

A'Hern Agency

www.ahernagency.com



Insurance

Since 1951

Name of Applicant _____ Federal I.D. No. _____

(Exact Entity)

Address _____

(Number)

(Street)

(City)

(County)

(State)

(Zip)

Desired Effective Date _____ to _____

(12:01 a.m. standard time at the address shown above or _____ A.M./P.M.)

Applicant is: Individual Partnership Corporation Other: _____

Applicant's Business _____ Years Experience in This Business _____

Location To Be Inspected (include directions if necessary) _____

Inspection Contact Person _____ Phone No. _____

Estimate of Financial Worth \$ _____ Gross Receipts Last Yr. \$ _____ Estimate For Next Yr. \$ _____

DESCRIPTION AND AREA OF OPERATIONS

Describe your operation including products or items hauled and normal routes _____

Do you ever: Transport hazardous products? _____ Do repossession? _____ Have emergency Use? _____ Explain YES responses in

REMARKS below.

List all states entered: _____

Maximum radius _____ miles. Largest cities entered or driven through _____

Do you haul for others? _____ If yes, for whom? _____

Is insurance to apply to all owned and leased vehicles? _____ If not, explain in REMARKS below. Number of vehicles owned _____

Do you hire any equipment? _____ If yes, what is Estimated Annual Cost of Hire? _____

FILINGS – CERTIFICATES – ADDITIONAL INSURERS

For prompt and accurate filing(s), complete information must be given including **exact name and address** and Docket No. under which authority exists. Failure to do so will result in delays and suspensions. Use separate sheet if necessary.

Do you have an I.C.C. permit? _____ If yes, Docket Number? _____ Form E? _____ Form H? _____

State filing(s) required? (Show states, permit numbers and indicate Form E, H, etc.) _____

Show exact name in which permits are issued: _____

Are any Additional Insureds needed to be named on policy? _____ If so, give full name and address and their interest in this coverage: _____

Are any certificates of insurance needed? _____ If yes, show name, address and any special instructions: _____

PREVIOUS INSURERS AND LOSS EXPERIENCE

Has insurance of the type applied for ever been cancelled, declined or renewal refused (not applicable in MO)? _____

If yes, explain fully in REMARKS giving name of insurance companies, dates and reason for cancellation or refusal.

LOSS EXPERIENCE AND EXPOSURE INFORMATION - Current and Previous 3 Years. MUST BE COMPLETED FULLY.

| Policy Period | | Name of Insurance Company | Number Of Vehicles | Premium Paid | | Total No. of Losses | Losses Paid and Reserves | | | |
|---------------|----|---------------------------|--------------------|-------------------|-----------------|---------------------|--------------------------|---------------|-----------------|---------------|
| From | To | | | BI/PD and Med Pay | Physical Damage | | BI/PD and Med Pay | No. of Losses | Physical Damage | No. of Losses |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |

REMARKS

Do you hire any drivers under 23? _____ Do you hire any drivers over 65? _____ Is equipment owner driven only? _____
 Do you hire any physically impaired drivers? _____
 Is a physical examination completed? _____ Is a check made of previous employment? _____
 Are drivers paid by the load? _____ Hourly? _____ % of the gross? _____
 List all drivers both full and part time. (Attach schedule if more space is Needed)

| DRIVERS NAME | Date Employed | Date of Birth | Drivers License | STATE | No. Years Commercial Experience | LIST ACCIDENTS/VIOLATIONS (3 years) |
|--------------|---------------|---------------|---------------------|-------|---------------------------------|-------------------------------------|
| | | | Social Security No. | | | |
| | | | DL# | | | |
| | | | SS# | | | |
| | | | DL# | | | |
| | | | SS# | | | |
| | | | DL# | | | |
| | | | SS# | | | |
| | | | DL# | | | |
| | | | SS# | | | |
| | | | DL# | | | |
| | | | SS# | | | |

IMPORTANT NOTICE: ALL NEW DRIVERS HIRED DURING THE TERM OF THIS POLICY MUST BE IMMEDIATELY REPORTED TO THE COMPANY. FAILURE TO REPORT MAY RESULT IN TERMINATION OF THIS POLICY. REPORT NEW DRIVER TO YOUR AGENT.

| | COVERAGES | LIMITS OF INSURANCE | PREMIUM |
|-----------------|---|--|---------|
| LIABILITY | Bodily Injury and Property Damage (CSL) | \$ each Accident | |
| | OR | | |
| | Bodily Injury | \$ each Person \$ each Accident | |
| | Property Damage | \$ each Accident | |
| | Medical Payments | \$ each Person | |
| | Uninsured and / or Underinsured Motorists Coverage* | \$ (Indicate Limits and Coverage Applicable) | |
| | Personal Injury Protection* | \$ each Person | |
| | Property Protection (Michigan Only) | | |
| PHYSICAL DAMAGE | Specified Causes of Loss | Stated Amount less \$ Deductible | |
| | Collision | Stated Amount less \$ Deductible | |
| | MISC. | | |
| | Cargo | \$ each loss less \$ Deductible | |
| | Other | | |
| | TOTAL | | |

| SCHEDULE OF AUTOMOBILES | | | | | | | | |
|-------------------------|------------|------------|--|--|---------------------------------|------------------|---------------|-------------------------------|
| Unit No. | Model Year | Trade Name | Serial Number (Full Number is required) | Body Type (Truck, Tractor, Semi-Trailer, etc.) | Principal Garage Location | Radius of Use | Rate Terr. | GVW or Seating Capacity |
| 1 | | | | | | | | |
| 2 | | | | | | | | |
| 3 | | | | | | | | |
| 4 | | | | | | | | |
| 5 | | | | | | | | |
| 6 | | | | | | | | |
| 7 | | | | | | | | |
| 8 | | | | | | | | |
| 9 | | | | | | | | |
| 10 | | | | | | | | |

| PHYSICAL DAMAGE COVERAGE IF DESIRED | | | | | | | |
|-------------------------------------|---------------|------------------|----------------------------------|-------------------|-----------------------|----------------|--|
| Unit No. | Original Cost | Date of Purchase | Stated Amount (Current Value) | Coverages Desired | | | Loss Payees (Name & Address) (Indicate Applicable Unit) |
| | | | | Comp. Ded. | Specified Causes Ded. | Collision Ded. | |
| 1 | | | | | | | |
| 2 | | | | | | | |
| 3 | | | | | | | |
| 4 | | | | | | | |
| 5 | | | | | | | |
| 6 | | | | | | | |
| 7 | | | | | | | |
| 8 | | | | | | | |
| 9 | | | | | | | |
| 10 | | | | | | | |

THIS APPLICATION MAY NOT BE USED TO BIND COVERAGE 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.

If the laws or regulations of any governmental regulatory body in which the undersigned applicant intends to operate requires a special endorsement or rider to be attached to the policy, the applicant hereby agrees as an inducement to Empire for the issuance of the policy, that if Empire shall be obliged to pay any claim which it would not have been required to pay except for said endorsement, the Applicant shall reimburse Empire for any and all claims disbursements of every kind, including loss payments, costs and expenses which it shall have paid in connection with such claim, plus expenses incurred by Empire in enforcing the terms of this agreement. The terms of this agreement shall apply not only to the original policy or policies issued in connection with this application, but also to any renewals or extensions thereof. **READ ABOVE CONDITIONS CAREFULLY!**

APPLICABLE IN THE STATE OF FLORIDA
 ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

APPLICABLE IN THE STATE OF NEW YORK
 Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

WITNESS _____ DATE _____ APPLICANT'S SIGNATURE _____ DATE _____

AGENT'S OR BROKER'S NAME AND ADDRESS _____ LICENSE NUMBER _____

***NOTICE REGARDING PIP AND UM COVERAGES**
 If required by law in your state, you must complete an additional form(s) rejecting coverage or selecting limits of liability desired for Uninsured / Underinsured Motorists and Personal Injury Protection coverage. Selecting coverage will increase your premium. Be sure your agent provides you with the necessary form(s), explains your options and advised you of the cost of your selection.