PUBLIC AUTO INSURANCE APPLICATION - MICHIGAN

1. GENERAL

Applicant's name _____

Address _____ Phone # _____

Insured: ☐ Individual ☐ Partnership Proposed effective date: _____

☐ Corporation ☐ _____ Expiration date: _____

2. COVERAGES REQUESTED

☐ Liability _____ ☐ No Fault Property Damage Liability *See Section 10* ☐ Physical Damage - *See Section 8*

☐ Uninsured/Underinsured Motorists _____ ☐ Personal Injury Protection - *See Section 11* ☐ Collision Options - *See Section 9*

☐ Other _____

3. OPERATIONS

A. Describe your business _____

B. Is your operation: Government funded? ☐ Yes ☐ No Seasonal? ☐ Yes ☐ No Non-profit? ☐ Yes ☐ No

C. Years in business? _____ Maximum radius of operation? _____ miles

D. List the largest cities into or through which vehicles are operated:

1) _____ 2) _____ 3) _____ 4) _____ 5) _____

E. Do you travel out of state regularly? ☐ Yes ☐ No If yes, please describe?

_____

F. Do you travel into Ontario? ☐ Yes ☐ No If yes, how many days per month? _____

G Average no. of hours per day each vehicle is operated _____ Percent of night driving _____

H. Describe personal use of any vehicles _____

I. Do you ever transport: Professional athletes or entertainers? ☐ Yes ☐ No Mentally handicapped? ☐ Yes ☐ No

Physically handicapped? ☐ Yes ☐ No If yes, are vehicles specially equipped? How?

J. Do you lease or rent vehicles: From others? ☐ Yes ☐ No To others? ☐ Yes ☐

K. Filings required:

4. PRIOR INSURANCE CARRIERS (3 previous years)

Prior carriers	Year	Policy #	# of trucks & tractors	Premium	Cancelled or non-renewed? (Reason?)

5. LOSS EXPERIENCE FOR PAST THREE YEARS (Add additional sheet, if necessary)

Date of loss	Description, incl. driver's name, liability or physical damage	Amount paid	Current reserve

6. DRIVER INFORMATION (Add additional sheet, if necessary)

Driver's name (as on driver's license)	Date of birth	Driver license no. & state where licensed	Years licensed	Years driving similar vehicle	Date of hire	Accidents and violations in the last three years

Are all drivers your employees? ☐ Yes ☐ No Are your employees covered by Workers' Compensation? ☐ Yes ☐ No

Do you agree to promptly report all drivers to us? ☐ Yes ☐ No Drivers are paid by? ☐ Load ☐ Mileage ☐ Hourly ☐ Other _____

During the last 12 months, how many drivers were: Hired? _____ Fired? _____ Quit? _____

7. VEHICLE INFORMATION (Add additional sheet, if necessary)

Auto No.	Model year	Trade name	Body type (tractor, truck-tractor, trailer)	Vehicle ID no.	GVW/GCW Of Vehicle	Radius of operation (in miles)	Town & state principally garaged
1							
2							
3							
4							
5							
6							
7							

A. Do you have a regular vehicle inspection and preventive maintenance program? ☐ Yes ☐ No
If yes, describe _____

B. Do you own any vehicles which will not be covered under this policy? ☐ Yes ☐ No If yes, describe all other vehicles and other liability insurance _____

C. Any vehicles specially equipped? ☐ Yes ☐ No If yes, please explain _____

8. PHYSICAL DAMAGE (Add additional sheet, if necessary)

No.	Purchased new or used (N or U)	Date purchased	Cost when purchased	Amount of insurance (must equal present value)	Collision Deductible	Specified causes of loss deductible	Loss payee
1							
2							
3							
4							
5							
6							
7							

9. COLLISION INSURANCE OPTIONS

If you selected Collision Coverage in Section 8, you must choose the type of collision coverage you wish to purchase. Please make your choice by initialing one of these options:

_____ Limited Collision Coverage – If you purchase this insurance, we will pay for collision damages when the driver of your insured vehicle is not more than 50% responsible for the accident. You will not have to pay a deductible amount. If the driver of your insured vehicle is more than 50% responsible for the accident, we will not pay for collision damages.

_____ Collision Coverage – If you purchase this insurance, we will pay collision damages to your insured vehicle, regardless of who is responsible for the accident. You must pay a deductible amount for each accident.

_____ Broadened Collision Coverage – If you purchase this insurance, we will pay collision damages to your insured vehicle regardless of who is responsible for the accident. If the driver of your insured vehicle is not at fault, no deductible applies.

10. NO-FAULT PROPERTY DAMAGE LIABILITY COVERAGE

If you select this coverage, we will pay liability losses you incur for property damage to autos, subject to a limit of $500 per claim.

_____ I reject no-fault property damage liability coverage.

_____ I want no-fault property damage liability coverage included in my policy.

11. PERSONAL INJURY PROTECTION COORDINATION OF BENEFITS

This section applies only to an individual named insured and the named insured's resident relatives.

Michigan Personal Injury Protection premiums may be reduced with respect to autos owned by an individual if 1) health and accident coverage exists (such as group/individual medical insurance) which provides medical, surgical, hospital and/or work loss benefits and; 2) the individual elects to make these benefits primary for himself, his spouse and other resident relatives.

Such an election would make the automobile policy secondary. Your automobile policy would be responsible only for those Personal Injury Protection benefits not covered by your health and accident provider, thus, eliminating any duplication of benefits.

Please indicate your Personal Injury Protection coverage preference by initialing the appropriate statement(s) below.

_____ I have other health and accident coverage to cover allowable medical expenses and want this automobile policy to become secondary to such coverage.

_____ I have other health and accident coverage to cover work loss benefits and want this automobile policy to become secondary to such coverage.

_____ I have no other health and accident coverage to cover either allowable medical expenses and/or work loss benefits and want this automobile policy to be primary insurance.

12. AGREEMENTS AND SIGNATURES

APPLICANT: I BELIEVE THE STATEMENTS IN THIS APPLICATION ARE TRUE AND CORRECT. I UNDERSTAND THAT THE INSURER WILL RELY ON THESE STATEMENTS IF A POLICY IS ISSUED. I AGREE TO PROMPTLY REPORT ALL FULL TIME AND PART TIME DRIVERS. MY EMPLOYEES UNDERSTAND THAT MOTOR VEHICLE REPORTS WILL BE ORDERED. ON THEIR BEHALF, I AUTHORIZE THE INSURER TO ORDER THESE REPORTS ON EACH DRIVER I EMPLOY OR CONTRACT. THIS APPLICATION ALONE DOES NOT BIND COVERAGE.

NOTICE TO INSUREDS: A MICHIGAN CATASTROPHIC CLAIMS ASSOCIATION (MCCA) SURCHARGE WILL BE INCLUDED IN YOUR FINAL PERSONAL INJURY PROTECTION (PIP) PREMIUM.

FRAUD WARNING: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

Applicant's Signature _____ Producer's Signature _____

Date _____ Date _____