vehicle	Rating Territory (2)	Orig. Cost New (3)	Comp. Symbol / Coll. Symbol / Size (L-M-H-EH)	Purpose Of Use (P or B) (S-R-C)	Final Rating	Loss Payee City, State, Zip Code
	List where vehicle is permitted to operate.		For Public and Long Distance, list all cities through and in which vehicles operate.					
Veh. 1	2006	1FDXE45S36DA16398	14 PASSENGER	C=Commercial	0	Business	9-20	NONE
	FORD	PHILADELPHIA, PA	PA	N/A	0	L=Local	0	NONE
	Public Auto	MED TRANSIT	14	20,000 / 0 / 0 / L=Light		O=All Other	0	NONE
	PA		PHILADELPHIA					
Veh. 2								
Veh. 3								
Veh. 4								
Veh. 5								

(1) Type – Truck=T, Truck-Tractor=TT, Trailer=TR, Semi-Trailer=ST, Public Auto=PA
(2) For public automobiles, use the highest rated territory where the vehicles pick up or discharge passengers.
(3) Chassis and Body including Special Equipment.

For applicants with more than five vehicles, all additional vehicles must be listed on An AIP3500 Supplemental Vehicle Schedule and mailed with the original application to the Plan.

NOTE: For items where space is insufficient, use Remarks Section.

SECTION 12.a. COVERAGES AND PREMIUMS As provided by the Rules of the Plan.

All vehicles written under the same policy shall have the same Limits of Liability. Check appropriate boxes to indicate limits/deductibles	Vehicle 1 Est. Prem.	Vehicle 2 Est. Prem.	Vehicle 3 Est. Prem.	Vehicle 4 Est. Prem.	Vehicle 5 Est. Prem.
Liability – Combined Single Limit (as required by law) ☐ $35,000 CSL ☐ $100,000 CSL ☐ $250,000 CSL ☐ $300,000 CSL ☒ $350,000 CSL ☐ Other:	2,554				
Medical Benefit (Required) ☒ $5,000 ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ $100,000	125				
Income Loss Benefit ☐ $1,000/$5,000 ☐ $1,000/$15,000 ☐ $1,500/$25,000 ☐ $2,500/$50,000					
Funeral Benefit (Optional) ☐ None ☐ $1,500 ☐ $2,500					
Accidental Death Benefit (Optional) ☒ None ☐ $5,000 ☐ $15,000 ☐ $25,000					
Combination First Party Benefit ($177,500) ☐ Yes ☐ No					
Uninsured Motorist Coverage (Optional) (Not to exceed liability limits) ☒ None ☐ $35,000 CSL ☐ $100,000 CSL ☐ $250,000 CSL ☐ $300,000 CSL ☐ $350,000 CSL					
If "None" is checked, attach a signed Rejection of Uninsured Motorist Protection statement found on current Form PA-2000A to this application. Proceed to Underinsured Motorist Coverage. Since uninsured motorist protection is selected, **does the applicant accept stacked limits of Uninsured Motorist Coverage.** ☐ Yes ☐ No **If "No" is checked, attach a signed Rejection of Stacked Uninsured Motorist Coverage Limits statement found on current Form PA-2000B to this application.**					
Underinsured Motorist Coverage (Optional) (Not to exceed liability limits) ☒ None ☐ $35,000 CSL ☐ $100,000 CSL ☐ $250,000 CSL ☐ $300,000 CSL ☐ $350,000 CSL					
If "None" is checked, attach a signed Rejection of Underinsured Motorist Protection statement found on current Form PA-3000A to this application. Proceed to the Extraordinary Medical Benefits Coverage statement. Since underinsured motorist protection is selected, **does the applicant accept stacked limits of Underinsured Motorist Coverage.** ☐ Yes ☐ No **If "No" is checked, attach a signed Rejection of Stacked Underinsured Motorist Coverage Limits statement found on current Form PA-3000B to this application.**					
EXTRAORDINARY MEDICAL BENEFIT COVERAGE (EMBC): UNLESS THE APPLICANT INITIALS THE STATEMENT PROVIDED BELOW, NO EXTRAORDINARY MEDICAL BENEFITS COVERAGE WILL BE PROVIDED. ☐ I REQUEST EXTRAORDINARY MEDICAL BENEFIT COVERAGE X _____ (Applicant's Signature)					
Physical Damage Comprehensive Deductibles $100* $200* $250* $500 $1,000 $5,000** Veh. 1 _____ Veh. 2 _____ Veh. 3 _____ Veh. 4 _____ Veh. 5 _____ *For, **Not for private passenger, light commercial, motorcycle and recreational trailers and camper bodies only.					
Physical Damage Collision Deductibles $100* $200* $250* $500 $1,000 $5,000** Veh. 1 _____ Veh. 2 _____ Veh. 3 _____ Veh. 4 _____ Veh. 5 _____ *For, **Not for private passenger, light commercial, motorcycle and recreational trailers and camper bodies only.					
Loss Of Use* Veh. 1 ☐ Yes ☐ No, Veh. 2 ☐ Yes ☐ No, Veh. 3 ☐ Yes ☐ No, Veh. 4 ☐ Yes ☐ No, Veh. 5 ☐ Yes ☐ No *For private passenger, light commercial, motorcycle and recreational trailers and camper bodies only.					
Pollution Liability					
Total Estimated Premium per vehicle	$ 2,679	$ 0	$ 0	$ 0	$ 0
Total Estimated Premium for vehicles 1-5					2,679
Total Estimated Premium for supplemental vehicles					
Total Estimated Premium for all vehicles					2,679
Nonowned Auto Liability Coverage – If requested, select the Bodily Injury Liability Limit or Combined Single Limit above and complete Section 12.b.					
Garagekeepers Coverage – If requested, Complete Section 12.c.					0
Hired Auto Coverage – If requested, select the Bodily Injury Liability Limit or Combined Single Limit above and complete Section 12.d.					0
Drive Other Car Coverage - If requested, select the Bodily Injury Liability Limit or Combined Single Limit above and complete Section 12.d. Number of individuals to be covered: _____					
Registration Plates Not Issued For A Specific Auto Number of plates: _____ ☐ $35,000 CSL ☐ $100,000 CSL ☐ $250,000 CSL ☐ $300,000 CSL ☐ $350,000 CSL ☐ Other: _____					

NOTE: For items where space is insufficient, use Remarks Section.

Partnership As The Named Insured Nonownership Liability Select the Bodily Injury Liability Limit or Combined Single Limit above Number of active and inactive partners: _____		
Total Estimated Premium for all vehicles and all coverages		$ 2,679

SECTION 12.b. NONOWNED AUTO LIABILITY COVERAGE

Total No. Employees _____ What percentage of the applicant's employees operate their vehicles in the business? _____

PREPARED FOOD DELIVERY SERVICES ONLY

Average No. Drivers _____

AUTO REPAIR SHOPS AND AUTOS HELD FOR INSPECTION BY AN OFFICIAL INSPECTION STATION

Location	Address	No. of Employees	Rating Territory	Premium
1.				
2.				

Are any other vehicles owned by the Applicant? ☐ Yes ■ No
If "Yes" complete the following.

Are any vehicles hauling exclusively for one firm/carrier? ☐ Yes ■ No
If "Yes", complete the following.

Name of Insurance Company	Policy No.	Name of Firm/Carrier
Address of Insurance Company		Type of Business

Description of any owned, leased, hired, and non-owned vehicles which are *not* to be insured.

Year	Trade Make	Body Type	Vehicle Identification No.

SECTION 12.c. GARAGEKEEPERS COVERAGE

Applicable only to official Inspection Stations approved by the PA DOT..

Total Values for All Locations	Specified Causes of Loss Deductible	Specified Causes of Loss Premium	Collision Deductible	Collision Premium

SECTION 12.d. HIRED AUTO COVERAGE

☐ Check here if **desired.**

Estimated Annual Cost of Hire	Rates Per $100	Estimated Premium
	B.I. and P.D.	B.I. and P.D.
$		

SECTION 12.e. DRIVE OTHER CAR COVERAGE

For Non-Owned Automobiles.

Name of Individual(s) (If necessary, use Remarks Section)

SECTION 13. FILINGS OR CERTIFICATES

Is filing or specific limit(s) of liability needed? ■ Yes ☐ No If "Yes" to comply with:

☐ Motor Carrier Act of 1980 Type: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Bus Regulatory Act of 1982 ☐ ICC Regulation - Docket No. _____

☐ Local Ordinance (attach copy) ☐ State Regulation ☐ U. S. DOT No. _____ ■ Other PA PUC--- A6414780

If block(s) are checked, list state(s) and city(ies) requiring filings or limits of liability required by law.

Is applicant required to file evidence of financial responsibility? ☐ Yes ☐ No If "Yes", complete the following.

Last Name	First Name	MI	Social Security No.

Type of Filing ☐ Owner's (operation of owned vehicles) ☐ Operator's (operation of non-owned vehicles) ☐ Both

State where Filing required	Case or file No.	Reason for Filing

NOTE: For items where space is insufficient, use Remarks Section.

SECTION 14. PAYMENT PLANS

☐ Option 1 - Full Annual Premium
☐ Option 2 – Advance Premium Payment of 30% as provided by the Rules of the Plan.
Balance of annual premium to be paid within 30 days after receipt of the policy or notice of premium due.
☐ Option 3 - Installment Premium Payments of 30% as provided by the Rules of the Plan.*
Balance of annual premium to be paid in five (5) monthly installments to be completed six (6) months after the policy effective date. A $4.00 installment charge must be paid with each installment.
In order to ensure timely and proper credit, installment premium payments should be made only to the assigned carrier. Please note that neither the Pennsylvania Assigned Risk Plan nor the producer of record are agents of the assigned carrier.
☑ Premium to be Financed – Name of Premium Finance Company**
ARIZONA PREMIUM FINANCE

Payment by: Check	Check No. 710
Total Estimated Premium (all units and coverages)	$ 2,679
Deposit Premium	$ 536
Amount Submitted with this Application	$ 536

** Not Available on Premium Financed Policies.*
*** Attach a copy of Premium Finance contract.*

SECTION 15. PREVIOUS AUTOMOBILE INSURANCE CARRIER

Information for the past three years. Attach loss statements from previous carrier.

Name of latest carrier	Address of latest carrier	
NATIONAL CONTINENTAL		
Policy No.	Was coverage through Plan? ☑ Yes ☐ No	Termination Date 02/05/2015

If "Yes", give reason terminated.

Complete the following for Motor Carriers of Property and Passengers:

	Policy No.	Policy Period From	To	Name and Address of Insurance Company
1st Prior Year				
2nd Prior Year				
3rd Prior Year				

EVERY POOLED CAP APPLICATION MUST BE ACCOMPANIED BY FOUR (4) YEARS OF THE APPLICANT'S ACCOUNT HISTORY (INCLUDING CLAIMS AND LOSS EXPERIENCE), UNLESS THE RISK HAS BEEN IN BUSINESS LESS THAN FOUR (4) YEARS, IN WHICH EVENT THE ACCOUNT HISTORY FOR THAT PERIOD MUST BE FURNISHED.

SECTION 16. EVIDENCE OF INSURANCE AND REQUESTED EFFECTIVE DATE OF COVERAGE

This application, having been completed and duly executed, shall be, from the effective date and time shown below, evidence of insurance in the limits and coverages specified, subject to the following conditions:
IS EASi IMMEDIATE BINDING COVERAGE REQUESTED ☑ YES ☐ NO

1. Coverage is effective at the time and on the date shown below, provided the EASi Immediate Binding Procedure authorized by Sections 24 and 38 of the Pennsylvania Assigned Risk Plan has been utilized. You must make proper payment in accordance with Section 14 of this application. The applicant is advised to sign this application in the presence of the producer of record. If EASi Immediate Binding Coverage is utilized, confirmation of the effective date is established by the EASi Reference Number.

If immediate binding coverage is not required, or the applicant is a **Pooled CAP** risk ineligible for immediate binding coverage, then the effective date of Plan coverage will be as shown below in accordance with the provisions of Pennsylvania Plan Section 38 but in no event shall coverage be effective prior to 12:01 A.M. on the day following the **date of mailing** of the completed application and prescribed deposit.
2. A premium charge will be made for these coverages if the policy, when and as issued, is not accepted by the insured.
3. The insurance afforded hereunder shall be subject to all the terms and conditions of the Policy Form prescribed for use in accordance with the rules of the Pennsylvania Assigned Risk Plan.

Requested Effective Date and Time of Coverage: (Not to exceed 30 days from the date of application submission)	IN NO EVENT SHALL COVERAGE BE EFFECTIVE PRIOR TO THE DATE AND HOUR OF COMPLETION OF THIS APPLICATION.
2/4/2015 10:49 pm Example: 09/ 01/2003 11:30 AM	

Applicants requiring filings or a limit of liability in excess of $350,000 Combined Single Limits will be subject to a 15 calendar day delay in the effective date as specified in Section 38 of the Pennsylvania Assigned Risk Plan.

IMPORTANT: FOR POOLED CAP RISKS REQUIRING FILINGS (ICC, PUC, etc.) OR LIMITS IN EXCESS OF $350,000 COMBINED SINGLE LIMITS, COVERAGE WILL BE EFFECTIVE ON A DATE SPECIFIED BY THE APPLICANT OR FIFTEEN (15) CALENDAR DAYS FOLLOWING THE PLAN ASSIGNMENT DATE, WHICHEVER IS LATER, UNLESS THE APPLICANT PROVIDES BOTH A DECLARATION PAGE FROM THE INSURER SHOWING COVERAGE THROUGH THE DATE OF APPLICATION, AND EITHER A NOTICE OF ESTIMATED RENEWAL PREMIUM OR A TERMINATION NOTICE PURSUANT TO ACT 86 FOR A REASON OTHER THAN NON-PAYMENT OF PREMIUM, FRAUD OR MATERIAL MISREPRESENTATION, IN WHICH CASE THE EFFECTIVE DATE OF COVERAGE SHALL BE IN ACCORDANCE WITH PENNSYLVANIA PLAN SECTION 38.

NOTE: In the event there is no U.S. postmark (a metered mail postmark, electronic stamp, or other postage service or stamp are not considered a U.S. postmark), coverage will become effective no earlier than 12:01 a.m. on the day following receipt in the Plan Office.

NOTE: For items where space is insufficient, use Remarks Section.