

PUBLIC AUTO INSURANCE APPLICATION

1. GENERAL			
Applicant's name _____			
Address _____		Phone # _____	
Insured:	<input type="checkbox"/> Individual	<input type="checkbox"/> Partnership	Proposed effective date: _____
	<input type="checkbox"/> Corporation	<input type="checkbox"/> _____	Expiration date: _____

2. COVERAGES REQUESTED		
<input type="checkbox"/> Bodily Injury _____	<input type="checkbox"/> Uninsured Motorists _____	<input type="checkbox"/> Physical Damage - See Section 8 _____
<input type="checkbox"/> Property Damage _____	<input type="checkbox"/> Underinsured Motorists _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Combined Limit (CSL) _____	(where applicable)	
<input type="checkbox"/> Medical Payments _____	<input type="checkbox"/> PIP _____	

3. OPERATIONS	
A. Describe your business? _____	
B. Is your operation: Government funded? <input type="checkbox"/> Yes <input type="checkbox"/> No Seasonal? <input type="checkbox"/> Yes <input type="checkbox"/> No Non Profit? <input type="checkbox"/> Yes <input type="checkbox"/> 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 to Michigan? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many days per month? _____	
F. Average no. of hours per day each vehicle is operated _____ Percent of night driving _____	
G. Describe personal use of any vehicles? _____	
H. Do you ever transport: Professional athletes or entertainers? <input type="checkbox"/> Yes <input type="checkbox"/> No Mentally handicapped? <input type="checkbox"/> Yes <input type="checkbox"/> No Physically handicapped? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, are vehicles specially equipped? How? _____	
I. Do your vehicles have safety belts for passengers? <input type="checkbox"/> Yes <input type="checkbox"/> No	
J. Do you lease or rent vehicles: From others? <input type="checkbox"/> Yes <input type="checkbox"/> No To others? <input type="checkbox"/> Yes <input type="checkbox"/> No	
K. Filings required: _____	

4. PRIOR INSURANCE CARRIERS (3 previous years)					
Prior carriers	Year	Policy #	# of vehicles	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 If not, are they: Independent Contractors? Volunteers Other _____

Are your employees covered by Workers' Compensation? Yes No

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

Do you agree to promptly report all drivers to us Yes No

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

Auto No.	Model year	Trade name	Body type (tractor, truck-tractor, trailer)	Vehicle ID no.	Seating capacity	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 _____

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. 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.

FRAUD WARNING: ANY PERSON WHO, 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 _____