

Small Fleet Trucker Application

IT IS SPECIFICALLY REPRESENTED THAT THE STATEMENTS IN THIS APPLICATION ARE TRUE AND CORRECT. IT IS FURTHER UNDERSTOOD THAT THE REPRESENTATIONS IN THIS APPLICATION HAVE BEEN MADE TO THE INSURANCE COMPANY FOR THE PURPOSE OF INDUCING THE INSURANCE COMPANY TO ISSUE THE INSURANCE POLICY, AND THE INSURANCE COMPANY IS RELYING UPON THE TRUTHFULNESS OF THE STATEMENTS IN MAKING THE DECISION TO ACCEPT THIS RISK.

GENERAL APPLICANT INFORMATION:				
APPLICANT LEGAL NAME INCLUDING COMPANY "DBA" OR "TA" IF ANY :				CELL PHONE NUMBER:
BUSINESS PHONE AND FAX NUMBERS: PHONE: FAX:	E-MAIL ADDRESS:	ENTITY TYPE: <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> LLC <input type="checkbox"/> CORPORATION <input type="checkbox"/> OTHER (EXPLAIN) _____		
FEIN NUMBER IF CORP , LLC, PARTNERSHIP OR OTHER:	SOCIAL SECURITY NO. IF INDIVIDUAL OF DBA:	IS A FMCSA FILING REQUIRED: <input type="checkbox"/> YES <input type="checkbox"/> NO. IF YES, US DOT OR MC NUMBER: _____		
IS THIS A NEW VENTURE? <input type="checkbox"/> YES <input type="checkbox"/> NO	YEARS IN BUSINESS	IS GARAGE LOCATION INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, NAME OF CITY _____		
MAILING ADDRESS		CITY	STATE	ZIP
PHYSICAL ADDRESS REQUIRED IF MAILING ADDRESS IS A POSTAL BOX			CONTACT PERSON NAME AND PHONE NUMBER (FOR INSPECTION)	
GARAGE ADDRESS, IF DIFFERENT		CITY	STATE	ZIP
POLICY TERM	FROM	TO	NEW RENEWAL <input type="checkbox"/>	IF RENEWAL -EXPIRING POLICY NO: _____
BRIEF DESCRIPTION OF BUSINESS OPERATIONS				
IS THIS YOUR PRIMARY BUSINESS? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, EXPLAIN:		HAVE YOU EVER FILED BANKRUPTCY? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHEN _____ PLEASE EXPLAIN:		
HAVE YOU EVER HAD A POLICY CANCEL FOR NON-PAYMENT IN THE PAST FIVE YEARS <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES , WHEN _____ PLEASE EXPLAIN: (NOT APPLICABLE IN MISSOURI)		DO YOU ENTER MEXICO? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE EXPLAIN: DO YOU ENTER CANADA? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE EXPLAIN:		
WHAT COMPANY (IES) DO YOU HAUL FOR? (NAME, ADDRESS AND PHONE NO.)				
GIVE PRINCIPAL COMMODITIES TRANSPORTED AND PERCENTAGE (INCLUDING ANY COMMODITIES BACKHAULED):				
%	%	%	%	%
%	%	%	%	%
IF ANY OF THE FOLLOWING COMMODITIES ARE TRANSPORTED, GIVE PERCENTAGE OF GROSS RECEIPTS: _____% PHARMACEUTICALS <input type="checkbox"/> % LIQUOR _____% TOBACCO _____% COSMETICS _____% LPG _____% EXPLOSIVES _____% CORROSIVES _____% OTHER PETROLEUM _____% ACIDS AND CHEMICALS _____% ANHYDROUS AMMONIA _____% NUCLEAR SPENT FUEL OR WASTE _____% OTHER VOLATIVES, TOXIC, OR HAZARD _____% OTHER TARGET COMMODITIES				
EXPLAIN OTHER: _____				
OPERATIONS: (CHECK APPLICABLE) <input type="checkbox"/> CONTRACT CARRIER <input type="checkbox"/> COMMON CARRIER <input type="checkbox"/> EXEMPT CARRIER <input type="checkbox"/> FREIGHT BROKER <input type="checkbox"/> OTHER: _____				
LIST PERCENTAGE OF TRIPS IN EACH RADIUS GROUP: _____% 0-50 MILES _____% 51-200 MILES _____% 201-1000 MILES _____% OVER 1000 MILES				

INDICATE ALL LOCATIONS WHERE YOU REGULARLY PICK-UP OR DROP OFF LOADS:

- | | | | | | |
|---|--|---|--|---|---|
| <input type="checkbox"/> 1 ATLANTA | <input type="checkbox"/> 9 DALLAS/FT WORTH | <input type="checkbox"/> 18 LOS ANGELES | <input type="checkbox"/> 27 OKLAHOMA CITY | <input type="checkbox"/> 36 SAN FRANCISCO | <input type="checkbox"/> 47 SOUTHEAST |
| <input type="checkbox"/> 2 BALTIMORE/
WASHINGTON | <input type="checkbox"/> 10 DENVER | <input type="checkbox"/> 19 LOUISVILLE | <input type="checkbox"/> 28 OMAHA | <input type="checkbox"/> 37 TULSA | <input type="checkbox"/> 48 EASTERN |
| <input type="checkbox"/> 3 BOSTON | <input type="checkbox"/> 11 DETROIT | <input type="checkbox"/> 20 MEMPHIS | <input type="checkbox"/> 29 PHOENIX | <input type="checkbox"/> 40 PACIFIC COAST | <input type="checkbox"/> 49 NEW ENGLAND |
| <input type="checkbox"/> 4 BUFFALO | <input type="checkbox"/> 12 HARTFORD | <input type="checkbox"/> 21 MIAMI | <input type="checkbox"/> 30 PHILADELPHIA | <input type="checkbox"/> 41 MOUNTAIN | <input type="checkbox"/> 50 ALASKA |
| <input type="checkbox"/> 5 CHARLOTTE | <input type="checkbox"/> 13 HOUSTON | <input type="checkbox"/> 22 MILWAUKEE | <input type="checkbox"/> 31 PITTSBURGH | <input type="checkbox"/> 42 MIDWEST | <input type="checkbox"/> 51 SAN DIEGO |
| <input type="checkbox"/> 6 CHICAGO | <input type="checkbox"/> 14 INDIANAPOLIS | <input type="checkbox"/> 23 MINN./ST PAUL | <input type="checkbox"/> 32 PORTLAND | <input type="checkbox"/> 43 SOUTHWEST | <input type="checkbox"/> 52 SEATTLE |
| <input type="checkbox"/> 7 CINCINNATI | <input type="checkbox"/> 15 JACKSONVILLE | <input type="checkbox"/> 24 NASHVILLE | <input type="checkbox"/> 33 RICHMOND | <input type="checkbox"/> 44 NORTH CENTRAL | <input type="checkbox"/> 53 SACRAMENTO |
| <input type="checkbox"/> 8 CLEVELAND | <input type="checkbox"/> 16 KANSAS CITY | <input type="checkbox"/> 25 NEW ORLEANS | <input type="checkbox"/> 34 ST. LOUIS | <input type="checkbox"/> 45 MIDEAST | <input type="checkbox"/> 54 SAN ANTONIO |
| | <input type="checkbox"/> 17 LITTLE ROCK | <input type="checkbox"/> 26 NEW YORK CITY | <input type="checkbox"/> 35 SALT LAKE CITY | <input type="checkbox"/> 46 GULF | |

PROVIDE STATE THAT YOU HAVE CHOSEN AS YOUR BASE STATE TO COMPLY WITH SINGLE-STATE REGISTRATION: _____

INDICATE STATES WHERE YOU REQUIRE A FORM E FILING DUE TO SPECIFIC AUTHORITY APPLICATION: _____

IF YOU HOLD A BROKERS LICENSE, IDENTIFY NAME WITH FMCSA, DOCKET NO. OR MOTOR CARRIER NO. AND RECEIPTS FROM BROKERAGE OPERATIONS.	IS AN INTRASTATE FILING NEEDED? <input type="checkbox"/> YES <input type="checkbox"/> NO. IF YES, SHOW STATE AND PERMIT NO.	IS MCS 90 ENDORSEMENT NEEDED? <input type="checkbox"/> YES <input type="checkbox"/> NO
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FILING REQUIRED-LIABILITY AND CARGO INDICATE BELOW : SHOW EXACT NAME AND ADDRESS IN WHICH PERMITS ARE ISSUED:

LIABILITY BMC 91X	LIABILITY -FORM E STATE	OVERSIZED/OVERWEIGHT	HAZARDOUS
CARGO BMC 34	CARGO FORM H STATE	INDICATE ANY OTHER FILING REQUIRED:	

DO YOU OPERATE AS A SUBSIDIARY OF ANOTHER COMPANY?	<input type="checkbox"/> YES <input type="checkbox"/> NO	DO YOU LEASE YOUR AUTHORITY?	<input type="checkbox"/> YES <input type="checkbox"/> NO
HAVE THERE BEEN ANY CHANGES IN THE OWNERSHIP, MANAGEMENT OR NAME OF THE OPERATION IN THE PAST FIVE YEARS?	<input type="checkbox"/> YES <input type="checkbox"/> NO	DO YOU ACT AS A FREIGHT FORWARDER, FREIGHT BROKER OR ARRANGE LOADS FOR OTHERS?	<input type="checkbox"/> YES <input type="checkbox"/> NO
DO YOU OWN OR MANAGE ANY OTHER TRANSPORTATION OPERATION THAT IS NOT COVERED?	<input type="checkbox"/> YES <input type="checkbox"/> NO	DO YOU APPOINT AGENTS OR HIRE INDEPENDENT CONTRACTORS TO OPERATE UNDER YOUR AUTHORITY WITH THEIR OWN INSURANCE POLICY?	<input type="checkbox"/> YES <input type="checkbox"/> NO
HAVE YOU PURCHASED, SOLD, OR APPLIED FOR AUTHORITY OVER THE PAST 3 YEARS?	<input type="checkbox"/> YES <input type="checkbox"/> NO	HAVE YOU EVER LOST OR HAD AUTHORIZATION WITHDRAWN, OR HAVE YOU BEEN/ARE UNDER PROBATION BY ANY REGULATORY AUTHORITY (FHWA, PUC, ETC)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
IS YOUR POLICY TO COVER ALL VEHICLES OWNED, OPERATED OR UNDER LEASE TO YOU OR YOUR BUSINESS?	<input type="checkbox"/> YES <input type="checkbox"/> NO	DO YOU HAUL OR HAVE AUTHORITY TO HAUL ANY COMMODITY CONSIDERED HAZARDOUS BY EPA AND/OR THE DOT?	<input type="checkbox"/> YES <input type="checkbox"/> NO
DO YOU HAUL INTERMODAL/CONTAINERIZED FREIGHT?	<input type="checkbox"/> YES <input type="checkbox"/> NO	DO YOU PULL OVERSIZED/OVERWEIGHT LOADS?	<input type="checkbox"/> YES <input type="checkbox"/> NO
DO YOU LEASE TO OTHERS?	<input type="checkbox"/> YES <input type="checkbox"/> NO	DO YOU HIRE OWNER OPERATORS ON A TRIP LEASE BASIS?	<input type="checkbox"/> YES <input type="checkbox"/> NO
DO YOU PULL DOUBLE/TRIPLE TRAILERS?	<input type="checkbox"/> YES <input type="checkbox"/> NO	DO YOU LEND, LEASE OR RENT TRUCKS, TRACTORS OR TRAILERS TO OTHERS WITHOUT DRIVERS?	<input type="checkbox"/> YES <input type="checkbox"/> NO
DO YOU HAVE A FORMAL WRITTEN PROCEDURE FOR OBTAINING AND MAINTAINING CERTIFICATES OF INSURANCE ? IS IT A PERIOD GREATER THAN 18 MONTHS AFTER THE POLICY PERIOD?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO	DO YOU HAVE A FORMAL WRITTEN PROCEDURE FOR OBTAINING AND MAINTAINING SUBCONTRACTOR CONTRACTS RELATING	<input type="checkbox"/> YES <input type="checkbox"/> NO
CIRCLE PERCENTAGE OF TIME YOU USE THE SAME SUBCONTRACTOR(S) ≤ 15% ≥ 16% to 25% ≥ 26% to 49% ≥ 50%-85% ≥ 86% to 100%	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	ARE ANY VEHICLES USED TO TRANSPORT EMPLOYEES? ARE GUEST PASSENGERS PERMITTED IN THE VEHICLE	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO
DO YOU HAVE ANY OTHER INSURANCE WITH OUR COMPANY	<input type="checkbox"/> YES <input type="checkbox"/> NO	EXPLAIN ANY YES ANSWERS ABOVE:-ATTACH SEPARATE SHEET IF REQUIRED	

AUTOMOBILE COVERAGES: (SEPARATE STATE SPECIFIC LIMITS AND COVERAGE MAY APPLY)

LIABILITY			MEDICAL PAYMENTS	PERSONAL INJURY PROTECTION	UNINSURED MOTORIST	UNDERINSURED MOTORIST
COMBINED SINGLE LIMIT (CSL) BI AND PD	SPLIT LIMITS				SPLIT LIMITS	SPLIT LIMITS
	BODILY INJURY(BI)	PROPERTY DAMAGE(PD)				
	EACH PERSON	EACH ACCIDENT	EACH ACCIDENT			
				CSL	CSL	

NON-TRUCKING LIABILITY COVERAGE YES NO IF APPLYING FOR NON-TRUCKING COVERAGE PROVIDE NAME AND MOTOR CARRIER NUMBER OF THE LESSEE TO WHOM YOU ARE PERMANENTLY LEASED.

SCHEDULE OF EQUIPMENT: ATTACH SEPARATE SHEET IF MORE THAN 7 UNITS

*VEHICLE TYPE: BOX TRUCK (BX)--TRUCK (TK)--TRACTOR (TR)- TRAILER (TL) ** OWNERSHIP OF VEHICLE: OWNED (O)-- LONG LEASE PURCHASE (LL)--SHORT LEASE (LESS THAN 6 MTH) (SL)-- TRAILER ONLY (TO)--TRAILER INTERCHANGE (TI) *** GROSS VEHICLE WEIGHT

UNIT NO.	YEAR	MAKE	VEHICLE IDENTIFICATION NUMBER /SERIAL NUMBER	*VEHICLE TYPE	*OWNER-SHIP	STATED AMOUNT	***GVW	RADIUS MAXIMUM MILES
1								
2								
3								
4								
UNIT NO.	YEAR	MAKE	VEHICLE IDENTIFICATION NUMBER /SERIAL NUMBER	*VEHICLE TYPE	*OWNER-SHIP	STATED AMOUNT	**GVW	RADIUS MAXIMUM MILES
5								
6								
7								

TRAILER INTERCHANGE:

LIMIT EACH TRAILER	NUMBER OF TRAILERS: EACH DAY _____ EACH WEEK _____	(CHECK ONE) COVERAGE SELECTION: COLLISION AND SPECIFIED CAUSES OF LOSS _____ COLLISION AND COMPREHENSIVE _____ (CIRCLE ONE) DEDUCTIBLE \$500 \$1,000	IN THE EVENT OF A LOSS, TRAILER INTERCHANGE AGREEMENTS WILL BE REQUIRED
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PHYSICAL DAMAGE COVERAGES:

(CIRCLE ONE) DEDUCTIBLE \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/>	(CHECK ONE) COVERAGE SELECTION : COLLISION AND SPECIFIED CAUSES OF LOSS <input type="checkbox"/> _____ COLLISION AND COMPREHENSIVE <input type="checkbox"/> _____
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TRUCKERS GENERAL LIABILITY LIMITS(THIS IS FOR BUSINESSES SOLELY INVOLVED IN "FOR-HIRE " TRANSPORTATION OF PROPERTY)

TOTAL PAYROLL :	NUMBER OF EMPLOYEES:	NUMBER OF OWNERS:
DO YOU HAVE DOG(S) AT PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO DO YOU CARRY A FIREARM? <input type="checkbox"/> YES <input type="checkbox"/> NO DO YOU GENERATE INCOME FROM OTHER ACTIVITIES BESIDES THE TRUCK(S) OPERATION? <input type="checkbox"/> YES <input type="checkbox"/> NO EXPLAIN ANY YES ANSWER:		
LIMITS: EACH OCCURRENCE LIMIT:\$ _____ GENERAL AGGREGATE LIMIT: \$ _____		
PRODUCTS-COMPLETED OPERATIONS AGGREGATE LIMIT: \$ _____ PERSONAL AND ADVERTISING INJURY LIMIT: \$ _____		
DAMAGE TO PREMISES RENTED TO YOU \$ _____ ANY ONE PREMISES MEDICAL EXPENSE LIMIT: \$ _____ ANY ONE PERSON		

MOTOR TRUCK CARGO COVERAGE:

LIMIT PER VEHICLE:	MAXIMUM LIMIT:	(CIRCLE ONE) STANDARD <input type="checkbox"/> PREFERRED <input type="checkbox"/>
(CIRCLE ONE) DEDUCTIBLE: \$500 \$1,000 \$2,500 \$5,000 REFRIGERATION BREAKDOWN ____ Yes ____ No		
PERCENTAGE OF COMMODITIES HAULED: DRY FREIGHT ____% BUILDING MATERIALS ____% REFRIGERATED GOODS ____% HOUSEHOLD GOODS ____% AUTOS ____% BOATS ____% LIGHT MACHINERY ____% MOBILE HOMES ____% ELECTRONIC ____% SEAFOOD ____% CONTAINERIZED FREIGHT ____% OTHER ____%		

ADDITIONAL INTEREST:

ADDITIONAL INTEREST: ATTACH SEPARATE SHEET IF NECESSARY INTEREST TYPE AUTO: (1)-ADDITIONAL INSURED (2) INTERMODAL (3) ADDITIONAL INSURED WAIVER RIGHTS RECOVERY (4) ADDITIONAL INSURED HIRED/NON-OWNED (5) LOSS PAYEE (6) LOSS PAYEE AND ADDITIONAL INSURED GENERAL LIABILITY (7) DESIGNED PERSON OR ORGANIZATION (8) VICARIOUS LIABILITY FOR OWNERS,LESSEES OR CONTRACTORS (9) OTHER

UNIT NO.	INTEREST TYPE	NAME	COMPLETE ADDRESS

CERTIFICATES OF INSURANCE: (ATTACH SEPARATE SHEET IF NECESSARY)

NAME	COMPLETE ADDRESS
NAME	COMPLETE ADDRESS
NAME	COMPLETE ADDRESS

DRIVERS INFORMATION: (ALL DRIVERS MUST BE LISTED-ATTACH A SEPARATE SHEET IF NECESSARY)

DRIVER NAME (LEGAL NAME)	DATE OF BIRTH	STATE	DRIVER LICENSE NUMBER	DATE OF HIRE	SOCIAL SECURITY NUMBER
1)					
2)					
3)					
4)					
5)					

DO YOU HAVE A DRIVER RECRUITMENT PROGRAM? IF SO, EXPLAIN	<input type="checkbox"/> YES <input type="checkbox"/> NO	DO YOU HAVE A SAFETY PROGRAM? IF SO, EXPLAIN	<input type="checkbox"/> YES <input type="checkbox"/> NO
DO YOU HAVE A DRIVER TRAINING PROGRAM? IF SO, EXPLAIN	<input type="checkbox"/> YES <input type="checkbox"/> NO	DO YOU HAVE A PREVENTATIVE AUTO MAINTENANCE PROGRAM? IS SO, EXPLAIN	<input type="checkbox"/> YES <input type="checkbox"/> NO

LOSS EXPERIENCE REQUIRED – PROVIDE PRIOR INSURANCE CARRIERS INFORMATION FOR A MINIMUM OF THE PAST FIVE YEARS

POLICY TERM		INSURANCE COMPANY NAME	NO. OF MOTOR POWERED VEHICLES	NO OF ACCIDENTS	PREMIUM LIABILITY	TOTAL AMOUNT CLAIMS PAID & RESERVES			
FROM	TO					BI	PD	COMP/COLL	OTHER
/ /	/ /								
/ /	/ /								
/ /	/ /								
/ /	/ /								
/ /	/ /								

**GIVE DETAILS OF CLAIMS IN EXCESS OF \$25,000.
(ATTACH SEPARATE SHEET IF NECESSARY AND COPY OF ACCIDENT REPORT IF AVAILABLE)**

DATE	RESERVES	TOTAL INCURRED LOSSES AUTOMOBILE LIABILITY	TOTAL INCURRED LOSSES AUTO PHYSICAL DAMAGE	TOTAL INCURRED LOSSES MOTOR TRUCK CARGO	TOTAL NUMBER OF CLAIMS

The applicant hereby applies to the Insurance Company for a policy of insurance as set forth in this application on the basis of statements contained herein. Applicant agrees that such policy coverage may be canceled or a claim may be denied if such information is materially false or misleading so that the Insurance Company would have either rejected the risk, ab initio or have sought relief under any other applicable statute. Applicant understands that an inquiry may be made which will provide applicable information concerning character, general reputation, financial stability and other pertinent financial data, personal characteristics, mode of living or other background information the Insurance Company deems necessary in order to determine whether the Insurance Company will accept or reject applicant for coverage. Upon written request, additional information as to the nature and scope, if one made, will be provided.

THIS APPLICATION MUST BE SIGNED AND DATED BY BOTH APPLICANT AND THE INSURED'S AGENT. INSURED'S AGENT MAY NOT SIGN FOR BOTH.

("I understand this application is not a binder unless indicated as such on this form by the insured's agent.")

Signed this _____ day of _____, 20____ At: _____ City _____ State _____

The insured and the insured's agent agree that the policy of insurance (including any endorsements) associated with this application of insurance is deemed delivered to the insured by providing the insured's agent a link to electronically access, print and store a true and correct electronic record of the policy of insurance

SIGNATURE _____
NAMED INSURED (REPRESENTING ALL INSUREDS) (PRINT) NAME AND TITLE OF SIGNATURE PARTY

If a Partnership or Corporation, signatory must be empowered by Articles of Incorporation, etc. to bind to insurance agreements. This application is in compliance with State Statutes, and is submitted in the best interest of the applicant or insured to whom a copy has been furnished and coverage is: () Bound Effective _____ (time) _____ (date)

To Expiration _____ (time) _____ (date) () Not bound *

I agree that if my down payment or full payment check is returned by the bank because of non-sufficient funds, coverage will be cancelled from inception.

SIGNATURE _____
SIGNATURE OF INSURED'S AGENT PRINT AGENT NAME AND LICENSE NUMBER

NAME OF AGENCY _____ PHONE NO. _____

THIS IS NOT A BINDER

UNDERWRITING REPRESENTATION

PLEASE DISCUSS THE FOLLOWING WITH YOUR INSURED

As an inducement for the Insurance Company to underwrite and cover this risk, the insured affirmatively represents and warrants that all insured vehicles will, at inception and throughout the policy term, have the following equipment functioning, in safe working order, and in full compliance with any and all applicable federal, state, municipal, or other statutes, ordinances, or other regulations, on any insured vehicle; that such vehicle, or vehicles will not be used, driven or otherwise operated until the required repairs or corrections have been completed.

TIRES AND WHEELS	Including non-drive, non-steering and/or non-braking tires and wheels.
BRAKES	Including brake-related components and "Jake Brakes."
STEERING COMPONENTS	
WINDSHEILD	Including wipers
MIRRORS	
LIGHTS	Including required marker lamps and reflectors
ALARMS	BACK UP ALARMS on vehicles with a gross vehicle weight of over 10,000 lbs. and not a tractor trailer combination. LOW AIR WARNING DEVICE on vehicles with air brakes. POWER TAKE-OFF ALARM on vehicles with dump beds or tilt bodies.
SAFETY EQUIPMENT	Including fire extinguishers, and flares or reflectors

NON-PREAPPROVED DRIVERS NOT COVERED

Further, All drivers submitted for approval to operate an insured auto under any policy of insurance with the Insurance Company are required to have a minimum of 2 years of driving history in a motor vehicle similar to the type of motor vehicle insured under this policy of insurance. All drivers must be reported to the Insurance Company and approved prior to the operation of any insured unit. A Motor Vehicle Report (MVR) will be ordered, reviewed, and insured will be notified of the acceptability of additional drivers.

VEHICLE CHANGES

Further, all vehicle changes must be reported to the insurance Company to be effective prior to placing in service. NO AUTOMATIC COVERAGE IS AFFORDED UNDER THIS BINDER AND/OR POLICY FOR NEW, REPLACEMENT AND/OR TEMPORARY SUBSTITUTE VEHICLES.

NO RECAP TIRES OR HAULING OF HAZARDOUS WASTE

Finally, the insured affirmatively represents and warrants that all insured vehicles will, at inception and throughout binder and/or the policy term:

Immediately replace all recap tires on the front axle and use no recap tires on this axle.

Not carry material commonly known as "hazardous waste" in or on any insured vehicle during the binder and/or policy period.

I HAVE READ AND UNDERSTOOD THE FOREGOING REPRESENTATIONS, UNDERSTOOD AND ACKNOWLEDGE THAT THESE REPRESENTATIONS ARE BEING MADE IN ORDER TO INDUCE THE INSURANCE COMPANY TO UNDERWRITE THE RISK AND THAT THE INSURANCE COMPANY WOULD NOT HAVE UNDERWRITTEN THIS RISK BUT FOR RELIANCE UPON SAID REPRESENTATION, INCLUDING THIS STATEMENT.

SIGNATURE

NAMED INSURED

PRINT NAME & TITLE OF
SIGNATURE PARTY

DATE

PRIVACY NOTICE

PERSONAL INFORMATION ABOUT YOU MAY BE COLLECTED FROM PERSONS OTHER THAN YOU IN CONNECTION WITH THIS APPLICATION FOR INSURANCE. SUCH INFORMATION AS WELL AS OTHER PERSONAL AND PRIVILEGED INFORMATION COLLECTED BY US OR OUR AGENT MAY IN CERTAIN CIRCUMSTANCES BE DISCLOSED TO THIRD PARTIES. YOU HAVE THE RIGHT TO REVIEW YOUR PERSONAL INFORMATION IN OUR FILES AND CAN REQUEST CORRECTION OF ANY INACCURACIES. A MORE DETAILED DESCRIPTION OF YOUR RIGHTS AND OUR PRACTICES REGARDING SUCH INFORMATION IS AVAILABLE UPON REQUEST. CONTACT YOUR AGENT OR BROKER FOR INSTRUCTIONS TO SUBMIT A REQUEST TO US. YOUR AUTHORIZATION IS VALID FOR NO MORE THAN 24 MONTHS.

FRAUD STATEMENTS

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER 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 SUBJECTS THE PERSON TO CRIMINAL AND [NY: SUBSTANTIAL] CIVIL PENALTIES

Fraud Warning

ALABAMA, ARKANSAS, LOUISIANA, MARYLAND, NEW JERSEY, NEW MEXICO and VIRGINIA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an Application for insurance is guilty of a crime. In Alabama, Arkansas, Louisiana and Maryland, that person may be subject to fines, imprisonment or both. In New Mexico, that person may be subject to civil fines and criminal penalties. In Virginia, penalties may include imprisonment, fines and denial of insurance benefits.

COLORADO: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DISTRICT OF COLUMBIA, KENTUCKY and PENNSYLVANIA: 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 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. In District of Columbia, penalties include imprisonment and/or fines. In addition, the Insurer may deny insurance benefits if the Applicant provides false information materially related to a claim. In Pennsylvania, the person may also be subject to criminal and civil penalties.

FLORIDA and OKLAHOMA: Any person who knowingly and with intent to injure, defraud or deceive the Insurer, files a statement of claim or an Application containing any false, incomplete or misleading information is guilty of a felony. In Florida it is a felony to the third degree.

KANSAS: An act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an Insurer, purported Insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for personal or commercial insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto is considered a crime.

MAINE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against the Insurer, submits an Application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OREGON: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

TENNESSEE and WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and/or denial of insurance benefits.

Print Named of Insured

Print Name of Witness Signature

Signature of Insured

Signature of Witness

Date Insured Signed Application

Date Witnessed

Insured's Agent Signature

Insured's Agent Insurance License Number

NOTIFICATION PROCEDURE OUTLINE

PLEASE DISCUSS THE FOLLOWING WITH YOUR INSURED

CLAIMS REPORTING

All claims are to be reported immediately, directly to the Insurance Company.

The Insurance Company has established a claim hot-line for this purpose.

1-866-272-9267

ALL ACCIDENTS OR CLAIMS MUST BE REPORTED IMMEDIATELY, REGARDLESS OF FAULT!

INSPECTIONS

ALL units insured through the Insurance Company must be inspected. These inspections will be accomplished as follows:

Over 4 Power Units: A formal inspection will be ordered by the Insurance Company

1 to 4 Power Units: "Mechanics Inspection" forms may be utilized by the insured wherein a local mechanic may inspect each unit. The cost of these inspections will be borne by the insured and the inspection forms must be returned with color photos of each unit and a receipt for the cost of the inspection.

Exceptions:

a) 5 years old or newer vehicles require the signed Underwriting Representation form and color photo in lieu of the insurance company inspection.

b) DOT inspection which is not more than 12 months old and color photo is acceptable in lieu of insurance company inspection

**** A SATISFACTORY INSPECTION MUST BE ACCOMPLISHED ON EACH INSURED UNIT WITHIN 30 DAYS FROM BINDING. FAILURE TO COMPLY WITH THIS REQUIREMENT WILL CAUSE CANCELLATION OF THE BINDER.**

VEHICLE CHANGES

All vehicle changes must be reported to the Insurance Company to be effective prior to placing in service. NO AUTOMATIC COVERAGE IS AFFORDED UNDER THIS BINDER AND/OR POLICY FOR NEW, REPLACEMENT AND/OR TEMPORARY SUBSTITUTE VEHICLES.

INITIAL AND ADDITIONAL DRIVERS

All drivers submitted for approval to operate an insured auto under any policy of insurance with the Insurance Company are required to have a minimum of 2 years of driving history in a motor vehicle similar to the type of motor vehicle insured under this policy of insurance. All drivers must be reported to the Insurance Company and approved prior to the operation of any insured unit. A Motor Vehicle Report (MVR) will be ordered and reviewed and insured will be notified of the acceptability of additional drivers.

NO RECAP TIRES OR HAULING OF HAZARDOUS WASTE

Please be advised that the insured's failure to comply with the aforementioned requirements concerning additional/replacement vehicles and additional drivers is a material change in risk and may result in policy cancellation and possible claim and/or coverage denial.

Insured: I have read and fully understand my obligation concerning immediate claim reporting, vehicle inspections, vehicle changes and additional drivers. I further understand that the producer signature who appears below is my agent and not the agent of the Insurance Company. The agent has no authority to bind the Insurance Company without first obtaining confirmation from the Insurance Company through a telephonic binder and receiving a corresponding binder number. The agent has no right to make, alter, modify or discharge any contract or policy issued on the basis of this application.

Date

Signature _____
Insured's Signature

Insured's Agent: I certify that I have discussed the insured's obligation with my client and that I also fully understand the procedures concerning claims reporting, vehicle inspections, vehicle changes and additional drivers.

Date

Signature _____
Insured's Agent Signature

NEW VENTURE QUESTIONNAIRE

NAMED INSURED INCLUDING DBA: _____

EFFECTIVE DATE OF NEW VENTURE: _____

FEIN# AND/OR SS# FOR NEW VENTURE: _____

HOW LONG HAVE YOU BEEN DRIVING TRACTOR/TRAILER UNITS? _____

DATE AND STATE FIRST CDL RECEIVED? _____

WHO DID YOU DRIVE FOR PRIOR TO BECOMING A NEW VENTURE? _____

WHAT DID YOU HAUL PRIOR TO BECOMING A NEW VENTURE? _____

PROVIDE YOUR PRIOR ROUTE? _____

WHAT WILL YOUR FUTURE ROUTE BE? _____

WHAT WILL YOU BE HAULING AND FOR WHOM? _____

WILL THE VENTURE REQUIRE FINANCING OF THE OPERATION? _____

IF YES, WITH WHOM? _____

ARE YOU APPLYING FOR AN ICC AUTHORITY WITH NAMED INSURED ABOVE? _____ IF YES
WHEN? _____ IF NO, WHOSE AUTHORITY ARE YOU GOING
TO USE? _____

DO YOU EXPECT TO INCREASE THE NUMBER OF VEHICLES WITHIN ONE YEAR? _____

IF YES, HOW MANY? _____ WHEN? _____

DESCRIBE YOUR DRIVER HIRING PRACTICES. _____

DESCRIBE YOUR VEHICLE MAINTENANCE PROGRAM. _____

WILL YOU ALLOW TRIP LEASING? _____ WILL YOU USE TEAM DRIVERS? _____

ARE FAMILY MEMBERS TRAVELING WITH YOU? _____ IF SO, WHOM _____

WHAT IS THE ANTICIPATED GROSS RECEIPTS? _____

TOTAL ANNUAL MILEAGE? _____

NOTICE OF INFORMATION PRACTICES (PRIVACY)

Personal Information about you, including information from a credit or other investigative report, may be collected from persons other than you in connection with this application for insurance and subsequent amendments and renewals. Such information as well as other personal and privileged information collected by us or our agents may in certain circumstances be disclosed to third parties without your authorization. Credit scoring information may be used to help determine either your eligibility for insurance or the premium you will be charged. We may use a third party in connection with the development of your score. You may have the right to review your personal information in our files and request correction of any inaccuracies. You may also have the right to request in writing that we consider extraordinary life circumstances in connection with the development of your credit score. These rights may be limited in some states. Please contact your agent or broker to learn how these rights may apply in your state or for instructions on how to submit a request to us for a more detailed description of your rights and our practices regarding personal information.

AZ: As described in ARIZONA revised statute 20-2104(D), a credit report or other investigative report about you may be requested in connection with this application for insurance. Any information which we have or may obtain about you or other individuals listed as policyholders on our policy will be treated confidentially. However, this information, as well as other personal or privileged information subsequently collected, may under certain circumstances, be disclosed without prior authorization to non-affiliated third parties. We may also share such information with affiliated companies for such purposes as claims handling, servicing, underwriting and insurance marketing. You have the right to see personal information collected about you, and you have the right to correct any information which may be wrong. Also, pursuant to ARIZONA revised statute 20-2104(C), if you are interested in obtaining a complete description of our information practices, and your rights regarding information we collect, please write us at the address provided with your policy.

CA: This authorization shall expire one year from the date you signed the authorization.

MA: Credit scoring information may be used to determine your eligibility for insurance but not for rating purposes.

MN: We are required to obtain this authorization from you pursuant to Minnesota Statute 72A.501. I, the undersigned, hereby authorize the agent named above, if any, and/or the underwriting department of the insurance company named above to collect credit-related and other information about me from credit bureaus and other organizations providing personal or privileged information. I understand this information will be used for the purpose of making underwriting decisions in connection with the insurance for which I have applied, sought reinstatement or requested a change in benefits. These decisions may include determinations to grant or deny me coverage and/or the rates I will be charged. I also understand that I have the right to request in writing that extraordinary life circumstances be considered in connection with the development of my credit score.

OR: In connection with my application for insurance to the company shown above, ("You"), I hereby authorize you to collect and disclose personal, privileged information, about me, by and to consumer reporting agencies, your authorized representatives, assignees, agents and affiliates. The information collected and disclosed extends to my credit standing, credit worthiness, credit capacity, personal characteristics and mode of living. I understand that credit scoring information may be used to either determine my eligibility for insurance or the premium I will be charged. Credit scoring cannot be used for renewals unless requested by the insured. I understand that I am entitled to receive a copy of this authorization and, upon request, a record of any subsequent disclosures of personal or privileged information that must include the name, mailing address and institutional affiliation of the party to which the information was disclosed as well as the date of the disclosure, and to the extent practicable, a description of the information being disclosed.

VA: In accordance with applicable federal and state laws, a credit report or other investigative report about you may be requested in connection with this application for insurance. Credit scoring information may be used to help determine either your eligibility for insurance or the premium you will be charged. We may use a third party in connection with the development of your score. You may request that your credit information be updated and if you question the accuracy of the credit information, we will, upon your request, reevaluate you based on corrected credit information from consumer reporting agency. Any information which we have or may obtain about you or other individuals listed as policyholders on your policy will be treated confidentially. However, this **VA Cont.:** information, as well as other personal or privileged information subsequently collected, may, under certain circumstances, and where permitted by law, be disclosed without prior authorization to non-affiliated third parties. We may also share such information with affiliated companies for such purposes as claims

handling, servicing, underwriting and insurance marketing. You have the right to request in writing that we consider extraordinary life circumstances in connection with the development of your credit score. You have the right to see personal information collected about you, and you have the right to correct any information which may be wrong. If you are interested in obtaining a complete description of our information practices, and your rights regarding information we collect, ask your agent, or if you have been issued a policy, please write us at the address provided with your policy.

An insurer authorized to do business in certain states that uses credit information to underwrite or rate risks for a policy of personal insurance may, on written request from a consumer, provide reasonable exceptions to the insurer's rates, rating classifications, company or tier placement, or underwriting rules or guidelines for a consumer who has experienced and whose credit information has been directly influenced by events considered extraordinary life circumstances such as:

1. Catastrophic event, as declared by the federal or a state government.
2. Serious illness or injury, or serious illness or injury to an immediate family member.
3. Death of a spouse, child, or parent.
4. Divorce or involuntary interruption of legally owed alimony or support payments.
5. Identity theft.
6. Temporary loss of employment for a period of three months or more, if such loss results from involuntary termination of employment.
7. Military deployment overseas.
8. Other events, as determined by the insurer

If a consumer submits a request for an exception as set forth above, an insurer may, in its sole discretion, but is not required to, do any of the following:

1. Require the consumer to provide reasonable written and independently verifiable documentation of the event.
2. Require the consumer to demonstrate that the event had direct and meaningful impact on the consumer's credit information.
3. Require such request to be made no more than sixty days from the date of the application for insurance or the policy renewal.
4. Grant an exception despite the fact that the consumer did not provide the initial request for an exception in writing.
5. Grant an exception where the consumer asks for consideration of repeated events or the insurer has considered this event previously.

FRAUD STATEMENTS

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER 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 SUBJECTS THE PERSON TO CRIMINAL AND [NY: SUBSTANTIAL] CIVIL PENALTIES

Fraud Warning

AL, AR, DC, LA, MD, NM, RI and WV: Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. *Applies in MD Only.

CO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

FL and OK: 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)*. *Applies in FL Only.

KS: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

ME, TN, VA, and WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties (may)* include imprisonment, fines and denial of insurance benefits. *Applies in ME Only.

KY, NY, OH, and PA: 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 subjects such person to criminal and civil penalties (not to exceed five thousand dollars and the stated value of the claim for each such violation)*. *Applies in NY Only.

OR: Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

NJ: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Signature

APPLICANT SIGNATURE

DATE

SIGNATURE OF INSURED'S AGENT

PRINT AGENT NAME AND LICENSE NUMBER

NAME OF AGENCY

AGENCY PHONE NUMBER

CALIFORNIA UNINSURED MOTORISTS COVERAGE SELECTION/REJECTION

Applicant/Named Insured:
Company:

California law permits you to make certain decisions regarding Uninsured Motorists Coverage. This document describes this coverage and the options available.

You should read this document carefully and contact us or your agent if you have any questions regarding Uninsured Motorists Coverage and your options with respect to this coverage.

This document includes general descriptions of coverage. However, no coverage is provided by this document. You should read your policy and review your Declarations Page(s) and/or Schedule(s) for complete information on the coverages you are provided.

A. Mandatory Offer Of Bodily Injury Uninsured Motorists Coverage

Please indicate your choices by initialing next to the appropriate item(s) below.

1. Selection Of Bodily Injury Uninsured Motorists Coverage

<p>(Initials)</p> <p>_____</p>	<p>I select Bodily Injury Uninsured Motorists Coverage at limits equal to the limits of my Bodily Injury Liability Coverage (split limits) or Combined Single Limit for Liability Coverage.</p>
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2. Rejection Of Bodily Injury Uninsured Motorists Coverage

The California Insurance Code requires that we provide you with the following information:

"The California Insurance Code requires an insurer to provide uninsured motorists coverage in each bodily injury liability insurance policy it issues covering liability arising out of the ownership, maintenance, or use of a motor vehicle. Those provisions also permit the insurer and the applicant to delete the coverage completely or to delete the coverage when a motor vehicle is operated by a natural person or persons designated by name. Uninsured motorists coverage insures the insured, his or her heirs, or legal representatives for all sums within the limits established by law, which the person or persons are legally entitled to recover as damages for bodily injury, including any resulting sickness, disease, or death, to the insured from the owner or operator of an uninsured motor vehicle not owned or operated by the insured or a resident of the same household. An uninsured motor vehicle includes an underinsured motor vehicle as defined in subdivision (p) of Section 11580.2 of the Insurance Code".

(Initials)	
_____	I reject Bodily Injury Uninsured Motorists Coverage entirely.
_____	I delete Bodily Injury Uninsured Motorists Coverage only with respect to the following individuals:
	(Name of Excluded Driver(s))

3. Lower Limit(s) For Bodily Injury Uninsured Motorists Coverage

The California Insurance Code requires that we provide you with the following information:

"The California Insurance Code requires an insurer to provide uninsured motorists coverage in each bodily injury liability insurance policy it issues covering liability arising out of the ownership, maintenance, or use of a motor vehicle. Those provisions also permit the insurer and the applicant to agree to provide the coverage in an amount less than that required by subdivision (m) of Section 11580.2 of the Insurance Code but not less than the financial responsibility requirements. Uninsured motorists coverage insures the insured, his or her heirs, or legal representatives for all sums within the limits established by law, which the person or persons are legally entitled to recover as damages for bodily injury, including any resulting sickness, disease, or death, to the insured from the owner or operator of an uninsured motor vehicle not owned or operated by the insured or a resident of the same household. An uninsured motor vehicle includes an underinsured motor vehicle as defined in subdivision (p) of Section 11580.2 of the Insurance Code".

(Initials)

I reject Bodily Injury Uninsured Motorists Coverage at limits equal to my Bodily Injury Liability Coverage (split limits) or Combined Single Limit for Liability Coverage and I select the following lower limits.

(Choose one):

(Initials)	Split Limits	OR	(Initials)	Combined Single Limit
_____	\$ 15,000/30,000		_____	\$ 30,000
_____	20,000/40,000		_____	40,000
_____	25,000/50,000		_____	50,000
_____	30,000/60,000		_____	60,000
_____	50,000/100,000		_____	100,000
_____	100,000/300,000		_____	250,000
_____	250,000/500,000		_____	300,000
_____	500,000/1,000,000		_____	500,000
_____	\$ _____		_____	1,000,000
	(Other)		_____	\$ _____
				(Other)

B. Mandatory Offer Of Property Damage Uninsured Motorists Coverage

Uninsured Motorists Coverage may also include Property Damage Uninsured Motorists Coverage. Property Damage Uninsured Motorists Coverage provides insurance protection to an insured for compensatory damages for injury to or destruction of a covered auto caused by an automobile accident which an insured is legally entitled to recover from the owner or operator of certain types of uninsured motor vehicles. However, Property Damage Uninsured Motorists Coverage is available only:

1. If you have not rejected Bodily Injury Uninsured Motorists Coverage; and
2. For autos for which you have not purchased Collision Coverage.

Please indicate your choices by initialing next to the appropriate item(s) below.

(Initials) _____	I select Property Damage Uninsured Motorists Coverage at a limit of \$3,500 for each accident for the following vehicle(s): (Specify Year/Make/Model) _____ _____ _____
(Initials) _____ _____	I reject Property Damage Uninsured Motorists Coverage entirely. I delete Property Damage Uninsured Motorists Coverage only with respect to the following individuals: (Name of Excluded Driver(s)) _____ _____

Applicant's/Named Insured's Signature

Date