

Commercial Auto Application

SIERRA SPECIALTY INSURANCE

License: 0E81019

Underwritten by

TOPA Insurance Company

This application will not be given consideration unless:

- 1. It is fully completed and every question is answered;**
- 2. Accompanied by a current MVR for ALL drivers and**
- 3. Application is signed personally by the Applicant and Agent.**

Agent's Name and Address	
Phone Number	Code
Applicant's full name	
D.B.A., if any	
Mailing Address - If P.O. Box, then give the actual address below	
City	State Zip Code
Phone Number	Name of Contact Person
Place of principal garaging. If same as mailing address then write "SAME".	
Proposed Effective Date	POLICY TERM
at 12:01 A.M. Standard Time	<input type="checkbox"/> 12 Months <input type="checkbox"/> 6 months

Policy Requested:	<input type="checkbox"/> Liability and Physical Damage <input type="checkbox"/> Physical Damage Only
<input type="checkbox"/> New Business <input type="checkbox"/> Renewal of Topa Policy #	
Is the applicant: <input type="checkbox"/> An Individual <input type="checkbox"/> A Partnership <input type="checkbox"/> A Corporation or <input type="checkbox"/> Other - If Other please specify:	
How long has the applicant been in business? _____ Years	
Is this a new venture? <input type="checkbox"/> No <input type="checkbox"/> Yes if yes, explain past experience.	
Describe the business operations of the applicant.	

NOTE: Coverage cannot be bound until approved by the Company. When approved the application and payment must be postmarked within 48 hours of the effective date; otherwise coverage will be effective at 12:01 A.M. on the date following the postmark on the envelope.

GENERAL INFORMATION ALL QUESTIONS MUST BE FULLY ANSWERED!

1. Must the applicant comply with the Motor Carrier Act of 1980? <input type="checkbox"/> No <input type="checkbox"/> YES - If 'yes' the risk is unacceptable.	9. Is there a vehicle maintenance program in place? <input type="checkbox"/> No - Why not? <input type="checkbox"/> Yes - Explain
2. Does the risk EVER haul hazardous substances, flammables, explosives, chemicals or acids? <input type="checkbox"/> No <input type="checkbox"/> Yes - Not eligible	10. Does the applicant ever operate outside the resident State? <input type="checkbox"/> No <input type="checkbox"/> Yes - How often and where?
3. Does the applicant operate on a regular route? <input type="checkbox"/> No <input type="checkbox"/> Yes - List cities and destinations.	11. Are any sub-haulers utilized? <input type="checkbox"/> No <input type="checkbox"/> Yes - What percentage?
4. Does the applicant rent or lease vehicles to others? <input type="checkbox"/> No <input type="checkbox"/> Yes - If "yes" the risk is unacceptable	12. Do other truckers operate under the applicant's filing authority? <input type="checkbox"/> No <input type="checkbox"/> Yes
5. 15 the applicant under contract or lease to haul for a single firm? <input type="checkbox"/> No <input type="checkbox"/> Yes - Give full name.	13. Number of Employees?
6. Are ALL vehicles owned or operated shown on the application? <input type="checkbox"/> Yes <input type="checkbox"/> NO - where insured?	14. Do any employees use their own vehicles during the course of employment on a regular basis? <input type="checkbox"/> No <input type="checkbox"/> Yes.
7. Is the applicant the registered owner of all units listed, except "non-owned trailers"? <input type="checkbox"/> Yes <input type="checkbox"/> No - explain	15. What are the applicant's annual gross receipts? \$
8. Any policy or coverage declined, canceled or nonrenewed in the past 3 yrs. <input type="checkbox"/> No <input type="checkbox"/> Yes - explain	16. Are any vehicles registered or garaged outside of the applicant's resident State? <input type="checkbox"/> No <input type="checkbox"/> Yes - explain:

Type of cargo or goods hauled and percentage of each. Be specific-

FILINGS: PUC Filing - Your Cert # _____ ICC # _____ DMV # _____
 Other: _____ NOTE: There is a fully earned fee for each filing. We must insure ALL vehicles owned or operated by the applicant to make a regulatory filing.

LIST ALL INSURANCE POLICIES FOR THE PAST THREE YEARS.

Insurance Company	Policy Number	Policy Period Dates	Coverages (BI/PD/COMP/COLL)

LIST ALL CLAIMS IN THE PAST 3YEARS

Date of Loss	Type of Loss	Description of Loss	Amount Paid	Driver

Coverages & Limits of Liability (in thousands)

<input type="checkbox"/> Liability Split Limits	Bl: \$ PD\$	Per Person \$ Per Accident	Per Accident	<input type="checkbox"/> Uninsured Motorist - PD: \$ California Only and cannot have Collision	Per Accident
<input type="checkbox"/> Liability	S	Combined Single Limit		<input type="checkbox"/> Underinsured Motorist	\$ Each Person \$ Each Acct.
<input type="checkbox"/> Medical Payments	\$	Each Person		<input type="checkbox"/> Hired Auto Liability Cost of Hire = \$ _____	
<input type="checkbox"/> Uninsured Motorist - BI S		Per Person \$	Per Accident	<input type="checkbox"/> Non-owned Auto Liab. Number of Employees =	

NOTE: MEd. Pay, UM-BI, UM-PD and UIM- BI coverage may be rejected depending on your state's laws. Please attach your States acceptance/rejection form.
 Liability Deductible: BI = \$ PD = \$ A deductible may be imposed by the Company even it not requested.

VEHICLE INFORMATION - COMPLETE FOR EACH VEHICLE TO BE INSURED. USE ADDITIONAL APPLICATIONS IF NECESSARY!

Unit # 1	How is this unit used?	No. of trips per day?
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Year	Manufacturer and Model	Body Type	Complete Serial Number	Stated Amount
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GVW or Gallons	Use <input type="checkbox"/> Comm <input type="checkbox"/> Serv <input type="checkbox"/> Retail <input type="checkbox"/> Ultra <input type="checkbox"/> Personal <input type="checkbox"/> Hvy	Maximum Radius [] 100 [] 200 [] 300 [] 500 Miles	Anti-lock brakes <input type="checkbox"/> Yes <input type="checkbox"/> No	4 wheel drive <input type="checkbox"/> No <input type="checkbox"/> Yes	Spec. Perils Ded.	Coll. Ded	On-Hook Liab. [] 25,000 [] 50,000 Deductible [] 500 [] 1000
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Garage Location including zip code:
 Loss Payee Name & Address
 Additional Insured Name & Address

Unit # 2	How is this unit used?	No. of trips per day?
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Year	Manufacturer and Model	Body Type	Complete Serial Number	Stated Amount
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GVW or Gallons	Use <input type="checkbox"/> Comm <input type="checkbox"/> Serv <input type="checkbox"/> Retail <input type="checkbox"/> Ultra <input type="checkbox"/> Personal <input type="checkbox"/> Hvy	Maximum Radius [] 100 [] 200 [] 300 [] 500 Miles	Anti-lock brakes <input type="checkbox"/> Yes <input type="checkbox"/> No	4 wheel drive <input type="checkbox"/> No <input type="checkbox"/> Yes	Spec. Perils Ded.	Coll. Ded	On-Hook Liab. [] 25,000 [] 50,000 Deductible [] 500 [] 1000
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Garage Location including zip code:
 Loss Payee Name & Address
 Additional Insured Name & Address

Unit # 3	How is this unit used?	No. of trips per day?
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Year	Manufacturer and Model	Body Type	Complete Serial Number	Stated Amount
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GVW or Gallons	Use <input type="checkbox"/> Comm <input type="checkbox"/> Serv <input type="checkbox"/> Retail <input type="checkbox"/> Ultra <input type="checkbox"/> Personal <input type="checkbox"/> Hvy	Maximum Radius [] 100 [] 200 [] 300 [] 500 Miles	Anti-lock brakes <input type="checkbox"/> Yes <input type="checkbox"/> No	4 wheel drive <input type="checkbox"/> No <input type="checkbox"/> Yes	Spec. Perils Ded.	Coll. Ded	On-Hook Liab. [] 25,000 [] 50,000 Deductible [] 500 [] 1000
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Garage Location including zip code:
 Loss Payee Name & Address
 Additional Insured Name & Address

Unit # 4	How is this unit used?	No. of trips per day?
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Year	Manufacturer and Model	Body Type	Complete Serial Number	Stated Amount
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GVW or Gallons	Use <input type="checkbox"/> Comm <input type="checkbox"/> Serv <input type="checkbox"/> Retail <input type="checkbox"/> Ultra <input type="checkbox"/> Personal <input type="checkbox"/> Hvy	Maximum Radius [] 100 [] 200 [] 300 [] 500 Miles	Anti-lock brakes <input type="checkbox"/> Yes <input type="checkbox"/> No	4 wheel drive <input type="checkbox"/> No <input type="checkbox"/> Yes	Spec. Perils Ded.	Coll. Ded	On-Hook Liab. [] 25,000 [] 50,000 Deductible [] 500 [] 1000
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Garage Location including zip code:
 Loss Payee Name & Address
 Additional Insured Name & Address

DRIVER INFORMATION - LIST ALL PART-TIME, FULL-TIME OR OCCASIONAL DRIVERS- ALL DRIVERS MUST BE LISTED)

Does applicant review MVR's prior to hiring? YES NO Does applicant require current D.O.T. physicals on all drivers? YES No

Driver #	Full name as on Drivers License	Date of Birth	Year Experience	Driver's License Number	State
1					
2					
3					
4					
5					

Driver #	Date	List ALL violations, convictions and accidents in the past 3 years. Provide proof on no-fault accidents	Accidents or Losses
1			
2			
3			
4			
5			

APPLICANT QUESTIONNAIRE - TO BE COMPLETED AND INITIALED IN THE APPLICANT'S HANDWRITING

Have all drivers who may operate an insured vehicle on an occasional, part-time or full time basis been listed in the driver section? This includes family members who may operate a listed vehicle.	<input type="checkbox"/> Yes <input type="checkbox"/> No explain below Initials:
Are all owned or operated (including vehicles under a 30 day or longer lease) commercial vehicles listed in the vehicle section?	<input type="checkbox"/> Yes <input type="checkbox"/> No explain below Initials
Are all vehicles listed on the application which are operated under the insured's regulatory filing?	<input type="checkbox"/> Yes <input type="checkbox"/> No - explain below Initials
Explain:	< = = Explain any "no" answers

PREMIUM SUMMARY

This is only a summary of the premium and fees due. The premium breakdown by coverage and vehicle will be provided to you under a separate quote sheet. Do not sign this application until you have reviewed the actual quote sheet details. I have reviewed the actual quote: Applicant's Initials: X _____.	Total Premium for All Vehicles	\$
	Hired & Non-Owned Auto Premium - if any	\$
	Filing Fees -if any	\$
	Fully Earned Policy Fee	\$
	Total Premium Due	\$
	AMOUNT REMITTED WITH APPLICATION	\$

APPLICANT AND AGENT SIGNATURES. THIS MUST BE SIGNED OR APPLICATION WILL BE REJECTED.

I hereby declare and warrant that to the best of my knowledge the statements made on the application are true and complete and that these statements are made as an inducement to the Company to issue the insurance policy for which I am applying. I agree that such policy shall be null and void if my premium payment check does not clear the bank when initially presented. I acknowledge that a \$10.00 charge will apply for all checks returned due to insufficient funds

I understand a routine investigation may be made as to my insurability, including requesting a copy of my motor vehicle record from the Department of Motor Vehicles, character, general reputation, personal characteristics, credit history, condition of vehicles and their use. Upon written request, additional information as to the nature and scope of the report, if one is made, will be provided.

I further declare that I have not had an accident or loss in the last 72 hours and that I am the legal and/or registered owner of all vehicles.

APPLICANT'S SIGNATURE: _____ Time: _____ AM - PM Date _____

I warrant and certify that all information contained herein is correct to the best of my knowledge, that this application was completed and then signed by the insured/applicant, that a completed copy hereof has been given to the insured/applicant, and that I am retaining a duplicate copy.

AGENT'S SIGNATURE: _____ Time: _____ AM - PM Date: _____

DRIVER EXCLUSION

It is hereby understood and agreed that all coverages and OUR obligation to defend under this policy shall not apply nor accrue to the benefit of any INSURED or any third party claimant while any VEHICLE or MOBILE EQUIPMENT described in the policy or any other VEHICLE or MOBILE EQUIPMENT, to which the terms of the policy are extended, is being driven, used or operated by any person designated below.

The driver exclusion shall be binding upon every INSURED to whom such policy or endorsements provisions apply while such policy is in force and shall conliritie to be binding with respect to any continuation, renewal or replacement of such policy by the Named Insured or with respect to any reinstatement of such policy within 30 days of any lapse thereof. This DRIVER EXCLUSION provisions shall conform to State statutes and laws.

Name of Person Excluded	Reason For Exclusion	Date of Birth or Social Security #
_____	_____	_____
_____	_____	_____
_____	_____	_____

Acceptance by signature of Named Insured: _____ Date _____