

Business Auto Application

Applicant Information	
Business Name:	Contact:
Applicant	Business Number:
Mailing Address	Cellular Number:
City	Fax Number:
State and Zip Code	Email:
Web-Site	Premium:
Organization Type (Individual/Partnership/Corporation/LLC)	Financing:
Desired Policy Effective Date:	Down Payment:

Garaging Street Address: _____
City: _____ County: _____
State: _____ Zip: _____ Is this location secured? () Yes () No Describe:
* If More than one, please put in Note Field

Safety Management:	Yes	No
Written Safety Program that is implemented and enforced at your company?	<input type="checkbox"/>	<input type="checkbox"/>
Safety meetings are held? <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly	<input type="checkbox"/>	<input type="checkbox"/>
Written Driver Training Program?	<input type="checkbox"/>	<input type="checkbox"/>
Is there a Written vehicle take-home policy?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a drug-testing program in place?	<input type="checkbox"/>	<input type="checkbox"/>
If you answered NO to any of the above Questions, if requested, would management implement a program designed to assist with that item within the first 30 Days of the effective date of this insurance? <input type="checkbox"/> <input type="checkbox"/>		
Owners Initials _____		

Driver Management Section:	Yes	No
Pre-hire Screening:		
Obtain a Motor Vehicle Record Report (MVR) on each driver prior to hiring?	<input type="checkbox"/>	<input type="checkbox"/>
Check ALL prior job references a driver provides prior to hiring?	<input type="checkbox"/>	<input type="checkbox"/>
Road test ALL drivers prior to hiring?	<input type="checkbox"/>	<input type="checkbox"/>
Order MVR's on ALL company drivers at least on an Annual basis?	<input type="checkbox"/>	<input type="checkbox"/>
What driver training do you provide for your employees? _____		
Do you require your employees to take outside training courses? <input type="checkbox"/> Yes <input type="checkbox"/> No. If yes what courses do they take? _____		

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General Operations:	Yes	No
Lease vehicles from other individuals or companies?	<input type="checkbox"/>	<input type="checkbox"/>
Lease vehicles to other individuals or companies?	<input type="checkbox"/>	<input type="checkbox"/>
Are all vehicles titled under the business name?	<input type="checkbox"/>	<input type="checkbox"/>
Have any additional vehicles owned or leased by your company NOT on this schedule?	<input type="checkbox"/>	<input type="checkbox"/>
Employees required complete incidence reports?	<input type="checkbox"/>	<input type="checkbox"/>
What percentage of your driving is: within: 50 Miles _____ %, 51-100 Miles _____%, 101-300 Miles _____%, Over 301Miles_____.		

Maintenance:	Yes	No
Do you maintain maintenance logs on each vehicle?	<input type="checkbox"/>	<input type="checkbox"/>
Do you provide the routine maintenance on your equipment?	<input type="checkbox"/>	<input type="checkbox"/>
If you do not perform maintenance who does? _____		
Are they Professionally Certified as Mechanics?	<input type="checkbox"/>	<input type="checkbox"/>
Are your drivers in any way responsible for the cost of the maintenance of your equipment?	<input type="checkbox"/>	<input type="checkbox"/>
Do your drivers perform daily maintenance checks on ALL vehicles?	<input type="checkbox"/>	<input type="checkbox"/>

Coverage Section	Limits			
Business Liability	Symbol 7	() \$300,000	() \$500,000	() \$1,000,000
Under/Uninsured Motorist Liability	Symbol 7	() \$300,000	() \$500,000	() \$1,000,000
Medical Payments	Symbol 7	() \$5,000		
Personal Injury Protection	Symbol 5	() \$10,000	() \$25,000	() \$ 35,000
Comprehensive – Scheduled per Auto	Symbol 7	() \$500	() \$1,000	() \$2,500
Collision - Scheduled Per Auto	Symbol 7	() \$500	() \$1,000	() \$2,500
Hired and Non-Owned Auto	Symbol 8,9	() \$300,000	() \$500,000	() \$1,000,000

Prior Insurance Information:

Company	Policy Dates	Premium	Losses (describe below)

History of business:

Has any insurance carrier cancelled or declined to renew your coverage? () Yes () No
 If so, why? _____ 2 of 7

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Prior claims or pending claims within the last three years? YES[] NO[] If yes, please explain with dates, amount and description. Please attach your company loss reports, which can be obtained by your agent.

Date of Loss	Total Amount	Coverage Type	Driver	Date of Loss	Total Amount	Coverage Type	Driver
1.	\$			5.	\$		
2.	\$			6.	\$		
3.	\$			7.	\$		
4.	\$			8.	\$		

Notes:

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 of insurance issued.

NOTICE: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON, FILES THIS QUESTIONNAIRE FOR INSURANCE CONTAINING ANY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

My signing this application you have read the above and you understand all drivers must be reported prior to driving and part of your hiring practice is to secure a motor vehicle report of the driver dated within 6 months of hiring.

Applicant's Signature

Date

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Vehicle Schedule

Print Additional Pages if required

Applicant: _____ Date: _____

: _____ Year: _____ Make: _____ Model: _____ GVWR: _____ Radius: _____
Garage Location _____ VIN: _____ / _____ / _____ / _____
Value: Cost New \$ _____ or Stated Value \$ _____ Personal Use () Yes () No
Comprehensive Coverage: \$500 \$1,000 \$2,500 Collision Coverage: \$500 \$1,000 \$2,500
 Loss Payee Additional Insured – Leased Auto Assigned Driver _____

: _____ Year: _____ Make: _____ Model: _____ GVWR: _____ Radius: _____
Garage Location _____ VIN: _____ / _____ / _____ / _____
Value: Cost New \$ _____ or Stated Value \$ _____ Personal Use () Yes () No
Comprehensive Coverage: \$500 \$1,000 \$2,500 Collision Coverage: \$500 \$1,000 \$2,500
 Loss Payee Additional Insured – Leased Auto Assigned Driver _____

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Garage Location _____ VIN: _____ / _____ / _____ / _____
Value: Cost New \$ _____ or Stated Value \$ _____ Personal Use () Yes () No
Comprehensive Coverage: \$500 \$1,000 \$2,500 Collision Coverage: \$500 \$1,000 \$2,500
 Loss Payee Additional Insured – Leased Auto Assigned Driver _____

: _____ Year: _____ Make: _____ Model: _____ GVWR: _____ Radius: _____
Garage Location _____ VIN: _____ / _____ / _____ / _____
Value: Cost New \$ _____ or Stated Value \$ _____ Personal Use () Yes () No
Comprehensive Coverage: \$500 \$1,000 \$2,500 Collision Coverage: \$500 \$1,000 \$2,500
 Loss Payee Additional Insured – Leased Auto Assigned Driver _____

: _____ Year: _____ Make: _____ Model: _____ GVWR: _____ Radius: _____
Garage Location _____ VIN: _____ / _____ / _____ / _____
Value: Cost New \$ _____ or Stated Value \$ _____ Personal Use () Yes () No
Comprehensive Coverage: \$500 \$1,000 \$2,500 Collision Coverage: \$500 \$1,000 \$2,500
 Loss Payee Additional Insured – Leased Auto Assigned Driver _____

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Lien Holders Schedule

Print Additional Pages if required

Applicant:

Loss Payee Additional Insured

Vehicle Number from App Schedule: _____

Entity Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (____) - _____ Fax: (____) - _____ Contact: _____

Loss Payee Additional Insured

Vehicle Number from App Schedule: _____

Entity Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (____) - _____ Fax: (____) - _____ Contact: _____

Loss Payee Additional Insured

Vehicle Number from App Schedule: _____

Entity Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (____) - _____ Fax: (____) - _____ Contact: _____

Loss Payee Additional Insured

Vehicle Number from App Schedule: _____

Entity Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (____) - _____ Fax: (____) - _____ Contact: _____

Loss Payee Additional Insured

Vehicle Number from App Schedule: _____

Entity Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (____) - _____ Fax: (____) - _____ Contact: _____

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Applicant _____

Date: _____

Employee List: Please include ALL employees employed with the Named Insured

No.	Last Name	First Name	Initial	Job Duties	Years Employed	Date of Birth	Years Experience	License Number
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								

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No.	Last Name	First Name	Initial	Job Duties	Years Employed	Date of Birth	Years Experience	License Number
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
31								

Person Completing Drivers List:
