

**EASTERN ATLANTIC INSURANCE COMPANY  
COMMERCIAL AUTOMOBILE APPLICATION \***



Name of Applicant \_\_\_\_\_

Address \_\_\_\_\_  
(No.) (Street) (City) (State) (County)

Desired Effective Date \_\_\_\_\_ to \_\_\_\_\_  
(12:01 A.M. Standard Time at address shown above or \_\_\_\_\_ A.M. / P.M.)

Applicant is:  Individual  Partnership  Corporation  Other

Applicant's Business \_\_\_\_\_ Years Experience in This Business \_\_\_\_\_

Have you ever operated under a different name? \_\_\_\_\_ If yes, explain. \_\_\_\_\_

Location to Be Inspected \_\_\_\_\_

Inspection Contact Person \_\_\_\_\_ Phone No. \_\_\_\_\_ Cellular Phone No. \_\_\_\_\_

Estimate of Financial Worth \$ \_\_\_\_\_ Previous Year's Gross Receipts \$ \_\_\_\_\_

Estimate of Next Year's Receipts \$ \_\_\_\_\_ Have you filed bankruptcy in the last 10 years? \_\_\_\_\_  
If yes, explain \_\_\_\_\_

**DESCRIPTION AND AREA OF OPERATIONS**

Describe your operation including products or items hauled and normal routes \_\_\_\_\_  
\_\_\_\_\_

Check All Applicable:  Transport Hazardous Products  Do Repossessions  Emergency Use  
 Haul oversize/overweight loads (Explain all Checked: \_\_\_\_\_)

List All States Entered \_\_\_\_\_

Maximum Radius \_\_\_\_\_ miles. Largest cities entered or driven through \_\_\_\_\_

Radius Breakdown: 0-100 miles \_\_\_\_\_% 101-300 miles \_\_\_\_\_% 301-600 miles \_\_\_\_\_% 600+ miles \_\_\_\_\_%

Do you haul for others? \_\_\_\_\_ If yes, for whom? \_\_\_\_\_

Is insurance to apply to all owned and leased vehicles? \_\_\_\_\_ If not, please explain \_\_\_\_\_

Number of vehicles owned \_\_\_\_\_ Do you own or operate vehicles not scheduled? \_\_\_\_\_

Do you hire equipment? \_\_\_\_\_ If yes, what is the Estimated Annual Cost of Hire? \_\_\_\_\_

Do you allow passengers in company vehicles? \_\_\_\_\_ If yes, explain: \_\_\_\_\_

**FILINGS, CERTIFICATES – ADDITIONAL INSURED**

For prompt and accurate filing(s), complete information must be given including EXACT name and address and Docket No. under which authority exists. Failure to do so will result in delays and suspensions. Use a separate sheet if necessary.

Do you have an I.C.C. (FMCSA) permit? \_\_\_\_\_ If yes, Docket No. \_\_\_\_\_ D.O.T. No. \_\_\_\_\_  
Form E \_\_\_\_\_ Form H \_\_\_\_\_

State Filings required? Indicate states, permit numbers Forms E, H or Base State \_\_\_\_\_

IF BASE STATE FILING REQUIRED, PLEASE SUBMIT A COPY OF RS-1 AND RS-2.

Are any special filings required; i.e. State Highway Departments, Oversize/Overweight, City Permits?

If yes, please give details: \_\_\_\_\_

Indicate exact name in which permits are issued: \_\_\_\_\_

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Are any Additional Insured(s) to be named on the policy? \_\_\_\_\_ If so, please give the full name and address and their interest in this coverage: \_\_\_\_\_

Are any certificates of insurance needed? \_\_\_\_\_ If so, please indicate the name, address and any special instructions: \_\_\_\_\_

**PREVIOUS INSURANCE AND LOSS EXPERIENCE**

Has insurance of the type applied for ever been cancelled, declined or renewal refused? \_\_\_\_\_  
If yes, explain fully giving name of insurance companies, dates and reason for cancellation or refusal. Use additional sheet, if necessary. \_\_\_\_\_

**LOSS EXPERIENCE AND EXPOSURE INFORMATION – MUST BE COMPLETED FULLY**  
(Current and previous two (2) years)

POLICY PERIOD		PRIOR CARRIER INFO.		PREMIUM PAID TO PRIOR CARRIERS			LOSSES PAID & RESERVES SET (INCLUDE L.A.E. & RECOVERIES)				
From	To	Co. Name & Policy No.	No. of Veh.	Deduct. Amount	Liability & Medical	Phy. Dmg.	Total No of Losses	Liability & Medical	No of Losses	Phy. Dmg	No of Losses

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Please explain any losses/accidents listed above and/or any accidents/details not indicated above \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Do you hire any drivers under 23? \_\_\_\_\_ Do you hire drivers with less than 2 years experience? \_\_\_\_\_  
 Is equipment owner driven only? \_\_\_\_\_ Do you hire any physically impaired drivers? \_\_\_\_\_  
 Are motor vehicle records ordered prior to hiring? \_\_\_\_\_ Are all drivers covered by Worker's Comp.? \_\_\_\_\_  
 Are physical examinations completed per D.O.T. regs.? \_\_\_\_\_ Are pre-employment background checks made? \_\_\_\_\_  
 Do you conduct pre-employment road tests? \_\_\_\_\_ Are written tests given? \_\_\_\_\_  
 Are pre-employment drug tests done? \_\_\_\_\_ Is random drug testing done? \_\_\_\_\_  
 Are drivers paid by the load? \_\_\_\_\_ Hourly? \_\_\_\_\_ % of the gross? \_\_\_\_\_ Per trip?  
 Do you have a driver award/penalty or incentive program in place? \_\_\_\_\_ If yes, **ATTACH COPY.**

**LIST ALL DRIVERS BOTH FULL AND PART TIME**  
(Attach schedule if more space is needed.)

**(PLEASE SEE PAGE 5 OF 5 FOR IMPORTANT NOTICE REGARDING NEW DRIVERS)**

Driver's Name	Date Employed	D.O.B.	Operator No.	State	No. Years Commercial Experience	List Accidents/Violations (3 Yrs)
			OP#			
			OP#			
			OP#			
			OP#			

COVERAGES	LIMITS OF LIABILITY	PREMIUM
Liability		\$
Bodily Injury/Property Damages (CSL) OR	\$ each accident	
Bodily Injury	\$ each person \$ each accident	
Property Damage	\$ each accident	
Uninsured/Underinsured Motorists Coverage (UM)	\$ \$	
Basic First Party Benefits ** (See page 5 of 5)	\$ each person	
<b>TOTAL:</b>		\$

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<b>PHYSICAL DAMAGE</b>	<b>LIMITS AND DEDUCTIBLES</b>	<b>PREMIUM</b>
Comprehensive	State Amount Less \$ _____ Deductible	\$
Specified Perils of Loss	State Amount Less \$ _____ Deductible	
Collision	State Amount Less \$ _____ Deductible	
Trailer Interchange ( <b><u>Provide Copies of ALL Agreements</u></b> )	Maximum Value of (1) Trlr. \$ _____ No. of Trlrs. in Possession: _____ No. of Days in Possession: _____	
<b>TOTAL:</b>		\$

**SCHEDULE OF AUTOMOBILES**

<b>Unit No.</b>	<b>Model Yr.</b>	<b>Trade Name</b>	<b>Serial No. Full No. required)</b>	<b>Body Type</b>	<b>Principal Garage Location</b>	<b>Radius of Use</b>	<b>Rate Terr.</b>	<b>GVW or Seating Capacity</b>
1.								
2.								
3.								
4.								
5.								
6.								

**PHYSICAL DAMAGE COVERAGE IF DESIRED**

<b>Unit No.</b>	<b>Original Cost</b>	<b>Date of Purchase</b>	<b>Stated Amount (Current Value)</b>	<b>Comp Ded.</b>	<b>Specified Perils Ded.</b>	<b>Collision Ded.</b>	<b>Loss Payees (Name &amp; Address) (Indicate applicable Unit)</b>
1.							
2.							
3.							
4.							
5.							
6.							

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*\* ATTACH SEPARATE SHEET(S) FOR DETAILED EXPLANATION(S)*

**THIS APPLICATION MAY NOT BE USED TO BIND COVERAGES AND NO COVERAGE COMMENCES.** Completion of this application by a prospective insurance buyer is for the purpose of transmitting information only. Any agreement or contract binding insurance coverage must be done on a separate document. **COVERAGE WILL COMMENCE** only upon the effective date of a separate contract binding insurance coverage (i.e. a policy or official binder form) issued by an agent authorized by the Company.

The Applicant hereby agrees that the foregoing statements and answers are a true representation of all the facts and circumstances with regard to the risk to be insured to the best of the applicant's knowledge and the same are therefore made the basis of any policy if Insurance is issued.

**\*\* NOTICE REGARDING BFBP AND UM COVERAGES** if required by law in your state, you must complete an additional form(s) rejecting coverage or selecting limits of liability desired for Uninsured/Underinsured Motorists and Basic First Party Benefit (BFPB) Coverages. Selected coverage will affect your premium. Be sure your agent provides you with the necessary form(s) and explains your options and advises you of the cost of your selections.

**IMPORTANT NOTICE: ALL NEW DRIVERS HIRED DURING THE POLICY TERM MUST BE IMMEDIATELY REPORTED TO THE COMPANY. FAILURE TO REPORT MAY RESULT IN TERMINATION OF THIS POLICY. REPORT NEW DRIVERS TO YOUR AGENT OR COMPANY.**

*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.*

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Signature of Agent

\_\_\_\_\_  
Print or Type Applicant's Name & Title

\_\_\_\_\_  
Print or Type Agent's Name & Title

\_\_\_\_\_  
Date Signed (month/day/year)