Used Auto and Motorhome Dealer Application

COLUMBIA INSURANCE COMPANY
NATIONAL FIRE & MARINE INSURANCE COMPANY
NATIONAL INDEMNITY COMPANY
NATIONAL INDEMNITY COMPANY OF MID-AMERICA
NATIONAL INDEMNITY COMPANY OF THE SOUTH
NATIONAL LIABILITY & FIRE INSURANCE COMPANY

Desired Policy Term From: _____ To: _____

GENERAL INFORMATION

1. Named Insured Information (please select one):

   Name "dba" (if applicable)

   ☐ Corporation _____
   ☐ Partnership _____
   ☐ Individual _____
   ☐ Other _____
2. Business (physical) Address: _____
3. Mailing address: _____
4. Web Site Address: _____
5. Are you the owner of this business location? ☐ Yes ☐ No

   If no, does owner of premises need to be named as additional insured? ☐ Yes ☐ No

   If yes, please provide owner's complete name. _____
6. Description of Operation: _____
7. Type of Operation:

   ☐ Franchised Dealer
   ☐ Non-franchised Dealer ☐ Repair Shop ☐ Wholesale Dealer/Auto Broker
   ☐ Equipment & Implement Dealer ☐ Automobile Dismantling ☐ Other _____
8. Please check those items below that are part of your dealer operation:

	% of Operation		% of Operation
☐ Private Passenger Autos		☐ Motor Homes	
☐ Mobile Homes		☐ Buses	
☐ Motorcycles		☐ Antique Auto	
☐ ATVs, Snowmobiles, Jet Skis		☐ Autos valued over $40,000	
☐ Trucks over 10,000 GVW		☐ Contractor Equipment	
☐ Tractors		☐ Internet sales of autos (incl. EBay)	
☐ Trailers		☐ Internet sales of parts/accessories	
☐ High Performance/ Exotic Car Sales		☐ Farm Equipment/Implement Dealer	
		☐ Other	

9. Person to Contact:

   For Inspection (Name & Phone Number) _____

   For Accounting Records (Name & Phone Number) _____
10. Current management has controlled the business since _____ (year) and has been in this type of business since _____ (year)
11. Is this a new venture? ☐ Yes ☐ No
12. (a) **PREVIOUS 3 YEARS' INSURANCE EXPERIENCE**

Policy Term	Insurance Company Name	Premium	Description of Loss (if any)	Loss Date	Amount Paid

(b) Have you ever been cancelled or non-renewed for this kind of insurance? ☐ Yes ☐ No If yes, explain. _____

(c) Are you aware of any facts or past incidents, circumstances or situations which could give rise to a claim under the insurance sought in this application? ☐ Yes ☐ No If yes, provide complete details _____

13. (a) List major owners/shareholders, management:

Name	Years with Company	% of Ownership

(b) What is estimated net worth of the business? _____ (c) Gross receipts last year? _____

(d) How many autos did you sell in the past year? _____

14. Has this business entity ever filed for bankruptcy? ☐ Yes ☐ No

Date filed _____ Date released _____

15. Do you accept autos on consignment? ☐ Yes ☐ No If yes, _____% of operation.

If yes, is value of consigned autos included in garagekeepers limit? ☐ Yes ☐ No

Please enclose copy of current consignment agreement.

16. Plates held by Applicant (indicate number held): _____ Dealer _____ Transporter

_____ Repairer _____ Other

List Plate Identification Numbers assigned by the state: _____

Are plates attached to owned autos? ☐ Yes ☐ No Describe _____

Are plates attached to tow trucks? ☐ Yes ☐ No Describe _____

COVERAGE INFORMATION

17. **Limits of Liability and Coverage(s) Requested (Check desired coverage and insert limits)**

I. LIABILITY

	Each Accident	Aggregate (Garage operations only)
☐ Bodily Injury & Property Damage Liability (Property Damage Liability subject to $100 deductible completed operations)	$ _____ (Combined Single Limit)	$ _____ (Maximum Aggregate Limit - 2 million)

List All Locations To Be Covered for bodily injury and property damage liability

Location No. 1 Address	Location No. 3 Address
Location No. 2 Address	Location No. 4 Address

II. MEDICAL PAYMENTS

☐ Premises Medical Payments (per person) Choose Limit: ☐ $500 ☐ $750 ☐ $1,000 ☐ $2,000 ☐ $5,000

III. UNINSURED/UNDERINSURED MOTORISTS

APPLICABLE UNINSURED AND/OR UNDERINSURED MOTORISTS INSURANCE SELECTION/REJECTION PAGE IS REQUIRED TO BE COMPLETED AND SIGNED BY THE NAMED INSURED WITH THE SUBMISSION OF THIS APPLICATION.

IV. GARAGEKEEPERS COVERAGE NOTE: In tow or on hook coverage is excluded from garagekeepers coverage

☐ SPECIFIED PERILS and Collision **OR** ☐ COMPREHENSIVE and Collision (available on Direct Primary basis only)

(pick one of the following)

☐ Legal Liability

☐ Direct Primary

GARAGEKEEPERS DEDUCTIBLE: ☐ $500 deductible per auto

☐ $1,000 deductible per auto

☐ $2,500 deductible per auto

☐ $5,000 deductible per auto

18. **List All Business Locations To Be Covered for Garagekeepers Coverage**

Loc. No.	Garagekeepers Limit	Garagekeepers			
		Average Value Per Auto	Maximum Value Per Auto	Average # of Autos	Maximum # of Autos

V. **DEALERS PHYSICAL DAMAGE** *Non-Reporting Form Only, 80% coinsurance clause applies

☐ Specified Causes of Loss (select desired deductible)

☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000

AND

Collision (select desired deductible)

☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000

List All Business Locations To Be Covered for Dealers Physical Damage Coverage

Loc. No.	Dealers Physical Damage Limit	Dealers Physical Damage			
		Average Value Per Auto	Maximum Value Per Auto	Average # of Autos	Maximum # of Autos

Any loss payees? ☐ Yes ☐ No If yes, give name and address of loss payee: _____

Is False Pretense Coverage desired? ☐ Yes ☐ No

If yes, select limit: ☐ $25,000 ☐ $50,000 ☐ $100,000

Have you experienced any past losses pertaining to False Pretense Coverage? ☐ Yes ☐ No

If yes, explain._____

19. **AUTOS USED IN CONNECTION WITH GARAGE OPERATION**

(a) Do you own and operate an Automobile Transporter, tow truck, tank truck or tank trailer? ☐ Yes ☐ No

(b) Do you desire coverage? ☐ Yes ☐ No

(No coverage afforded for specific autos unless autos are scheduled on the policy and assessed premium charge)

Vehicle #	Model Year	Vehicle Make & Model	Vehicle Identification Number	Gross Vehicle Weight (GVW)	Body Type (pickup, sedan, etc.)	Maximum Radius of Operation	Garaging Location (City, State)	Current Vehicle Value	Physical Damage Deductible	Is a plate permanently attached? Y or N
1										
2										
3										

Check desired coverages for scheduled autos and/or plates:

☐ Liability (Must match the garage liability limit)

☐ UM Limit (policy level) $ _____

☐ Medical Payments Limit (Must match the garage medical payments limit)

☐ Physical Damage (select type for each unit on which coverage is desired)

Unit #1: ☐ Specified Perils/Collision **OR** ☐ Comprehensive/Collision

Unit #2: ☐ Specified Perils/Collision **OR** ☐ Comprehensive/Collision

Unit #3: ☐ Specified Perils/Collision **OR** ☐ Comprehensive/Collision

Is intow desired? Which units? _____

Intow Limit: $ _____

Intow Deductible: $ _____

RATING INFORMATION

20. PROVIDE TOTAL NUMBER OF EMPLOYEES IN EACH OF THE FOLLOWING CATEGORIES:

CLASS I EMPLOYEES Number

Definitions:

(A) Proprietors, Partners, Executives active in the business _____
(B) Sales Persons _____
(C) General Managers _____
(D) Service Managers _____

Number

(E) Other employees whose principal duty is driving garage vehicles or who are furnished garage vehicles _____
(F) Other employees or operators whose duty is driving garage vehicles for delivery or Driveaway _____
(G) All other employees _____

COMPLETE ALL SECTIONS BELOW:

Owner & Employee Driver information

Loc. No.	Name	*Job Duty or Job Title	Full Time (FT) **Part Time (PT)	Date of Birth	State where licensed	Drivers License #	Number of Accidents last 3 years	Number of Violations last 3 years	Explain

*Insert letter from above definitions
**Part Time = less than 20 hours per week

Number

CLASS II EMPLOYEES (NON-EMPLOYEES)

(1) Any inactive proprietor, inactive executive or inactive partner to whom a covered auto has been furnished. _____
(2) Any active or inactive proprietor's, executive's or partner's household member to whom a covered auto has been furnished. _____
(3) List all members of your household who are 14 years of age and older regardless of whether licensed or operating vehicles. _____
(4) Any other persons furnished an auto.

List all non-employees as defined above:

Name	Date of Birth	If Member of Household, Show Relationship	State where licensed	Driver License #	Number of Accidents last 3 years	Number of Violations last 3 years	Explain

UNDERWRITING INFORMATION

21. Is the operation in question 6 your primary operation? If not, explain. _____ 21. ☐ Yes ☐ No
22. (a) Where do you obtain autos held for sale? _____
    (b) How are they delivered? (i.e. by drive-away, tow truck, auto transporter, etc.) _____
23. (a) If by drive-away, estimated total number of trips annually: _____
    (b) Who operates the units that are delivered by drive-away?
    ☐ Full-time employees ☐ Part-time employees ☐ Contractors
    (c) Name(s) of drive-away operators: _____
24. Maximum Mileage per drive-away or delivery ☐ 0-150 miles ☐ Over 150 miles
    (NOTE: Policy will include radius restriction based on indicated mileage):
25. Do you sell or distribute butane, propane, other liquefied gas under pressure, or ammonium nitrate? 25. ☐ Yes ☐ No
26. (a) Do you sell tires?
    _____% of Receipts ☐ New Tires_____% ☐ Used Tires _____% 26. (a) ☐ Yes ☐ No
    (b) Do you recap or retread tires? (b) ☐ Yes ☐ No
27. Do you install and/or repair trailer hitches or 5th wheel connections? If yes, _____ % of operation. 27. ☐ Yes ☐ No
28. Do you hold a salvage dealer license or operate a salvage yard? 28. ☐ Yes ☐ No
29. Do you salvage cars for resale? 29. ☐ Yes ☐ No
30. Do you dismantle automobiles for the purpose of re-sale of parts? If yes, _____% of operation. 30. ☐ Yes ☐ No
31. Do you weld gas tanks? 31. ☐ Yes ☐ No
32. Do you repossess autos? 32. ☐ Yes ☐ No
33. Do you sell parts? Gross Receipts from Parts Sold but not Installed: _____ 33. ☐ Yes ☐ No
    ☐ Used Parts _____% ☐ New Parts _____ %
34. Do you have automatic car washes on location? ($500 deductible applies) 34. ☐ Yes ☐ No
35. (a) Do you spray paint at your business location? 35. (a) ☐ Yes ☐ No
    (b) If yes, do you use a paint booth meeting Underwriters Laboratories (UL) standards? (b) ☐ Yes ☐ No
36. (a) Are customers permitted to test drive autos? 36. (a) ☐ Yes ☐ No
    (b) If yes, are customers accompanied by a salesperson during test drives? (b) ☐ Yes ☐ No
    (c) Are customers allowed test drive autos overnight? (c) ☐ Yes ☐ No
37. (a) Do you loan autos to customers? 37. (a) ☐ Yes ☐ No
    (b) Do you lease autos (including PPTs, trucks, motorcycles, ATVs, etc.)? (b) ☐ Yes ☐ No
38. Do you rent autos to customers while their units are left for service repair? 38. ☐ Yes ☐ No
39. Do you furnish autos to anyone? 39. ☐ Yes ☐ No
40. Do you sponsor any racing events? 40. ☐ Yes ☐ No
41. Do you repair autos (including cars, motorcycles, ATVs) that are used for racing? 41. ☐ Yes ☐ No
42. Do you pick up or deliver customers' autos? 42. ☐ Yes ☐ No
43. **PREMISES**
    Where are the units held for sale stored (in building, open lot, etc.)? _____
    If open lot, is lot floodlighted? 43. ☐ Yes ☐ No
    Are attendants or night watchmen employed? ☐ Yes ☐ No
    Is there an alarm system? If yes, what kind? _____ ☐ Yes ☐ No
    Is lot fenced? ☐ Yes ☐ No
    If yes, describe (e.g., chained, posts 4 feet apart). _____
    Are keys locked when stored after hours? ☐ Yes ☐ No
    Where are keys kept? Explain. _____
    Are customers permitted in the service area? ☐ Yes ☐ No
    How many service bays do you have? _____ Any service pits? If so, how many? _____
    Do you have fire and smoke alarms? ☐ Yes ☐ No
    Do you have fire extinguishers? ☐ Yes ☐ No
    Are firearms kept on premises? ☐ Yes ☐ No
    Do you occupy all of the premises? ☐ Yes ☐ No
    Do you lease part of premises to others? If yes, to whom? _____ ☐ Yes ☐ No
    Is your operation located at your private residence? ☐ Yes ☐ No
    If yes, do you have homeowners or renters insurance? ☐ Yes ☐ No

IMPORTANT NOTICE

Insurance companies operating in the Commonwealth of Pennsylvania are required by law to make available for your purchase the following benefits for you, your spouse or other relatives or minors in your custody or in the custody of your relatives, residing in your household, occupants of your motor vehicle or persons struck by your motor vehicle.

(1) Medical benefits, up to at least $100,000.

(1.1) Extraordinary medical benefits, from $100,000 to $1,100,000 which may be offered in increments of $100,000.

(2) Income loss benefits, up to at least $2,500 per month up to a maximum benefit of at least $50,000.

(3) Accidental death benefits, up to at least $25,000.

(4) Funeral benefits, $2,500.

(5) As an alternative to paragraphs (1), (2), (3) and (4), a combination benefit, up to at least $177,500 of benefits in the aggregate or benefits payable up to three years from the date of the accident, whichever occurs first, subject to a limit on accidental death benefit of up to $25,000 and a limit on funeral benefit of $2,500, provided that nothing contained in this subsection shall be construed to limit, reduce, modify or change the provisions of section 1715(d) (relating to availability of adequate limits).

(6) Uninsured, underinsured and bodily injury liability coverage up to at least $100,000 because of injury to one person in any one accident and up to at least $300,000 because of injury to two or more persons in any one accident or, at the option of the insurer, up to at least $300,000 in a single limit for these coverages, except for policies issued under the Assigned Risk Plan. Also, at least $5,000 for damage to property of others in any one accident.

Additionally, insurers may offer higher benefit levels than those enumerated above as well as additional benefits. However, an insured may elect to purchase lower benefit levels than those enumerated above.

Your signature on this notice or your payment of any renewal premium evidences your actual knowledge and understanding of the availability of these benefits and limits as well as the benefits and limits you have selected.

If you have any questions or you do not understand all of the various options available to you, contact your agent or company.

If you do not understand any of the provisions contained in this notice, contact your agent or company before you sign.

_____

Signature of First Named Insured

_____

Date

FIRST PARTY BENEFITS NOTICE

The options that you requested for Pennsylvania First Party Benefits are reproduced below. **These options determined your policy premium, but your policy may be changed by contacting the party listed below. Changing these indications may result in changes to your premium.** The State of Pennsylvania requires you to purchase a minimum of $5,000 for the Medical Expense Benefit. All of the other options listed below (including a higher limit of Medical Expenses) are choices you may make. The premium associated with each option is also listed.

If you are satisfied with your level of First Party Benefits this notice may be disregarded.

FIRST PARTY BENEFITS

A. MEDICAL EXPENSE BENEFIT *Coverage to reimburse you for reasonable and necessary medical treatment and services incurred.*

B. INCOME LOSS BENEFIT *Coverage to replace a portion of lost income and reimburse you for expenses in securing replacement services.*

C. ACCIDENTAL DEATH BENEFIT *A death benefit paid in the event of the death of an insured person due to a covered auto accident.*

D. FUNERAL BENEFIT *Coverage to pay for direct funeral, burial and other related expenses incurred as a result of the death of an insured person due to a covered accident.*

BENEFIT LEVEL OPTIONS: (Coverage is comprised of a selection from each one of A, B, C, and D or one selection from E. Coverage is also comprised of a selection from F.)

A. MEDICAL EXPENSES: (☒ indicates the option you selected)

☐ $5,000	per person, per accident	(Minimum)	$_____	Premium
☐ $10,000	per person, per accident		$_____	Premium
☐ $25,000	per person, per accident		$_____	Premium
☐ $50,000	per person, per accident		$_____	Premium
☐ $100,000	per person, per accident	(Maximum)	$_____	Premium

B. INCOME LOSS: (☒ indicates the option you selected, if any)

☐ None – Rejected	per month / per accident, per person	(Minimum)		
☐ $1,000 / $5,000	per month / per accident, per person		$_____	Premium
☐ $1,000 / $10,000	per month / per accident, per person		$_____	Premium
☐ $1,000 / $15,000	per month / per accident, per person		$_____	Premium
☐ $1,500 / $25,000	per month / per accident, per person		$_____	Premium
☐ $2,500 / $50,000	per month / per accident, per person	(Maximum)	$_____	Premium

C. ACCIDENTAL DEATH: (☒ indicates the option you selected, if any)

☐ None – Rejected	per person, per accident	(Minimum)		
☐ $5,000	per person, per accident		$_____	Premium
☐ $10,000	per person, per accident		$_____	Premium
☐ $25,000	per person, per accident	(Maximum)	$_____	Premium

D. FUNERAL EXPENSE: (☒ indicates the option you selected, if any)

☐ None – Rejected	per person, per accident	(Minimum)		
☐ $1,500	per person, per accident		$_____	Premium
☐ $2,500	per person, per accident	(Maximum)	$_____	Premium

OR

E. COMBINATION BENEFITS: Single Limit for all coverages, with specific benefit limits as shown (☒ indicates the option you selected, if any)

☐ $50,000	($2,500 Funeral and $10,000 Accidental Death Benefits)	$_____	Premium
☐ $100,000	($2,500 Funeral and $10,000 Accidental Death Benefits)	$_____	Premium
☐ $177,500	($2,500 Funeral and $25,000 Accidental Death Benefits)	$_____	Premium

AND

F. EXTRAORDINARY MEDICAL BENEFIT (EMB): (☒ indicates the option you selected, if any)

In accordance with Pennsylvania Law your First Party Benefits coverage may be extended to provide an extraordinary medical benefit (EMB) which will pay the medical and rehabilitation costs for you and your family members residing in your household which are more than $100,000 for each person injured as the result of an automobile accident, up to a lifetime benefit limits of $1,000,000 for each person. Since you are only required to carry $5,000 medical expense coverage under your First Party Benefits and EMB coverage only pays expenses that exceed $100,000, you may have a gap in coverage between your requested First Party Benefits and EMB coverage. We recommend you consider this when you make your medical expense selections.

☐ I purchased no EMB coverage.

☐ I purchased EMB coverage at the following limit:

☐ $100,000 ☐ $300,000 ☐ $500,000 ☐ $1,000,000

If you desire to change your coverage please contact:

UNDERINSURED MOTORIST COVERAGE SELECTION / REJECTION

Underinsured Motorist Coverage provides protection for damages incurred which exceed the limit of liability carried by the driver of a vehicle who injures you in an automobile accident. You have the right to purchase Underinsured Motorist Coverage in an amount equal to the amount of Bodily Injury Liability Coverage provided in your policy. The law does not require you to purchase Underinsured Motorist Coverage, and you have the right to reject this coverage. You also have the option to purchase Underinsured Motorist Coverage with limits of coverage less than that of your Bodily Injury Liability Coverage limit. Underinsured Motorist Coverage is an optional coverage, however, we are required to include it in your policy unless you take steps to reject it.

INDICATE YOUR CHOICE BY EITHER COMPLETING THE REJECTION OF UNDERINSURED MOTORIST COVERAGE SECTION (OPTION ONE) OR BY COMPLETING THE SELECTION OF UNDERINSURED MOTORIST COVERAGE AND STACKING OPTIONS SECTION (OPTION TWO)

OPTION ONE: REJECTION OF UNDERINSURED MOTORIST COVERAGE

By signing this waiver I am rejecting Underinsured Motorist Coverage under this policy, for myself and all relatives residing in my household. Underinsured coverage protects me and relatives living in my household for losses and damages suffered if injury is caused by the negligence of a driver who does not have enough insurance to pay for all losses and damages. I knowingly and voluntarily reject this coverage.

X _____ _____ _____
Signature of First Named Insured | Date Signed | Witness

OPTION TWO: SELECTION OF UNDERINSURED MOTORIST COVERAGE AND STACKING OPTIONS

A. Selection of UIM Coverage: I do wish to purchase Underinsured Motorist Coverage at $ _____ per person, $ _____ per accident split limits of liability or $ _____ per accident single limit of liability. (Your UIM limits selection cannot be greater than your policy Bodily Injury Liability Coverage Limit.)

B. Stacking Options: If you have chosen to purchase Underinsured Motorist Coverage, and you are an individual, your next option is to determine if you want to stack the limits of your policy. Stacking means you can claim a total of the amounts of Underinsured Motorist Coverage assigned to each vehicle in your policy. If you reject stacked limits, each vehicle insured under the policy will have its own limit of Underinsured Motorist Coverage. There is an additional premium for this coverage. Please check one box below to indicate your choice.

□ Purchase of Stacking: I wish to purchase stacking of Underinsured Motorist Coverage (only applicable if the Named Insured is an individual).

□ Rejection of Stacking: I wish to reject stacking of Underinsured Motorist Coverage. By signing this waiver, I am rejecting stacked limits of Underinsured Motorist Coverage under the policy for myself and members of my household under which the limits of coverage available would be the sum of limits for each motor vehicle insured under the policy. Instead the limits of coverage that I am purchasing shall be reduced to the limits stated in the policy. I knowingly and voluntarily reject the stacked limits of coverage. I understand that my premiums will be reduced if I reject this coverage.

X _____ _____ _____
Signature of First Named Insured | Date Signed | Witness

THE OPTIONS SELECTED SHALL CONTINUE IN FORCE AND EFFECT UNTIL REPLACEMENT WRITTEN NOTICE IS RECEIVED BY THE COMPANY, OR ITS REPRESENTATIVE.

UNINSURED MOTORIST COVERAGE SELECTION / REJECTION

Uninsured Motorist Coverage provides protection for damages incurred as a result of an accident with an uninsured motor vehicle. You have the right to purchase Uninsured Motorist Coverage in an amount equal to the amount of Bodily Injury Liability coverage provided in your policy. The law does not require you to purchase Uninsured Motorist Coverage, and you have the right to reject this coverage. You also have the option to purchase Uninsured Motorist Coverage with limits of coverage less than that of your Bodily Injury Liability Coverage limit. Uninsured Motorist Coverage is an optional coverage, however, we are required to include it in your policy unless you take steps to reject it.

INDICATE YOUR CHOICE BY EITHER COMPLETING THE REJECTION OF UNINSURED MOTORIST COVERAGE SECTION (OPTION ONE) OR BY COMPLETING THE SELECTION OF UNINSURED MOTORIST COVERAGE AND STACKING OPTIONS SECTION (OPTION TWO)

OPTION ONE: REJECTION OF UNINSURED MOTORIST COVERAGE

NOTE: 75 Pa.C.S.A. § 1731(b.1) forbids rejection of uninsured motorist coverage for "Common Carriers by Motor Vehicle" as defined in 66 Pa.C.S.A.§ 102.

By signing this waiver I am rejecting uninsured motorist coverage under this policy, for myself and all relatives residing in my household. Uninsured coverage protects me and relatives living in my household for losses and damages suffered if injury is caused by the negligence of a driver who does not have any insurance to pay for losses and damages. I knowingly and voluntarily reject this coverage.

X _____ _____ _____
Signature of First Named Insured | Date Signed | Witness

OPTION TWO: SELECTION OF UNINSURED MOTORIST COVERAGE AND STACKING OPTIONS

A. Selection of UM Coverage: I do wish to purchase Uninsured Motorist Coverage at $ _____ per person, $ _____ per accident split limits of liability or $ _____ per accident single limit of liability. (Your UM limits selection cannot be greater than your policy Bodily Injury Liability Coverage Limit.)

B. Stacking Options: If you have chosen to purchase Uninsured Motorist Coverage, and you are an individual, your next option is to determine if you want to stack the limits of your policy. Stacking means you can claim a total of the amounts of Uninsured Motorist Coverage assigned to each vehicle in your policy. If you reject stacked limits, each vehicle insured under the policy will have its own limit of Uninsured Motorist Coverage. There is an additional premium for this coverage.

□ Purchase of Stacking: I wish to purchase stacking of Uninsured Motorist Coverage (only applicable if the Named Insured is an individual).

□ Rejection of Stacking: I wish to reject stacking of Uninsured Motorist Coverage. By signing this waiver, I am rejecting stacked limits of Uninsured Motorist Coverage under the policy for myself and members of my household under which the limits of coverage available would be the sum of limits for each motor vehicle insured under the policy. Instead the limits of coverage that I am purchasing shall be reduced to the limits stated in the policy. I knowingly and voluntarily reject the stacked limits of coverage. I understand that my premiums will be reduced if I reject this coverage.

X _____ _____ _____
Signature of First Named Insured | Date Signed | Witness

THE OPTIONS SELECTED SHALL CONTINUE IN FORCE AND EFFECT UNTIL REPLACEMENT WRITTEN NOTICE IS RECEIVED BY THE COMPANY, OR ITS REPRESENTATIVE.

SIGNATURE IS ALSO REQUIRED ON LAST PAGE OF APPLICATION

MUST BE SIGNED BY THE APPLICANT PERSONALLY

No coverage is bound until the Company advises the Applicant or its representative that a policy will be issued and then only as of the policy effective date and in accordance with all policy terms. The Applicant acknowledges that the **Applicant's Representative named below is acting as Applicant's agent and not on behalf of the Company. The Applicant's Representative has no authority to bind coverage, may not accept any funds for the Company, and may not modify or interpret the terms of the policy.**

The Applicant agrees that the foregoing statements and answers are true and correct. The Applicant requests the Company to rely on its statements and answers in issuing any policy or subsequent renewal. The Applicant agrees that if its statements and answers are materially false, the Company may rescind any policy or subsequent renewal it may issue.

If any jurisdiction in which the Applicant intends to operate or the Interstate Commerce Commission requires a special endorsement to be attached to the policy which increases Company's liability, the Applicant agrees to reimburse the Company in accordance with the terms of that endorsement.

The Applicant agrees that any inspection of autos, vehicles, equipment, premises, operations, or inspection of any other matter relating to insurance that may be provided by the Company, is made for the use and benefit of the Company only, and is not to be relied upon by the Applicant or any other party in any respect.

The Applicant understands that an inquiry may be made into the character, finances, driving records, and other personal and business background information the Company deems necessary in determining whether to bind or maintain coverage. Upon written request, additional information will be provided to the Applicant regarding any investigation.

The Applicant represents that she/he has completed all relevant sections of this Application prior to execution and that the Applicant has personally signed below (or if Applicant is a Corporation a corporate officer has signed below).

Will premium be financed? ☐ Yes ☐ No If yes, with whom? _____

_____	_____	_____
Witness	Applicant's Signature	Date

TO BE COMPLETED BY APPLICANT'S REPRESENTATIVE

Is this direct business to your office? _____ If not, explain _____

Is this new business to your office? _____ If not, how long have you had the account? _____

How long have you known applicant? _____

REQUEST TO COMPANY GENERAL AGENT:

☐ Please quote ☐ Please bind at earliest possible date and issue policy

☐ Please issue policy effective _____ Coverage was bound by _____

(Time and Date Bound by General Agent) (Name of Person in Company General Agent's Office Binding Coverage)

_____

Applicant's Representative's Name and Address Phone No.