

# Contingent Liability Application (Bobtail & Deadhead)

COLUMBIA INSURANCE COMPANY  
 NATIONAL FIRE & MARINE INSURANCE COMPANY  
 NATIONAL INDEMNITY COMPANY  
 NATIONAL INDEMNITY COMPANY OF MID-AMERICA  
 NATIONAL INDEMNITY COMPANY OF THE SOUTH  
 NATIONAL LIABILITY & FIRE INSURANCE COMPANY

Policy Term From: \_\_\_\_\_ To \_\_\_\_\_

- Name (and "dba") \_\_\_\_\_  
 Individual/Proprietorship  Partnership  Corporation  Other Business Phone Number \_\_\_\_\_
- Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
- Premises Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
- Person to contact for inspection (name and phone number) \_\_\_\_\_
- Have you ever had insurance with one of the companies listed at the top of this page?  Yes  No  
 If yes, Policy Number(s) \_\_\_\_\_ Effective Date(s) \_\_\_\_\_

## DESCRIPTION OF OPERATIONS

- Describe business \_\_\_\_\_  
 Years experience \_\_\_\_\_ New Venture?  Yes  No Seasonal?  Yes  No
- Is this your primary business?  Yes  No If no, explain \_\_\_\_\_
- Have you ever filed for Bankruptcy?  Yes  No If yes, when \_\_\_\_\_ Explain \_\_\_\_\_
- Gross receipts last year \_\_\_\_\_ Estimate for coming year \_\_\_\_\_ Business for sale?  Yes  No
- Do you operate in more than one state?  Yes  No If yes, list states \_\_\_\_\_
- Show largest cities entered: \_\_\_\_\_ Do you pull double trailers?  Yes  No Triple trailers?  Yes  No
- Do you operate over a regular route?  Yes  No If yes, show towns operated between: \_\_\_\_\_
- List all types of cargo hauled: \_\_\_\_\_  
 Principal commodities outbound \_\_\_\_\_ Backhaul commodities \_\_\_\_\_
- Do you haul any hazardous or extra hazardous substances or materials as defined by EPA?  Yes  No  
 If yes, provide complete listing identifying all material(s) and/or chemical content: \_\_\_\_\_
- What percent of time are your vehicles operating under lease or dispatch? \_\_\_\_\_
- Equipment is under permanent/long term lease to \_\_\_\_\_
- How many companies have you been leased to in the last three years? \_\_\_\_\_
- Do you lease to anyone else?  Yes  No If yes, percent of time \_\_\_\_\_ %, for whom and explanation \_\_\_\_\_
- Do you trip lease on back hauls to others?  Yes  No If yes, percent of time \_\_\_\_\_ %, for whom and explanation \_\_\_\_\_

## LIABILITY COVERAGE – Complete for desired coverages by indicating limits of insurance.

| LIABILITY                     |               |               |                 | Medical Payments | Personal Injury Protection (where applicable) | IF PHYSICAL DAMAGE COVERAGE DESIRED, REFER TO FOLLOWING PAGE.<br><br>IF IN-TOW COVERAGE DESIRED, COMPLETE TOW TRUCK SUPPLEMENT. |
|-------------------------------|---------------|---------------|-----------------|------------------|---|---|
| Combined Single Limit BI & PD | Split Limits  |               | Property Damage |                  |   |   |
|                               | Bodily Injury | Each Accident |                 |                  |   |   |
|                               | Each Person   | Each Accident | Each Accident   |                  |   |   |

**APPLICABLE PERSONAL INJURY PROTECTION, UNINSURED AND/OR UNDERINSURED MOTORISTS INSURANCE SELECTION/REJECTION PAGE IS REQUIRED TO BE COMPLETED AND SIGNED BY THE NAMED INSURED WITH THE SUBMISSION OF THIS APPLICATION.**

## DRIVER INFORMATION – If additional space is needed, attach separate listing.

| Driver's Name | Date of Birth | Driver's Licenses |        |                       |                                | Experience                                    |              |
|---------------|---------------|-------------------|--------|-----------------------|--------------------------------|---|--------------|
|               |               | State             | Number | Class/Type (i.e. CDL) | Years Licensed (in Class/Type) | Type of Unit (Bus, Van, Truck, Tractor, etc.) | No. of Years |
| 1.            |               |                   |        |                       |                                |   |              |
| 2.            |               |                   |        |                       |                                |   |              |
| 3.            |               |                   |        |                       |                                |   |              |
| 4.            |               |                   |        |                       |                                |   |              |
| 5.            |               |                   |        |                       |                                |   |              |

**DRIVER INFORMATION (Continued) – If additional space is needed, attach separate listing.**

| No. Years Previous Commercial Driving Experience | Date of Hire | Accidents and Minor Moving Traffic Violations in Past 5 Years |         |                   |         | Major Convictions (DWI/DUI, Hit & Run, Manslaughter, Reckless, Driving While Suspended/ Revoked, Speed Contest, other felony) |         | Employee (E)<br>Ind. Cont. (IC)<br>Owner/Op. (O/O)<br>Franchisee (F) |
|--|--------------|---|---------|-------------------|---------|---|---------|--|
|  |              | No. of Accidents  | Date(s) | No. of Violations | Date(s) | Describe Conviction   | Date(s) |  |
| 1.   |              |   |         |                   |         |   |         |  |
| 2.   |              |   |         |                   |         |   |         |  |
| 3.   |              |   |         |                   |         |   |         |  |
| 4.   |              |   |         |                   |         |   |         |  |
| 5.   |              |   |         |                   |         |   |         |  |

**PLEASE ATTACH DETAILED EXPLANATION OF ACCIDENTS LISTED ABOVE.**

20. Are drivers covered by Workers Compensation?  Yes  No If yes, name of carrier \_\_\_\_\_
21. Minimum years driving experience required \_\_\_\_\_ Are vehicles owner-driven only?  Yes  No
22. Are drivers ever allowed to take vehicles home at night?  Yes  No If yes, will family members drive?  Yes  No
23. Do you order MVR's on all drivers prior to hiring?  Yes  No Driver's maximum driving hours \_\_\_\_ daily, \_\_\_\_ weekly
24. Do you agree to report all newly hired operators?  Yes  No
25. What is the basis for driver(s) pay?  Hourly  Trip  Mileage  Other, Explain \_\_\_\_\_

**SCHEDULE OF AUTOS/VEHICLES – Describe all vehicles for which application is made for insurance.**

| Veh. No. | Model Year | Vehicle Make & Model | Body Type (i.e. Truck, Tractor, Trailer, etc.) | Full Vehicle Identification Number | Gross Vehicle Weight (GVW) | Total # of rear axles | Principal Garaging Location (city & state) | Radius of Operation | Annual Mileage Per Vehicle | (A) Anti-Lock Brakes, (B) Air Bags |
|----------|------------|----------------------|--|------------------------------------|----------------------------|-----------------------|--|---------------------|----------------------------|------------------------------------|
| 1        |            |                      |  |                                    |                            |                       |  |                     |                            |                                    |
| 2        |            |                      |  |                                    |                            |                       |  |                     |                            |                                    |
| 3        |            |                      |  |                                    |                            |                       |  |                     |                            |                                    |
| 4        |            |                      |  |                                    |                            |                       |  |                     |                            |                                    |
| 5        |            |                      |  |                                    |                            |                       |  |                     |                            |                                    |

26. Will lessor be added as additional insured?  Yes  No If yes, give name and address of lessor for each vehicle \_\_\_\_\_
27. Number of vehicles owned: Pick-Ups \_\_\_\_\_ Trucks \_\_\_\_\_ Tractors \_\_\_\_\_ Semi-Trailers \_\_\_\_\_ Trailers \_\_\_\_\_ Pup Trailers \_\_\_\_\_
28. Number of vehicles leased: Pick-Ups \_\_\_\_\_ Trucks \_\_\_\_\_ Tractors \_\_\_\_\_ Semi-Trailers \_\_\_\_\_ Trailers \_\_\_\_\_ Pup Trailers \_\_\_\_\_

**PHYSICAL DAMAGE COVERAGE – Complete spaces below in detail for each respective auto/vehicle described above.**

| Veh. No. | Date Purchased | Cost When Purchased | Current Stated Value (excluding permanently attached equipment) | Value of Permanently Attached Special Equipment | Total Stated Amount to be Insured | Physical Damage Deductible   |           | Cargo Limit of Insurance |
|----------|----------------|---------------------|---|---|-----------------------------------|--|-----------|--------------------------|
|          |                |                     |   |   |                                   | <input type="checkbox"/> Comprehensive<br><input type="checkbox"/> Spec. C of Loss | Collision |                          |
| 1        |                |                     |   |   |                                   |  |           |                          |
| 2        |                |                     |   |   |                                   |  |           |                          |
| 3        |                |                     |   |   |                                   |  |           |                          |
| 4        |                |                     |   |   |                                   |  |           |                          |
| 5        |                |                     |   |   |                                   |  |           |                          |

29. Any loss payees?  Yes  No If yes, give name and address of mortgagee/loss payee for each vehicle \_\_\_\_\_

**LOSS EXPERIENCE – Provide prior insurance carriers information for past full three years.**

| Policy Term |     | Insurance Company Name | No. of Motor Powered Vehicles | No. of Accidents | Premium |          | Total Amount Claims Paid & Reserves |    |           |       |
|-------------|-----|------------------------|-------------------------------|------------------|---------|----------|-------------------------------------|----|-----------|-------|
| From        | To  |                        |                               |                  | Liab    | Phys Dam | BI                                  | PD | Comp/Coll | Other |
| / /         | / / |                        |                               |                  |         |          |                                     |    |           |       |
| / /         | / / |                        |                               |                  |         |          |                                     |    |           |       |
| / /         | / / |                        |                               |                  |         |          |                                     |    |           |       |

30. Is any applicant aware of any facts or past incidents, circumstances or situations which could give rise to a claim under the insurance coverage sought in this application?  Yes  No If yes, provide complete details \_\_\_\_\_
31. Have you ever been declined, cancelled or non-renewed for this kind of insurance?  Yes  No If yes, date and why \_\_\_\_\_

**IMPORTANT NOTICE**

Insurance companies operating in the Commonwealth of Pennsylvania are required by law to make available for your purchase the following benefits for you, your spouse or other relatives or minors in your custody or in the custody of your relatives, residing in your household, occupants of your motor vehicle or persons struck by your motor vehicle.


- (1) Medical benefits, up to at least \$100,000.
- (1.1) Extraordinary medical benefits, from \$100,000 to \$1,100,000 which may be offered in increments of \$100,000.
- (2) Income loss benefits, up to at least \$2,500 per month up to a maximum benefit of at least \$50,000.
- (3) Accidental death benefits, up to at least \$25,000.
- (4) Funeral benefits, \$2,500.
- (5) As an alternative to paragraphs (1), (2), (3) and (4), a combination benefit, up to at least \$177,500 of benefits in the aggregate or benefits payable up to three years from the date of the accident, whichever occurs first, subject to a limit on accidental death benefit of up to \$25,000 and a limit on funeral benefit of \$2,500, provided that nothing contained in this subsection shall be construed to limit, reduce, modify or change the provisions of section 1715(d) (relating to availability of adequate limits).
- (6) Uninsured, underinsured and bodily injury liability coverage up to at least \$100,000 because of injury to one person in any one accident and up to at least \$300,000 because of injury to two or more persons in any one accident or, at the option of the insurer, up to at least \$300,000 in a single limit for these coverages, except for policies issued under the Assigned Risk Plan. Also, at least \$5,000 for damage to property of others in any one accident.


Additionally, insurers may offer higher benefit levels than those enumerated above as well as additional benefits. However, an insured may elect to purchase lower benefit levels than those enumerated above.

Your signature on this notice or your payment of any renewal premium evidences your actual knowledge and understanding of the availability of these benefits and limits as well as the benefits and limits you have selected.

If you have any questions or you do not understand all of the various options available to you, contact your agent or company.

If you do not understand any of the provisions contained in this notice, contact your agent or company before you sign.

 \_\_\_\_\_  
Signature of First Named Insured

 \_\_\_\_\_  
Date

# FIRST PARTY BENEFITS NOTICE

The options that you requested for Pennsylvania First Party Benefits are reproduced below. **These options determined your policy premium, but your policy may be changed by contacting the party listed below. Changing these indications may result in changes to your premium.** The State of Pennsylvania requires you to purchase a minimum of \$5,000 for the Medical Expense Benefit. All of the other options listed below (including a higher limit of Medical Expenses) are choices you may make. The premium associated with each option is also listed.

If you are satisfied with your level of First Party Benefits this notice may be disregarded.

## FIRST PARTY BENEFITS

- A. MEDICAL EXPENSE BENEFIT**      *Coverage to reimburse you for reasonable and necessary medical treatment and services incurred.*
- B. INCOME LOSS BENEFIT**      *Coverage to replace a portion of lost income and reimburse you for expenses in securing replacement services.*
- C. ACCIDENTAL DEATH BENEFIT**      *A death benefit paid in the event of the death of an insured person due to a covered auto accident.*
- D. FUNERAL BENEFIT**      *Coverage to pay for direct funeral, burial and other related expenses incurred as a result of the death of an insured person due to a covered accident.*

**BENEFIT LEVEL OPTIONS:** (Coverage is comprised of a selection from each one of A, B, C, and D or one selection from E. Coverage is also comprised of a selection from F.)

**A. MEDICAL EXPENSES:**      (☒ indicates the option you selected)

- \$5,000      per person, per accident      (Minimum)      \$ \_\_\_\_\_ Premium
- \$10,000      per person, per accident      \$ \_\_\_\_\_ Premium
- \$25,000      per person, per accident      \$ \_\_\_\_\_ Premium
- \$50,000      per person, per accident      \$ \_\_\_\_\_ Premium
- \$100,000      per person, per accident      (Maximum)      \$ \_\_\_\_\_ Premium

**B. INCOME LOSS:**      (☒ indicates the option you selected, if any)

- None – Rejected      per month / per accident, per person      (Minimum)
- \$1,000 / \$5,000      per month / per accident, per person      \$ \_\_\_\_\_ Premium
- \$1,000 / \$10,000      per month / per accident, per person      \$ \_\_\_\_\_ Premium
- \$1,000 / \$15,000      per month / per accident, per person      \$ \_\_\_\_\_ Premium
- \$1,500 / \$25,000      per month / per accident, per person      \$ \_\_\_\_\_ Premium
- \$2,500 / \$50,000      per month / per accident, per person      (Maximum)      \$ \_\_\_\_\_ Premium

**C. ACCIDENTAL DEATH:** (☒ indicates the option you selected, if any)

- None – Rejected per person, per accident (Minimum)
- \$5,000 per person, per accident \$\_\_\_\_\_ Premium
- \$10,000 per person, per accident \$\_\_\_\_\_ Premium
- \$25,000 per person, per accident (Maximum) \$\_\_\_\_\_ Premium

**D. FUNERAL EXPENSE:** (☒ indicates the option you selected, if any)

- None – Rejected per person, per accident (Minimum)
- \$1,500 per person, per accident \$\_\_\_\_\_ Premium
- \$2,500 per person, per accident (Maximum) \$\_\_\_\_\_ Premium

**OR**

**E. COMBINATION BENEFITS:** Single Limit for all coverages, with specific benefit limits as shown  
(☒ indicates the option you selected, if any)

- \$50,000 (\$2,500 Funeral and \$10,000 Accidental Death Benefits) \$\_\_\_\_\_ Premium
- \$100,000 (\$2,500 Funeral and \$10,000 Accidental Death Benefits) \$\_\_\_\_\_ Premium
- \$177,500 (\$2,500 Funeral and \$25,000 Accidental Death Benefits) \$\_\_\_\_\_ Premium

**AND**

**F. EXTRAORDINARY MEDICAL BENEFIT (EMB):** (☒ indicates the option you selected, if any)

In accordance with Pennsylvania Law your First Party Benefits coverage may be extended to provide an extraordinary medical benefit (EMB) which will pay the medical and rehabilitation costs for you and your family members residing in your household which are more than \$100,000 for each person injured as the result of an automobile accident, up to a lifetime benefit limits of \$1,000,000 for each person. Since you are only required to carry \$5,000 medical expense coverage under your First Party Benefits and EMB coverage only pays expenses that exceed \$100,000, you may have a gap in coverage between your requested First Party Benefits and EMB coverage. We recommend you consider this when you make your medical expense selections.

I purchased no EMB coverage.

I purchased EMB coverage at the following limit:

- \$100,000
- \$300,000
- \$500,000
- \$1,000,000

**If you desire to change your coverage please contact:**

## UNDERINSURED MOTORIST COVERAGE SELECTION / REJECTION

Underinsured Motorist Coverage provides protection for damages incurred which exceed the limit of liability carried by the driver of a vehicle who injures you in an automobile accident. You have the right to purchase Underinsured Motorist Coverage in an amount equal to the amount of Bodily Injury Liability Coverage provided in your policy. The law does not require you to purchase Underinsured Motorist Coverage, and you have the right to reject this coverage. You also have the option to purchase Underinsured Motorist Coverage with limits of coverage less than that of your Bodily Injury Liability Coverage limit. Underinsured Motorist Coverage is an optional coverage, however, we are required to include it in your policy unless you take steps to reject it.

**INDICATE YOUR CHOICE BY EITHER COMPLETING THE REJECTION OF  
UNDERINSURED MOTORIST COVERAGE SECTION (OPTION ONE) OR BY COMPLETING THE SELECTION  
OF UNDERINSURED MOTORIST COVERAGE AND STACKING OPTIONS SECTION (OPTION TWO)**

### **OPTION ONE: REJECTION OF UNDERINSURED MOTORIST COVERAGE**

By signing this waiver I am rejecting Underinsured Motorist Coverage under this policy, for myself and all relatives residing in my household. Underinsured coverage protects me and relatives living in my household for losses and damages suffered if injury is caused by the negligence of a driver who does not have enough insurance to pay for all losses and damages. I knowingly and voluntarily reject this coverage.

X \_\_\_\_\_  
Signature of First Named Insured                      Date Signed                      Witness

### **OPTION TWO: SELECTION OF UNDERINSURED MOTORIST COVERAGE AND STACKING OPTIONS**

**A. Selection of UIM Coverage:** I do wish to purchase Underinsured Motorist Coverage at \$ \_\_\_\_\_ per person, \$ \_\_\_\_\_ per accident split limits of liability or \$ \_\_\_\_\_ per accident single limit of liability. (Your UIM limits selection cannot be greater than your policy Bodily Injury Liability Coverage Limit.)

**B. Stacking Options:** If you have chosen to purchase Underinsured Motorist Coverage, and you are an individual, your next option is to determine if you want to stack the limits of your policy. Stacking means you can claim a total of the amounts of Underinsured Motorist Coverage assigned to each vehicle in your policy. If you reject stacked limits, each vehicle insured under the policy will have its own limit of Underinsured Motorist Coverage. There is an additional premium for this coverage. Please check one box below to indicate your choice.

- Purchase of Stacking: I wish to purchase stacking of Underinsured Motorist Coverage (only applicable if the Named Insured is an individual).
- Rejection of Stacking: I wish to reject stacking of Underinsured Motorist Coverage. By signing this waiver, I am rejecting stacked limits of Underinsured Motorist Coverage under the policy for myself and members of my household under which the limits of coverage available would be the sum of limits for each motor vehicle insured under the policy. Instead the limits of coverage that I am purchasing shall be reduced to the limits stated in the policy. I knowingly and voluntarily reject the stacked limits of coverage. I understand that my premiums will be reduced if I reject this coverage.

X \_\_\_\_\_  
Signature of First Named Insured                      Date Signed                      Witness

**THE OPTIONS SELECTED SHALL CONTINUE IN FORCE AND EFFECT UNTIL REPLACEMENT WRITTEN NOTICE IS RECEIVED BY THE COMPANY, OR ITS REPRESENTATIVE.**

## UNINSURED MOTORIST COVERAGE SELECTION / REJECTION

Uninsured Motorist Coverage provides protection for damages incurred as a result of an accident with an uninsured motor vehicle. You have the right to purchase Uninsured Motorist Coverage in an amount equal to the amount of Bodily Injury Liability coverage provided in your policy. The law does not require you to purchase Uninsured Motorist Coverage, and you have the right to reject this coverage. You also have the option to purchase Uninsured Motorist Coverage with limits of coverage less than that of your Bodily Injury Liability Coverage limit. Uninsured Motorist Coverage is an optional coverage, however, we are required to include it in your policy unless you take steps to reject it.

**INDICATE YOUR CHOICE BY EITHER COMPLETING THE REJECTION OF UNINSURED MOTORIST COVERAGE SECTION (OPTION ONE) OR BY COMPLETING THE SELECTION OF UNINSURED MOTORIST COVERAGE AND STACKING OPTIONS SECTION (OPTION TWO)**

### **OPTION ONE: REJECTION OF UNINSURED MOTORIST COVERAGE**

NOTE: 75 Pa.C.S.A. § 1731(b.1) forbids rejection of uninsured motorist coverage for "Common Carriers by Motor Vehicle" as defined in 66 Pa.C.S.A. § 102.

By signing this waiver I am rejecting uninsured motorist coverage under this policy, for myself and all relatives residing in my household. Uninsured coverage protects me and relatives living in my household for losses and damages suffered if injury is caused by the negligence of a driver who does not have any insurance to pay for losses and damages. I knowingly and voluntarily reject this coverage.

X \_\_\_\_\_  
Signature of First Named Insured                      Date Signed                      Witness

### **OPTION TWO: SELECTION OF UNINSURED MOTORIST COVERAGE AND STACKING OPTIONS**

**A. Selection of UM Coverage:** I do wish to purchase Uninsured Motorist Coverage at \$ \_\_\_\_\_ per person, \$ \_\_\_\_\_ per accident split limits of liability or \$ \_\_\_\_\_ per accident single limit of liability. (Your UM limits selection cannot be greater than your policy Bodily Injury Liability Coverage Limit.)

**B. Stacking Options:** If you have chosen to purchase Uninsured Motorist Coverage, and you are an individual, your next option is to determine if you want to stack the limits of your policy. Stacking means you can claim a total of the amounts of Uninsured Motorist Coverage assigned to each vehicle in your policy. If you reject stacked limits, each vehicle insured under the policy will have its own limit of Uninsured Motorist Coverage. There is an additional premium for this coverage.

Purchase of Stacking: I wish to purchase stacking of Uninsured Motorist Coverage (only applicable if the Named Insured is an individual).

Rejection of Stacking: I wish to reject stacking of Uninsured Motorist Coverage. By signing this waiver, I am rejecting stacked limits of Uninsured Motorist Coverage under the policy for myself and members of my household under which the limits of coverage available would be the sum of limits for each motor vehicle insured under the policy. Instead the limits of coverage that I am purchasing shall be reduced to the limits stated in the policy. I knowingly and voluntarily reject the stacked limits of coverage. I understand that my premiums will be reduced if I reject this coverage.

X \_\_\_\_\_  
Signature of First Named Insured                      Date Signed                      Witness

**THE OPTIONS SELECTED SHALL CONTINUE IN FORCE AND EFFECT UNTIL REPLACEMENT WRITTEN NOTICE IS RECEIVED BY THE COMPANY, OR ITS REPRESENTATIVE.**

**SIGNATURE IS ALSO REQUIRED ON LAST PAGE OF APPLICATION**

**MUST BE SIGNED BY THE APPLICANT PERSONALLY**

No coverage is bound until the Company advises the Applicant or its representative that a policy will be issued and then only as of the policy effective date and in accordance with all policy terms. The Applicant acknowledges that the **Applicant's Representative named below is acting as Applicant's agent and not on behalf of the Company. The Applicant's Representative has no authority to bind coverage, may not accept any funds for the Company, and may not modify or interpret the terms of the policy.**

The Applicant agrees that the foregoing statements and answers are true and correct. The Applicant requests the Company to rely on its statements and answers in issuing any policy or subsequent renewal. The Applicant agrees that if its statements and answers are materially false, the Company may rescind any policy or subsequent renewal it may issue.

If any jurisdiction in which the Applicant intends to operate or the Interstate Commerce Commission requires a special endorsement to be attached to the policy which increases the Company's liability, the Applicant agrees to reimburse the Company in accordance with the terms of that endorsement.

The Applicant agrees that any inspection of autos, vehicles, equipment, premises, operations, or inspection of any other matter relating to insurance that may be provided by the Company, is made for the use and benefit of the Company only, and is not to be relied upon by the Applicant or any other party in any respect.

The Applicant understands that an inquiry may be made into the character, finances, driving records, and other personal and business background information the Company deems necessary in determining whether to bind or maintain coverage. Upon written request, additional information will be provided to the Applicant regarding any investigation.

The Applicant represents that she/he has completed all relevant sections of this Application prior to execution and that the Applicant has personally signed below (or if Applicant is a Corporation, a corporate officer has signed below).

Will premium be financed?  Yes  No If yes, with whom \_\_\_\_\_

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

**TO BE COMPLETED BY APPLICANT'S REPRESENTATIVE**

Is this direct business to your office? \_\_\_\_\_ If not, explain \_\_\_\_\_

Is this new business to your office? \_\_\_\_\_ If not, how long have you had the account? \_\_\_\_\_

How long have you known applicant? \_\_\_\_\_

**REQUEST TO COMPANY GENERAL AGENT:**

Please quote  Please bind at earliest possible date and issue policy

Please issue policy effective \_\_\_\_\_ Coverage was bound by \_\_\_\_\_  
(Time and Date Bound by General Agent) (Name of Person in Company General Agency's Office Binding Coverage)

\_\_\_\_\_  
Applicant's Representative's Name and Address

\_\_\_\_\_  
Phone No.