Truck Application

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

DVUA Pittsburgh, Inc.
One Forestwood Drive, Suite 203
Pittsburgh, PA 15237
(412) 369-2500 FAX: (412) 366-1760

Policy Term From:_____ To _____

1. Name (and "dba") _____
   ☐ Individual/Proprietorship ☐ Partnership ☐ Corporation ☐ Other Business Phone Number _____
2. Mailing Address _____ City _____ State _____ Zip _____
3. Premises Address _____ City _____ State _____ Zip _____
4. Person to contact for inspection (name and phone number) _____
5. 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

6. Describe business _____
   Years experience _____ New Venture? ☐ Yes ☐ No If you are a tow truck operation, do you do repossessions? ☐ Yes ☐ No
7. Is this your primary business? ☐ Yes ☐ No If no, explain _____
   Seasonal? ☐ Yes ☐ No
8. Have you ever filed for Bankruptcy? ☐ Yes ☐ No If yes, when _____ Explain _____
9. Gross receipts last year _____ Estimate for coming year _____ Business for sale? ☐ Yes ☐ No
10. Do you operate in more than one state? ☐ Yes ☐ No If yes, list states _____
11. Do you haul for hire? ☐ Yes ☐ No Show largest cities entered _____
12. Do you operate over a regular route? ☐ Yes ☐ No If yes, show towns operated between _____
13. Are you a common carrier? ☐ Yes ☐ No Are you a contract hauler? ☐ Yes ☐ No If yes, for whom _____
14. List all types of cargo hauled _____
15. 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: _____
16. Do you haul your own cargo exclusively? ☐ Yes ☐ No If not, who owns it? _____
17. Do you pull double trailers? ☐ Yes ☐ No Triple trailers? ☐ Yes ☐ No
18. Do you rent or lease your vehicles to others? ☐ Yes ☐ No If yes, attach copy of rental or lease agreement form used.
19. Do you hire any vehicles? ☐ Yes ☐ No Complete Hired and Non-Owned Supplemental Questionnaire if coverage is desired.

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

LIABILITY				Medical Payments	Personal Injury Protection (where applicable)	
Combined Single Limit BI & PD	Split Limits					IF PHYSICAL DAMAGE COVERAGE DESIRED, REFER TO FOLLOWING PAGE.
	Bodily Injury		Property Damage			IF IN-TOW COVERAGE DESIRED, COMPLETE TOW TRUCK SUPPLEMENT.
	Each Person	Each Accident	Each Accident			HIRED, NON-OWNED - M-4055.

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) Ind. Cont. (IC) Owner/Op. (O/O) 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 (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										
6										
7										
8										
9										
10										

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
						☐ Comprehensive ☐ Spec. C of Loss	Collision	
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

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 _____

CARGO INFORMATION — 100% coinsurance clause applies. Use Tow Truck Supplement for In-Tow/On Hook coverage.

PREVIOUS CARGO CARRIER AND LOSS EXPERIENCE (list for the past three years with most recent carrier first).

Policy Term		Company & Policy Number	Premium	Number of Claims	Cause of Loss	Amount Paid	Reserves
From	To						
/ /	/ /						
/ /	/ /						
/ /	/ /						

Describe Cargo Hauled	% of Hauling	Maximum Value	Average Value	Limit of Insurance	Deductible
				SEE PHYSICAL DAMAGE COVERAGE SECTION	☐ $500 ☐ $1,000 ☐ $2,500 ☐ Other _____

If applicant hauls double wide mobile homes, Limit of Insurance must be equal to the value of both sides combined to satisfy co-insurance. Amount of insurance on each truck should equal maximum load carried.

32. Select type of cargo coverage desired: ☐ Named Perils or ☐ Broad Form

33. Additional Coverage Options (additional premium may apply): ☐ Additional Insured Endorsement (Lessee) ☐ Loading and Unloading Coverage ☐ Earned Freight Coverage ☐ Refrigeration Breakdown Coverage ☐ Hired Car Cargo Coverage ☐ Exclude Theft Coverage

FILING INFORMATION

34. Is an FHWA filing required? ☐ Yes ☐ No If yes, MC number _____
☐ Common ☐ Contract ☐ Broker Do you require FHWA cargo filing? ☐ Yes ☐ No

35. If you hold a Brokers license, identify name filed with FHWA, FHWA docket no. and receipts from brokerage operations _____

36. If you are an interstate regulated carrier, identify your registration or base state _____

37. Is an intrastate filing needed? ☐ Yes ☐ No If yes, show state and permit number _____
List states for which insured requires CARGO FILINGS (check name on permits) _____

38. Show exact name and address in which permits are issued _____

39 Is MCS 90 endorsement needed? ☐ Yes ☐ No

40. Is our policy to cover all vehicles owned, operated or under lease to applicant? ☐ Yes ☐ No If no, explain _____

41. Are oversize, overweight commodities hauled? ☐ Yes ☐ No If filing required, show states _____
Are escort vehicles towed on return trips? ☐ Yes ☐ No

42. Does your authority allow for transportation of hazardous commodities? ☐ Yes ☐ No

43. Do you allow others to haul hazardous commodities under your authority? ☐ Yes ☐ No

44. Have you ever changed your operating name? ☐ Yes ☐ No Do you operate under any other name? ☐ Yes ☐ No

45. Do you operate as a subsidiary of another company? Yes No

46. Do you own or manage any other transportation operations that are not covered? Yes No

47. Do you lease your authority? ☐ Yes ☐ No Do you appoint agents or hire independent contractors to operate on your behalf? ☐ Yes ☐ No

48. Have you purchased, sold or applied for authority over the past 3 years? ☐ Yes ☐ No

49. Have you ever lost or had authority withdrawn, or have you been/are under probation by any regulatory authority (FHWA, PUC, etc.)? ☐ Yes ☐ No

50. Is evidence/certificate(s) of coverage required? ☐ Yes ☐ No

51. Please explain any "yes" answer to questions 44 through 50 _____

52. Do you have agreements with other carriers for the interchange of equipment or transportation of loads? ☐ Yes ☐ No
If yes, attach a copy of current agreements and complete the following:
(a) With whom has such agreement(s) been made? _____
(b) Do the parties named in (a) carry automobile liability insurance? ☐ Yes ☐ No
If yes, name of insurance company and limits of liability (Bodily Injury & Property Damage) _____
(c) Under whose permit does each of the parties to the agreement(s) operate? _____
(d) Is there a hold harmless in the agreement(s)? ☐ Yes ☐ No

53. Do you barter, hire or lease any vehicles? ☐ Yes ☐ No If yes, explain _____

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.

I have read and acknowledge the information set out above.

X _____ _____ _____

Signature of First Named Insured | Date | Witness

FIRST PARTY BENEFITS NOTICE

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.*

Effective July 1, 1990 Act 6 changes what is required to be taken for first party benefits. You are required to purchase a minimum of $5,000 Medical Expenses. All other options listed below (including a higher limit of Medical Payments) are choices for you to make. Indicate your choice of options shown below for each coverage. Then date and sign this form and return to your Agent.

BENEFIT LEVEL OPTIONS: (Include your choice by marking the box for each coverage or for your choice of Combination Benefits option; a selection from F and either one from each of A, B, C, and D or one selection from E)

A. MEDICAL EXPENSES: (☒ indicates your choice)

☐ $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 your choice)

☐ None – Rejected	per month / per accident, per person	(Minimum)		
☐ $1,000 / $5000	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 your choice)

☐ 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 your choice)

☐ 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 your choice)

☐ $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 your choice)

☐ I wish to purchase EMB coverage at the following limit:

☐ $100,000 ☐ $300,000 ☐ $500,000 ☐ $1,000,000

☐ I do not wish to purchase EMB coverage.

In accordance with 1989 Pa. Laws 4, 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 selected first party benefits above an EMB coverage. We recommend you consider this when you make your medical expense selections.

I have had the coverages, benefit levels and options as set out above, fully explained to me and have indicated my choices (☒ indicates my choices) as shown. I understand that this is simply a summary of the coverages and benefits, and that the forms and endorsements attached to my policy actually make up my coverage.

_____ _____ X_____

Witness to signature of Named Insured(s) Date Signature of Named Insured(s)

Named Insured_____

Typed or printed name

THE CHOICES AND OPTIONS AS INDICATED ABOVE WILL CONTINUE IN FORCE AND EFFECT UNTIL WRITTEN REPLACEMENT NOTICE IS RECEIVED BY THE COMPANY OR ITS REPRESENTATIVE.

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.