



# COMMERCIAL INSURANCE APPLICATION

## APPLICANT INFORMATION SECTION

DATE (MM/DD/YYYY)

AGENCY	CARRIER	NAIC CODE:	UNDERWRITER	UNDERWRITER OFF.
	POLICIES OR PROGRAM REQUESTED			POLICY NUMBER
	<b>INDICATE SECTIONS ATTACHED</b> <input type="checkbox"/> ACCOUNTS RECEIVABLE/ VALUABLE PAPERS <input type="checkbox"/> BOILER & MACHINERY <input type="checkbox"/> BUSINESS AUTO <input type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CRIME/MISCELLANEOUS CRIME <input type="checkbox"/> DEALERS <input type="checkbox"/> DRIVER INFO SCHEDULE	<input type="checkbox"/> ELECTRONIC DATA PROC <input type="checkbox"/> EQUIPMENT FLOATER <input type="checkbox"/> GARAGE AND DEALERS <input type="checkbox"/> GLASS AND SIGN <input type="checkbox"/> INSTALLATION/BUILDERS RISK <input type="checkbox"/> OPEN CARGO <input type="checkbox"/> PROPERTY <input type="checkbox"/> TRANSPORTATION/ MOTOR TRUCK CARGO	<input type="checkbox"/> TRUCKERS/MOTOR CARRIER <input type="checkbox"/> UMBRELLA <input type="checkbox"/> VEHICLE SCHEDULE <input type="checkbox"/> WORKERS COMPENSATION <input type="checkbox"/> YACHT	
PHONE (A/C, No, Ext):				
FAX (A/C, No):				
E-MAIL ADDRESS:				
CODE:	SUB CODE:			
AGENCY CUSTOMER ID:				

**STATUS OF TRANSACTION****PACKAGE POLICY INFORMATION**

<input type="checkbox"/> QUOTE	<input type="checkbox"/> ISSUE POLICY	<input type="checkbox"/> RENEW	ENTER THIS INFORMATION WHEN COMMON DATES AND TERMS APPLY TO SEVERAL LINES, OR FOR MONOLINE POLICIES.		
BOUND (Give Date and/or Attach Copy):			PROPOSED EFF DATE	PROPOSED EXP DATE	BILLING PLAN
CHANGE	DATE	TIME			DIRECT BILL
CANCEL					AGENCY BILL
					PACKAGE POLICY PREMIUM: \$

**APPLICANT INFORMATION**

NAME (First Named Insured & Other Named Insureds)				MAILING ADDRESS INCL ZIP+4 (of First Named Insured)	
FEIN OR SOC SEC # (of First Named Insured):				PHONE (A/C, No, Ext):	
E-MAIL ADDRESS(ES):				WEBSITE ADDRESS(ES):	
<input type="checkbox"/> INDIVIDUAL	<input type="checkbox"/> CORPORATION	<input type="checkbox"/> SUBCHAPTER "S" CORPORATION NOT FOR PROFIT ORG	<input type="checkbox"/> LLC	NO. OF MEMBERS AND MANAGERS	CR BUREAU NAME:
<input type="checkbox"/> PARTNERSHIP	<input type="checkbox"/> JOINT VENTURE				ID NUMBER:
INSPECTION CONTACT:			ACCOUNTING RECORDS CONTACT:		
PHONE (A/C, No, Ext):		E-MAIL ADDRESS:	PHONE (A/C, No, Ext):		E-MAIL ADDRESS:

**PREMISES INFORMATION**

ACORD 823 attached for additional premises

LOC #	BLD #	STREET, CITY, COUNTY, STATE, ZIP+4	CITY LIMITS	INTEREST	YR BUILT	# EMPLOYEES	ANNUAL REVENUES	% OCCUPIED
			INSIDE	OWNER				
			OUTSIDE	TENANT				
			INSIDE	OWNER				
			OUTSIDE	TENANT				
			INSIDE	OWNER				
			OUTSIDE	TENANT				
			INSIDE	OWNER				
			OUTSIDE	TENANT				

**NATURE OF BUSINESS/DESCRIPTION OF OPERATIONS BY PREMISE(S)**

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**GENERAL INFORMATION**

EXPLAIN ALL "YES" RESPONSES		Y/N
1a. IS THE APPLICANT A SUBSIDIARY OF ANOTHER ENTITY ?		<input type="checkbox"/>
1b. DOES THE APPLICANT HAVE ANY SUBSIDIARIES?		<input type="checkbox"/>
2. IS A FORMAL SAFETY PROGRAM IN OPERATION?		<input type="checkbox"/>
3. ANY EXPOSURE TO FLAMMABLES, EXPLOSIVES, CHEMICALS?		<input type="checkbox"/>
4. ANY CATASTROPHE EXPOSURE?		<input type="checkbox"/>
5. ANY OTHER INSURANCE WITH THIS COMPANY OR BEING SUBMITTED?		<input type="checkbox"/>
6. ANY POLICY OR COVERAGE DECLINED, CANCELLED OR NON-RENEWED DURING THE PRIOR THREE (3) YEARS? (Not applicable in MO)		<input type="checkbox"/>
7. ANY PAST LOSSES OR CLAIMS RELATING TO SEXUAL ABUSE OR MOLESTATION ALLEGATIONS, DISCRIMINATION OR NEGLIGENT HIRING?		<input type="checkbox"/>
8. DURING THE LAST FIVE YEARS (TEN IN RI), HAS ANY APPLICANT BEEN INDICTED FOR OR CONVICTED OF ANY DEGREE OF THE CRIME OF FRAUD, BRIBERY, ARSON OR ANY OTHER ARSON-RELATED CRIME IN CONNECTION WITH THIS OR ANY OTHER PROPERTY? (In RI, this question must be answered by any applicant for property insurance. Failure to disclose the existence of an arson conviction is a misdemeanor punishable by a sentence of up to one year of imprisonment).		<input type="checkbox"/>
9. ANY UNCORRECTED FIRE CODE VIOLATIONS?		<input type="checkbox"/>
10. ANY BANKRUPTCIES, TAX OR CREDIT LIENS AGAINST THE APPLICANT IN THE PAST FIVE (5) YEARS?		<input type="checkbox"/>
11. HAS BUSINESS BEEN PLACED IN A TRUST? IF "YES", NAME OF TRUST:		<input type="checkbox"/>
12. ANY FOREIGN OPERATIONS, FOREIGN PRODUCTS DISTRIBUTED IN USA, OR US PRODUCTS SOLD/DISTRIBUTED IN FOREIGN COUNTRIES? (If "YES", attach ACORD 815 for Liability Exposure and/or ACORD 816 for Property Exposure)		<input type="checkbox"/>
<b>REMARKS/PROCESSING INSTRUCTIONS (Attach additional sheets if more space is required)</b>		
COPY OF THE NOTICE OF INFORMATION PRACTICES (PRIVACY) HAS BEEN GIVEN TO THE APPLICANT. (Not applicable in all states, consult your agent or broker for your state's requirements.)		
<p><b>NOTICE OF INSURANCE INFORMATION PRACTICES</b> - PERSONAL INFORMATION ABOUT YOU, INCLUDING INFORMATION FROM A CREDIT REPORT, MAY BE COLLECTED FROM PERSONS OTHER THAN YOU IN CONNECTION WITH THIS APPLICATION FOR INSURANCE AND SUBSEQUENT POLICY RENEWALS. SUCH INFORMATION AS WELL AS OTHER PERSONAL AND PRIVILEGED INFORMATION COLLECTED BY US OR OUR AGENTS MAY IN CERTAIN CIRCUMSTANCES BE DISCLOSED TO THIRD PARTIES WITHOUT YOUR AUTHORIZATION. YOU HAVE THE RIGHT TO REVIEW YOUR PERSONAL INFORMATION IN OUR FILES AND CAN REQUEST CORRECTION OF ANY INACCURACIES. A MORE DETAILED DESCRIPTION OF YOUR RIGHTS AND OUR PRACTICES REGARDING SUCH INFORMATION IS AVAILABLE UPON REQUEST. CONTACT YOUR AGENT OR BROKER FOR INSTRUCTIONS ON HOW TO SUBMIT A REQUEST TO US.</p> <p>ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER 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 THE PERSON TO CRIMINAL AND [NY: SUBSTANTIAL] CIVIL PENALTIES. (Not applicable in CO, FL, HI, MA, NE, OH, OK, OR, or VT; in DC, LA, ME, TN, VA and WA, insurance benefits may also be denied)</p> <p>IN FLORIDA, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.</p> <p>THE UNDERSIGNED IS AN AUTHORIZED REPRESENTATIVE OF THE APPLICANT AND REPRESENTS THAT REASONABLE ENQUIRY HAS BEEN MADE TO OBTAIN THE ANSWERS TO QUESTIONS ON THIS APPLICATION. HE/SHE REPRESENTS THAT THE ANSWERS ARE TRUE, CORRECT AND COMPLETE TO THE BEST OF HIS/HER KNOWLEDGE.</p>		
PRODUCER'S SIGNATURE	PRODUCER'S NAME (Please Print)	NATIONAL PRODUCER NUMBER
APPLICANT'S SIGNATURE		DATE

**PRIOR CARRIER INFORMATION**

LINE	CATEGORY	CLAIMS MADE		OCCURRENCE		CLAIMS MADE		OCCURRENCE		CLAIMS MADE		OCCURRENCE		CLAIMS MADE		OCCURRENCE	
<b>GENERAL COMMERCIAL LIABILITY</b>	CARRIER																
	POLICY NUMBER																
	POLICY TYPE																
	RETRO DATE																
	EFF-EXP DATE																
	GENERAL AGGREGATE																
	PRODUCTS COMP OP AGGREGATE																
	PERSONAL & ADV INJ																
	EACH OCCURRENCE																
	FIRE DAMAGE																
	MEDICAL EXPENSE																
	BODILY INJURY	OCCURRENCE															
		AGGREGATE															
	PROPERTY DAMAGE	OCCURRENCE															
	AGGREGATE																
COMBINED SINGLE LIMIT																	
MODIFICATION FACTOR																	
TOTAL PREMIUM																	
<b>AUTOMOBILE LIABILITY</b>	CARRIER																
	POLICY NUMBER																
	POLICY TYPE																
	EFF-EXP DATE																
	COMBINED SINGLE LIMIT																
	BODILY INJURY	EA PERSON															
		EA ACCIDENT															
	PROPERTY DAMAGE																
MODIFICATION FACTOR																	
TOTAL PREMIUM																	
<b>PROPERTY</b>	CARRIER																
	POLICY NUMBER																
	POLICY TYPE																
	EFF-EXP DATE																
	BUILDING	AMT															
	PERS PROP	AMT															
MODIFICATION FACTOR																	
TOTAL PREMIUM																	
<b>PROPERTY</b>	CARRIER																
	POLICY NUMBER																
	POLICY TYPE																
	EFF-EXP DATE																
	LIMIT																
	MODIFICATION FACTOR																
	TOTAL PREMIUM																

**LOSS HISTORY**

ENTER ALL CLAIMS OR LOSSES (REGARDLESS OF FAULT AND WHETHER OR NOT INSURED) OR OCCURRENCES THAT MAY GIVE RISE TO CLAIMS FOR THE PRIOR 5 YEARS (3 YEARS IN KS & NY)

DATE OF OCCURRENCE	LINE	TYPE/DESCRIPTION OF OCCURRENCE OR CLAIM	DATE OF CLAIM	AMOUNT PAID	AMOUNT RESERVED	CLAIM STATUS	
						OPEN	CLSD

REMARKS NOTE: FIDELITY REQUIRES A FIVE YEAR LOSS HISTORY ATTACHMENTS

STATE SUPPLEMENT(S) (If applicable)
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# ACORD<sup>TM</sup> BUSINESS AUTO SECTION

DATE (MM/DD/YYYY)

AGENCY	PHONE (A/C, No, Ext):	APPLICANT (First Named Insured)			
	FAX (A/C, No):				
EFFECTIVE DATE		EXPIRATION DATE	DIRECT BILL	PAYMENT PLAN	AUDIT
			AGENCY BILL		
CODE:		FOR COMPANY USE ONLY			
SUB CODE:					
AGENCY CUSTOMER ID:					

**COVERAGES/LIMITS**

USE ACORD 137 FOR YOUR STATE TO PROVIDE COVERAGES/LIMITS INFORMATION

**DRIVER INFORMATION** ACORD 163 attached for additional drivers

LIST ALL DRIVERS, INCLUDING FAMILY MEMBERS THAT WILL DRIVE COMPANY VEHICLES, AND EMPLOYEES WHO DRIVE OWN VEHICLES ON COMPANY BUSINESS.

DRIVER #	NAME (Include address, if required)	SEX	MAR STAT	DATE OF BIRTH	YRS EXP	YEAR LIC	DRIVERS LICENSE NUMBER/ SOCIAL SECURITY NUMBER	STATE LIC	DATE HIRE	BROADEN NO-FAULT	DOC	USE VEH #	% USE

**GENERAL INFORMATION**

EXPLAIN ALL "YES" RESPONSES	YES	NO	EXPLAIN ALL "YES" RESPONSES	YES	NO
1. WITH THE EXCEPTION OF ENCUMBRANCES, ARE ANY VEHICLES NOT SOLELY OWNED BY AND REGISTERED TO THE APPLICANT?			8. ANY HOLD HARMLESS AGREEMENTS?		
2. DO OVER 50% OF THE EMPLOYEES USE THEIR AUTOS IN THE BUSINESS?			9. ANY VEHICLES USED BY FAMILY MEMBERS? IF SO, IDENTIFY IN REMARKS.		
3. IS THERE A VEHICLE MAINTENANCE PROGRAM IN OPERATION?			10. DOES THE APPLICANT OBTAIN MVR VERIFICATIONS?		
4. ARE ANY VEHICLES LEASED TO OTHERS?			11. DOES THE APPLICANT HAVE A SPECIFIC DRIVER RECRUITING METHOD?		
5. ARE ANY VEHICLES CUSTOMIZED, ALTERED OR HAVE SPECIAL EQUIPMENT?			12. ARE ANY DRIVERS NOT COVERED BY WORKERS COMPENSATION?		
6. ARE ICC, PUC OR OTHER FILINGS REQUIRED?			13. ANY VEHICLES OWNED BUT NOT SCHEDULED ON THIS APPLICATION?		
7. DO OPERATIONS INVOLVE TRANSPORTING HAZARDOUS MATERIAL?			14. ANY DRIVERS WITH CONVICTIONS FOR MOVING TRAFFIC VIOLATIONS?		
DESCRIPTION OF GARAGE/STORAGE LOCATIONS			15. HAS AGENT INSPECTED VEHICLES?		
			MAXIMUM DOLLAR VALUE SUBJECT TO LOSS		
			\$		

**ADDITIONAL INTEREST/CERTIFICATE RECIPIENT** ACORD 45 attached for additional names

INTEREST	RANK:	NAME AND ADDRESS	REFERENCE #:	CERTIFICATE REQUIRED	INTEREST IN ITEM NUMBER
<input type="checkbox"/> ADDITIONAL INSURED					VEHICLE:
<input type="checkbox"/> LOSS PAYEE					SCHEDULED ITEM NUMBER:
<input type="checkbox"/> LIENHOLDER					OTHER
<input type="checkbox"/> EMPLOYEE AS LESSOR					
<input type="checkbox"/> OWNER					
<input type="checkbox"/> REGISTRANT					
ITEM DESCRIPTION:					

**REMARKS**

**VEHICLE DESCRIPTION**  **ACORD 129 attached for additional vehicles**

VEH #	YEAR	MAKE:	BODY TYPE:	VEHICLE TYPE			SYM/AGE	COST NEW				
		MODEL:	V.I.N.:	PP	SPEC	COML	\$					
CITY, STATE, ZIP WHERE GARAGED			LIC STATE	TERR	GVW/GCW	CLASS	SIC	FACTOR	SEAT CP	RADIUS	FARTHEST TERM	
DRIVE TO WORK/SCHOOL	USE	COMM'L	CHECK COVERAGES	ADD'L NO-FAULT	UNDRINS MOTOR	F	LSP	RENT REIMB	DEDUCTIBLES	ACV	COMP	SPEC C OF L
< 15 MILES	PLEASURE	RETAIL	LIAB	MED PAY	TOWING & LABOR	FT	COMP	FG	AA	ST AMT	\$	
15 MILES +	FARM	SERVICE	NO-FAULT	UNINS MOTOR	SPEC C OF L	FTW	COLL		\$		\$	COLL
NET VEH DR/CR:										TOTAL PREM \$		

  

VEH #	YEAR	MAKE:	BODY TYPE:	VEHICLE TYPE			SYM/AGE	COST NEW				
		MODEL:	V.I.N.:	PP	SPEC	COML	\$					
CITY, STATE, ZIP WHERE GARAGED			LIC STATE	TERR	GVW/GCW	CLASS	SIC	FACTOR	SEAT CP	RADIUS	FARTHEST TERM	
DRIVE TO WORK/SCHOOL	USE	COMM'L	CHECK COVERAGES	ADD'L NO-FAULT	UNDRINS MOTOR	F	LSP	RENT REIMB	DEDUCTIBLES	ACV	COMP	SPEC C OF L
< 15 MILES	PLEASURE	RETAIL	LIAB	MED PAY	TOWING & LABOR	FT	COMP	FG	AA	ST AMT	\$	
15 MILES +	FARM	SERVICE	NO-FAULT	UNINS MOTOR	SPEC C OF L	FTW	COLL		\$		\$	COLL
NET VEH DR/CR:										TOTAL PREM \$		

  

VEH #	YEAR	MAKE:	BODY TYPE:	VEHICLE TYPE			SYM/AGE	COST NEW				
		MODEL:	V.I.N.:	PP	SPEC	COML	\$					
CITY, STATE, ZIP WHERE GARAGED			LIC STATE	TERR	GVW/GCW	CLASS	SIC	FACTOR	SEAT CP	RADIUS	FARTHEST TERM	
DRIVE TO WORK/SCHOOL	USE	COMM'L	CHECK COVERAGES	ADD'L NO-FAULT	UNDRINS MOTOR	F	LSP	RENT REIMB	DEDUCTIBLES	ACV	COMP	SPEC C OF L
< 15 MILES	PLEASURE	RETAIL	LIAB	MED PAY	TOWING & LABOR	FT	COMP	FG	AA	ST AMT	\$	
15 MILES +	FARM	SERVICE	NO-FAULT	UNINS MOTOR	SPEC C OF L	FTW	COLL		\$		\$	COLL
NET VEH DR/CR:										TOTAL PREM \$		

  

VEH #	YEAR	MAKE:	BODY TYPE:	VEHICLE TYPE			SYM/AGE	COST NEW				
		MODEL:	V.I.N.:	PP	SPEC	COML	\$					
CITY, STATE, ZIP WHERE GARAGED			LIC STATE	TERR	GVW/GCW	CLASS	SIC	FACTOR	SEAT CP	RADIUS	FARTHEST TERM	
DRIVE TO WORK/SCHOOL	USE	COMM'L	CHECK COVERAGES	ADD'L NO-FAULT	UNDRINS MOTOR	F	LSP	RENT REIMB	DEDUCTIBLES	ACV	COMP	SPEC C OF L
< 15 MILES	PLEASURE	RETAIL	LIAB	MED PAY	TOWING & LABOR	FT	COMP	FG	AA	ST AMT	\$	
15 MILES +	FARM	SERVICE	NO-FAULT	UNINS MOTOR	SPEC C OF L	FTW	COLL		\$		\$	COLL
NET VEH DR/CR:										TOTAL PREM \$		

  

VEH #	YEAR	MAKE:	BODY TYPE:	VEHICLE TYPE			SYM/AGE	COST NEW				
		MODEL:	V.I.N.:	PP	SPEC	COML	\$					
CITY, STATE, ZIP WHERE GARAGED			LIC STATE	TERR	GVW/GCW	CLASS	SIC	FACTOR	SEAT CP	RADIUS	FARTHEST TERM	
DRIVE TO WORK/SCHOOL	USE	COMM'L	CHECK COVERAGES	ADD'L NO-FAULT	UNDRINS MOTOR	F	LSP	RENT REIMB	DEDUCTIBLES	ACV	COMP	SPEC C OF L
< 15 MILES	PLEASURE	RETAIL	LIAB	MED PAY	TOWING & LABOR	FT	COMP	FG	AA	ST AMT	\$	
15 MILES +	FARM	SERVICE	NO-FAULT	UNINS MOTOR	SPEC C OF L	FTW	COLL		\$		\$	COLL
NET VEH DR/CR:										TOTAL PREM \$		

  

VEH #	YEAR	MAKE:	BODY TYPE:	VEHICLE TYPE			SYM/AGE	COST NEW				
		MODEL:	V.I.N.:	PP	SPEC	COML	\$					
CITY, STATE, ZIP WHERE GARAGED			LIC STATE	TERR	GVW/GCW	CLASS	SIC	FACTOR	SEAT CP	RADIUS	FARTHEST TERM	
DRIVE TO WORK/SCHOOL	USE	COMM'L	CHECK COVERAGES	ADD'L NO-FAULT	UNDRINS MOTOR	F	LSP	RENT REIMB	DEDUCTIBLES	ACV	COMP	SPEC C OF L
< 15 MILES	PLEASURE	RETAIL	LIAB	MED PAY	TOWING & LABOR	FT	COMP	FG	AA	ST AMT	\$	
15 MILES +	FARM	SERVICE	NO-FAULT	UNINS MOTOR	SPEC C OF L	FTW	COLL		\$		\$	COLL
NET VEH DR/CR:										TOTAL PREM \$		



# FLORIDA COMMERCIAL AUTO COVERAGES/LIMITS SECTION

DATE (MM/DD/YYYY)

AGENCY

APPLICANT (First Named Insured)

## BUSINESS AUTO SECTION

COVERAGES	COVERED AUTO SYMBOLS	LIMITS	COVERAGES	COVERED AUTO SYMBOLS	LIMITS
LIABILITY	1 4 9 2 7 3 8	<input type="checkbox"/> CSL <input type="checkbox"/> BI EA PER \$ BI EACH ACCIDENT \$ PROPERTY DAMAGE \$			
PERSONAL INJURY PROTECTION	5 7	\$10,000 BASIC DED AP-PLIES TO: NAMED INS ONLY NAMED INS & DEP RES REL DED: \$250 \$500 \$1000 WK LOSS EXCL: NAMED INS ONLY NAMED INS & DEP RES REL	PHYSICAL DAMAGE		
EXTENDED P.I.P.	5 7	<input type="checkbox"/> INCLUDE WK LOSS <input type="checkbox"/> EXCLUDE WK LOSS	TOWING & LABOR	3 7	\$
ADDITIONAL P.I.P.	5 7	OPTION#: \$ <input type="checkbox"/> INCLUDE WK LOSS <input type="checkbox"/> EXCLUDE WK LOSS	COMPREHENSIVE	2 4 8 3 7	
MEDICAL PAYMENTS	2 4 8 3 7	EACH PERSON \$	SPECIFIED CAUSES OF LOSS	2 4 8 3 7	
UNINSURED MOTORIST	2 6 3 7 4	<input type="checkbox"/> CSL <input type="checkbox"/> BI EA PER \$ BI EACH ACCIDENT \$	COLLISION	2 4 8 3 7	
HIRED/BORROWED LIABILITY	YES STATES NO	COST OF HIRE \$ IF ANY BASIS	HIRED PHYSICAL DAMAGE	STATES # DAYS # VEH	COVERAGE/DEDUCTIBLE
NON-OWNED LIABILITY	YES STATES NO	GROUP TYPE NUMBER OF EMPLOYEES VOLUNTEERS PARTNERS		COVERAGE IS: PRIMARY SECONDARY	COMP \$ SPEC C OF L \$ COLL \$
<b>COVERED AUTO SYMBOLS</b>	(1) ANY AUTO (2) ALL OWNED AUTOS (3) OWNED PRIVATE PASSENGER AUTOS	(4) OWNED AUTOS OTHER THAN PRIVATE PASSENGER (5) ALL OWNED AUTOS WHICH REQUIRE NO-FAULT COVERAGE (6) OWNED AUTOS SUBJECT TO COMPULSORY U.M. LAW		(7) AUTOS SPECIFIED ON SCHEDULE (8) HIRED AUTOS (9) NON-OWNED AUTOS	

## TRUCKERS SECTION

COVERAGES	COVERED AUTO SYMBOLS	LIMITS	PHYSICAL DAMAGE			
			COVERAGES	COVERED AUTO SYMBOLS	LIMITS	DEDUCTIBLE
LIABILITY	41 X 46 42 43 50	<input checked="" type="checkbox"/> CSL <input type="checkbox"/> BI EA PER \$ BI EACH ACCIDENT \$ PROPERTY DAMAGE \$	COMPREHENSIVE	42 46 43 47		\$
PERSONAL INJURY PROTECTION	44 X 46	\$10,000 BASIC DED AP-PLIES TO: NAMED INS ONLY NAMED INS & DEP RES REL DED: \$250 \$500 \$1000 WK LOSS EXCL: NAMED INS ONLY NAMED INS & DEP RES REL	SPECIFIED CAUSES OF LOSS	42 46 43 47	SCL FT LSP F FTW	\$
EXTENDED P.I.P.	44 46	<input type="checkbox"/> INCLUDE WK LOSS <input type="checkbox"/> EXCLUDE WK LOSS	COLLISION	42 46 43 47		\$
ADDITIONAL P.I.P.	44 46	OPTION#: \$ <input type="checkbox"/> INCLUDE WK LOSS <input type="checkbox"/> EXCLUDE WK LOSS	TOWING & LABOR	46		\$
MEDICAL PAYMENTS	42 46 43	EACH PERSON \$	TRAILER INTERCHANGE			
UNINSURED MOTORIST	42 X 46 43 45	<input checked="" type="checkbox"/> CSL <input type="checkbox"/> BI EA PER \$ BI EACH ACCIDENT \$	COMPREHENSIVE	48 49	# TRAILERS STATE # DAYS RADIUS	DEDUCTIBLE
NON-TRUCKERS HIRED/BORROWED	YES STATES NO	COST OF HIRE \$ IF ANY BASIS	SPECIFIED CAUSES OF LOSS	48 49		
HIRED/BORROWED LIABILITY	YES STATES NO	COST OF HIRE \$ IF ANY BASIS	COLLISION	48 49		\$
NON-OWNED AUTO LIABILITY	YES STATES NO	GROUP TYPE NUMBER OF EMPLOYEES VOLUNTEERS PARTNERS	OTHER		COVERAGE IS: PRIMARY SECONDARY	
<b>COVERED AUTO SYMBOLS</b>	(41) ANY AUTO (42) OWNED AUTOS ONLY (43) OWNED COMMERCIAL AUTOS ONLY	(44) OWNED AUTOS SUBJECT TO NO-FAULT (45) OWNED AUTOS SUBJECT TO A COMPULSORY UNINSURED MOTORIST LAW		(46) SPECIFICALLY DESCRIBED AUTOS (47) HIRED AUTOS ONLY (48) TRAILERS IN YOUR POSSESSION UNDER A TRAILER INTERCHANGE AGREEMENT	(49) YOUR TRAILERS IN THE POSSESSION OF ANOTHER TRUCKER UNDER A TRAILER INTERCHANGE AGREEMENT (50) NON-OWNED AUTOS ONLY	

**MOTOR CARRIER SECTION**

COVERAGES		COVERED AUTO SYMBOLS		LIMITS				PHYSICAL DAMAGE																																																					
				CSL		BI EA PER \$		COVERAGES		COVERED AUTO SYMBOLS		LIMITS				DEDUCTIBLE																																													
LIABILITY		61	67			\$		COMPREHENSIVE		62	67					\$																																													
		62	68			\$				63	68																																																		
		63	71			\$				64																																																			
		64																																																											
PERSONAL INJURY PROTECTION		65		\$10,000 BASIC	DED AP-PLIES TO:	NAMED INS ONLY	NAMED INS & DEP RES REL	SPECIFIED CAUSES OF LOSS		62	67	SCL	FT	LSP	\$																																														
		67		DED:	\$250	\$500	\$1000			63	68	F	FTW																																																
				WK LOSS EXCL:	NAMED INS ONLY	NAMED INS & DEP RES REL				64																																																			
EXTENDED P.I.P.		65	67	INCLUDE WK LOSS		EXCLUDE WK LOSS		COLLISION		62	67					\$																																													
ADDITIONAL P.I.P.		65	67	OPTION#:		\$	INCLUDE WK LOSS		EXCLUDE WK LOSS		63	68																																																	
											64																																																		
MEDICAL PAYMENTS		62	64	EACH PERSON \$				TOWING & LABOR		63		\$																																																	
		63	67							67																																																			
UNINSURED MOTORIST		62	66	CSL		BI EA PER \$		<b>TRAILER INTERCHANGE</b> <table border="1"> <thead> <tr> <th>COVERAGES</th> <th>SYMBOL</th> <th># TRAILERS</th> <th>STATE</th> <th># DAYS</th> <th>RADIUS</th> <th>DEDUCTIBLE</th> </tr> </thead> <tbody> <tr> <td rowspan="2">COMPREHENSIVE</td> <td>69</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>70</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td rowspan="2">SPECIFIED CAUSES OF LOSS</td> <td>69</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>70</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td rowspan="2">COLLISION</td> <td>69</td> <td></td> <td></td> <td></td> <td></td> <td>\$</td> </tr> <tr> <td>70</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>								COVERAGES	SYMBOL	# TRAILERS	STATE	# DAYS	RADIUS	DEDUCTIBLE	COMPREHENSIVE	69						70						SPECIFIED CAUSES OF LOSS	69						70						COLLISION	69					\$	70					
	COVERAGES	SYMBOL	# TRAILERS	STATE	# DAYS	RADIUS	DEDUCTIBLE																																																						
	COMPREHENSIVE	69																																																											
70																																																													
SPECIFIED CAUSES OF LOSS	69																																																												
	70																																																												
COLLISION	69					\$																																																							
	70																																																												
		63	67			\$																																																							
		64																																																											
NON-TRUCKERS HIRED/BORROWED		YES	STATES	COST OF HIRE		IF ANY BASIS		COLLISION		69					\$																																														
		NO		\$						70																																																			
HIRED/BORROWED LIABILITY		YES	STATES	COST OF HIRE		IF ANY BASIS		HIRED PHYSICAL DAMAGE	STATES	# DAYS	# VEH																																																		
		NO		\$																																																									
NON-OWNED AUTO LIABILITY		YES	STATES	GROUP TYPE		NUMBER OF		OTHER	COVERAGE IS:			PRIMARY	SECONDARY																																																
		NO		EMPLOYEES																																																									
				VOLUNTEERS																																																									
				PARTNERS																																																									
OTHER																																																													

**ENDORSEMENTS**

PERSONAL INFORMATION ABOUT YOU MAY BE COLLECTED FROM PERSONS OTHER THAN YOU. SUCH INFORMATION AS WELL AS OTHER PERSONAL AND PRIVILEGED INFORMATION COLLECTED BY US OR OUR AGENTS MAY IN CERTAIN CIRCUMSTANCES BE DISCLOSED TO THIRD PARTIES WITHOUT YOUR AUTHORIZATION. YOU HAVE THE RIGHT TO REVIEW YOUR PERSONAL INFORMATION IN OUR FILES AND CAN REQUEST CORRECTION OF ANY INACCURACIES. A MORE DETAILED DESCRIPTION OF YOUR RIGHTS AND OUR PRACTICES REGARDING SUCH INFORMATION IS AVAILABLE UPON REQUEST. CONTACT YOUR AGENT OR BROKER FOR INSTRUCTION ON HOW TO SUBMIT A REQUEST TO US.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

I UNDERSTAND AND ACKNOWLEDGE THAT I HAVE BEEN OFFERED THE FOLLOWING UNINSURED MOTORIST OPTIONS: 1) STACKED UNINSURED MOTORIST COVERAGE 2) NON-STACKED UNINSURED MOTORIST COVERAGE 3) LIMITS EQUAL TO MY BODILY INJURY (BI) LIMITS 4) LIMITS LOWER THAN MY BI LIMITS, BUT NOT LESS THAN \$10,000/\$20,000 5) REJECTION OF THE COVERAGE COMPLETELY.

I HAVE ELECTED TO PURCHASE THE COVERAGE AND LIMITS SHOWN ON THE DECLARATIONS PAGE. IF I HAVE SELECTED OPTIONS 2, 4 OR 5, THEN I HAVE ALSO SIGNED THE STATE SUPPLEMENT FOR REJECTION OF UNINSURED MOTORIST COVERAGE AND/OR NON-STACKED COVERAGE.

I UNDERSTAND THAT THE COVERAGE SELECTION AND LIMIT CHOICES INDICATED HERE OR IN ANY STATE SUPPLEMENT WILL APPLY TO ALL FUTURE POLICY RENEWALS, CONTINUATIONS AND CHANGES UNLESS I NOTIFY YOU OTHERWISE IN WRITING.

APPLICANT'S SIGNATURE	DATE	PRODUCER'S SIGNATURE	NATIONAL PRODUCER NUMBER
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**FLORIDA AUTO SUPPLEMENT**

AGENCY	APPLICANT/NAMED INSURED	
POLICY NUMBER	CARRIER	NAIC CODE

**FRAUD WARNING: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.**

**REJECTION/ELECTION OF UNINSURED MOTORIST COVERAGE**

**YOU ARE ELECTING NOT TO PURCHASE CERTAIN VALUABLE COVERAGE WHICH PROTECTS YOU AND YOUR FAMILY OR YOU ARE PURCHASING UNINSURED MOTORIST LIMITS LESS THAN YOUR BODILY INJURY LIABILITY LIMITS WHEN YOU SIGN THIS FORM. PLEASE READ CAREFULLY.**

Florida law requires that your automobile policy includes Uninsured Motorists coverage; the amount of Uninsured Motorists coverage must equal the amount of bodily injury liability limits in your policy unless you select lower limits or reject Uninsured Motorists coverage entirely.

Uninsured Motorists coverage provides for payment of certain benefits for damages caused by owners or operators of uninsured motor vehicles because of bodily injury or death resulting therefrom. Such benefits may include payments for certain medical expense, lost wages, and pain and suffering subject to limitations and conditions contained in the policy. For the purpose of this coverage, an uninsured motor vehicle may include a motor vehicle as to which the bodily injury limits are less than your damages.

Please indicate by **initialing below** whether you desire to entirely reject Uninsured Motorists coverage, whether you desire this coverage at limits lower than the Bodily Injury liability limits of your policy, or whether you desire this coverage at limits equal to your Bodily Injury.

**(Initials)**

\_\_\_\_\_ I reject Uninsured Motorists coverage entirely.

\_\_\_\_\_ I select the following Uninsured Motorists limits which are lower than my bodily injury liability limits.

(Choose one):

**(Initials)** Split Limit

\_\_\_\_\_ \$ 10,000 / 20,000

\_\_\_\_\_ 15,000 / 30,000

\_\_\_\_\_ 25,000 / 50,000

\_\_\_\_\_ 50,000/100,000

\_\_\_\_\_ 100,000/300,000

\_\_\_\_\_ 250,000/500,000

\_\_\_\_\_ \$ \_\_\_\_\_

(Other)

**(Initials)** Combined Single Limit

\_\_\_\_\_ \$ 20,000

\_\_\_\_\_ 30,000

\_\_\_\_\_ 50,000

\_\_\_\_\_ 100,000

\_\_\_\_\_ 300,000

\_\_\_\_\_ 500,000

\_\_\_\_\_ \$ \_\_\_\_\_

(Other)

\_\_\_\_\_ I select Uninsured Motorist limits equal to my Bodily Injury limits. (If you select this option disregard the bold face statement above.)

Coverage is generally described here. Only the policy provides a complete description of the coverages and their limitations.

I understand that the coverage selection and limit choices indicated here will apply to all future renewals, continuations and changes unless I notify you otherwise in writing.

\_\_\_\_\_  
Applicant's Signature\_\_\_\_\_  
Date\_\_\_\_\_  
Effective Date



**ELECTION OF NON-STACKED COVERAGE**  
**(Do not complete if you have rejected Uninsured Motorists coverage)**

If you are an individual, and not a business, you have the option to purchase, at a reduced rate, non-stacked Uninsured Motorists coverage. Under this coverage, if injury occurs in an automobile owned or leased by you or any family member who resides with you, this policy will apply only to the extent of coverage, if any, which applies to that automobile in this policy. If an injury occurs while occupying someone else's automobile, or you are struck as a pedestrian, you are entitled to select the highest limits of Uninsured Motorists coverage available on any one automobile for which you are the named insured, insured family member, or insured resident of the named insured's household. This policy will not apply if you select the coverage available under any other policy issued to you or the policy of any other family member who resides with you.

If you do not elect to purchase non-stacked coverage, your policy limit(s) for each automobile are added together (stacked) for all covered injuries. Thus, your policy limits would automatically change during the policy term if you increase or decrease the number of automobiles covered under your policy.

**(Initials)**

\_\_\_\_\_ I elect the non-stacked form of Uninsured Motorists coverage.

Coverage is generally described here. Only the policy provides a complete description of the coverages and their limitations.

I understand that the coverage selection and limit choices indicated here will apply to all future renewals, continuations and changes unless I notify you otherwise in writing.

\_\_\_\_\_

<b>Applicant's Signature</b>	<b>Date</b>	<b>Effective Date</b>
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**PERSONAL INJURY PROTECTION**

**Offer of Deductible and Exclusion of Coverage For Loss of Gross Income and Earning Capacity**

A Florida law requires that, "For personal injury protection insurance, the named insured may elect a deductible and to exclude coverage for loss of gross income and loss of earning capacity ("lost wages"). These elections apply to the named insured alone, or to the named insured and all dependent resident relatives. A premium reduction will result from these elections. The named insured is hereby advised not to elect the lost wage exclusion if the named insured or dependent resident relatives are employed, since lost wages will not be payable in the event of an accident."

I hereby elect a deductible of \$ \_\_\_\_\_ (If "0" is entered, I do not want a deductible.)

Choose one. This deductible applies to the named insured only;  YES  NO  
 or to the named insured and all dependent resident relatives  YES  NO

I hereby elect to exclude coverage for loss of gross income and loss of earning capacity  YES  NO

Choose one. This election applies to the named insured only;  YES  NO  
 or to the named insured and all dependent resident relatives  YES  NO

Coverage is generally described here. Only the policy provides a complete description of the coverages and their limitations.

I understand that the coverage selection and limit choices indicated here will apply to all future renewals, continuations and changes unless I notify you otherwise in writing.

\_\_\_\_\_

**Applicant's Signature**

**Date**

**Effective Date**

## LOSS STATEMENT

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

To: Appalachian Underwriters, Inc.

From: \_\_\_\_\_  
Applicant's Name

This business has had   0   Automobile Claims, totaling \$   0   (paid and reserve) within the past three (3) years. There are   0   open claims.

*I understand that my policy, if accepted, is subject to possible cancellation or non-renewal if the company loss runs show a discrepancy from the information stated herein.*

Signed,

\_\_\_\_\_  
Signature of owner or officer of the insured

OWNER  
Title

\_\_\_\_\_  
Print Name

**New Venture Supplement**

1. Applicant: \_\_\_\_\_ Owner \_\_\_\_\_

2. Date business established: \_\_\_\_\_

3. a) Has applicant / owner ever operated business under another name?  Yes  No

b) If "Yes", list all businesses applicant / owner has owned in the past and years of operation:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

c) If "Yes", any commercial auto liability or physical damage claims or losses within past 36 months for any of those businesses?  Yes  No

4. Describe applicants experience in similar business, specify dates: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

Applicant's Signature (Producer may not sign for applicant)

Producer: \_\_\_\_\_ Agency: \_\_\_\_\_

## Garaging Location Warranty

This Garaging Location Warranty must be completed and signed by the Named Insured and submitted with the application for insurance.

Named Insured: \_\_\_\_\_

Street address of physical location where vehicles are garaged:

\_\_\_\_\_  
Street address

\_\_\_\_\_  
City, State and Zip

Name of insured contact for risk inspection purposes:

\_\_\_\_\_

Phone number of insured for risk inspection purposes:

\_\_\_\_\_

**I warrant the vehicles to be insured by this policy are parked at the above address when not in use, including overnight after close of business. I understand insurance premiums are developed in part by territories based on garaging location. Misrepresentation of the correct garaging location may result in additional premium charges or in cancellation of the policy:**

Named Insured's signature and title: \_\_\_\_\_

Print name: \_\_\_\_\_

Policy or Application Number: \_\_\_\_\_

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