



COMMERCIAL AUTO APPLICATION

- Acceptance Casualty Insurance Company
- Acceptance Indemnity Insurance Company

- Occidental Fire & Casualty Co. of North Carolina
- Wilshire Insurance Company

Agent/Agency: _____ Date Submitted: _____

1. APPLICANT INFORMATION

Applicant/Named Insured: _____

(DBA): _____

Mailing Address: _____

List all Garaging Locations: _____

Contact Name: _____ Phone: _____

Website Address: _____ Fax: _____

a. Form of business: Individual Corporation Partnership Other: _____

b. Proposed effective date: _____ Federal Tax ID #: _____ Years in business: _____

c. Are current financials attached? Yes No Have you ever filed for bankruptcy? Yes No

d. Ever operated under a different name? Yes No

If yes, provide name(s): _____

e. Do you have any subsidiaries? Yes No

If yes, provide details of relationship: _____

2. DESCRIPTION OF OPERATIONS

a. Carrier Type: Common Contract * Private Other: _____

* If Contract, for whom? _____

b. Description and scope of operations: _____

c. US DOT #: _____ MC #: _____ Latest DOT Rating: _____ Year: _____

d. Are state filings required? Yes No

List state(s) and cert #(s): _____

e. Have you been canceled or non-renewed by another carrier within the past three (3) years? Yes No

If yes, provide details: _____

f. Is Carrier involved in any non-trucking business? Yes No

If yes, complete the Non-Trucking Application.

3. OWNERSHIP INFORMATION

	Name	Position / Title	# Years	% Ownership
1.				
2.				
3.				
4.				
5.				

Risk Bound? Yes No Date Bound: _____ Time Bound: _____ Broker Initials: _____

4. COMMODITIES HAULED (List commodity and % hauled)

Commodity	%	Commodity	%	Commodity	%

5. SCOPE OF OPERATIONS

- a. Radius of operation: _____ Metro Areas? Yes No Delivery? Yes No
 Coastal? Yes No
- b. Radius by %: 0-100 miles: _____ 101-300 miles: _____ 301-500 miles: _____ Over 500 miles: _____
- c. Area(s): East Coast Southeast Northeast Southwest Midwest West Coast
- d. Average trip in miles: _____ Maximum trip in miles: _____
- e. Largest cities entered (list all traveled to or through): _____

6. EQUIPMENT OVERVIEW (Attach vehicle schedule)

Type of Equipment	# Owned	# Owner/Operators	Total # Units
Tractors			
Heavy Trucks			
Light Trucks/Vans			
Service Units			
Trailers			
Spare Trailers			

7. COVERAGES AND LIMITS

- a. Application for:
 Liability Physical Damage Motor Truck Cargo Other: _____
- b. Basis of quote:
 Annual Receipts Mileage Monthly Reporting Other: _____
- c. Coverage to be quoted:

Liability Coverage	Limits	Deductible	Notes/Comments
<input type="checkbox"/> Truckers Liability	\$	\$	
<input type="checkbox"/> Business Auto Liability	\$	\$	
<input type="checkbox"/> UM/UIM Coverage	\$	Not Applicable	
<input type="checkbox"/> Trailer Interchange	\$	\$	
<input type="checkbox"/> PIP or <input type="checkbox"/> Med Pay	\$	Not Applicable	
<input type="checkbox"/> Other:	\$	\$	
Physical Damage Coverage: <input type="checkbox"/> Collision <input type="checkbox"/> Specified Perils <input type="checkbox"/> Comprehensive			
Deductible(s) to Quote:			Total Insured Value: \$
Motor Truck Cargo: Commodity:		Limit: \$	Deductible: # of Units:

- d. Estimated annual receipts/mileage: _____
- e. Additional Coverage Comments/Notes: _____
- _____
- _____
- _____
- _____

8. LOSS HISTORY

a. Previous Insurance and Loss Experience. **Must be completed in its entirety.**

HARD COPY LOSS RUNS ARE REQUIRED.

Auto Liability	Current	1st Prior	2nd Prior
Insurance Company			
Policy Number			
Policy Term (mm/yy)	to	to	to
# Claims			
Total Paid in Claims	\$	\$	\$
Total in Reserve	\$	\$	\$
Deductible	\$	\$	\$
Premium	\$	\$	\$
Loss Ratio			

Physical Damage	Current	1st Prior	2nd Prior
Insurance Company			
Policy Number			
Policy Term (mm/yy)	to	to	to
# Claims			
Total Paid in Claims	\$	\$	\$
Total in Reserve	\$	\$	\$
Deductible	\$	\$	\$
Premium	\$	\$	\$
Loss Ratio			

Cargo	Current	1st Prior	2nd Prior
Insurance Company			
Policy Number			
Policy Term (mm/yy)	to	to	to
# Claims			
Total Paid in Claims	\$	\$	\$
Total in Reserve	\$	\$	\$
Deductible	\$	\$	\$
Premium	\$	\$	\$
Loss Ratio			

b. Description of any open claims or losses over \$25,000:

9. SCHEDULE OF UNITS

Unit #	Symbol Type	Year	Make/Model	Stated Value	Gross Vehicle Weight	Complete VIN	Loss Payee & Address
1				\$			
2				\$			
3				\$			
4				\$			
5				\$			
6				\$			
7				\$			
8				\$			
9				\$			
10				\$			
11				\$			
12				\$			
13				\$			
14				\$			
15				\$			
16				\$			
17				\$			
18				\$			
19				\$			
20				\$			
21				\$			
22				\$			
23				\$			
24				\$			
25				\$			

NOTE: If filings are required for this applicant, **ALL** units owned and/or leased (including owner/operators) by this applicant **MUST** be scheduled and covered **100%** of the time for this applicant to be in compliance. After coverage is bound, failure to have all units scheduled will result in an immediate cancellation of the insured's policy.

- a. Do you hire any drivers with less than 2 years CDL experience? Yes No
 Minimum experience required: _____
- b. Do you hire any part-time drivers? Yes No
- c. Do you check MVR before hiring a driver? Yes No
- d. Do you check prior employment? Yes No
- e. Are drivers drug tested prior to hire? Yes No
- f. Is random drug testing done after hire? Yes No
- g. Number of: Full-time employee drivers: _____ Part-time employee drivers: _____
 Owner/operators: _____ Team drivers: _____

My signature below indicates that I have reviewed this application, list of drivers, list of equipment and have assigned the Stated Value (defined as actual value of equipment at the time of loss incurred) to each unit to be insured for physical damage coverage. I am aware that the value of this equipment can vary with the current marketplace. I have assumed responsibility for insuring only the equipment shown on this application.

I authorize the Company to obtain a copy of my Motor Vehicle Record for rating/underwriting the insurance for which I have applied. I also understand that a routine inquiry may be made providing information concerning my character, general reputation, personal characteristics and mode of living. Upon written request, information as to the nature and scope of the report will be provided to me. I understand that misrepresentation or omission of material facts will be cause for cancellation and may void coverage.

Completion of this form does not bind coverage or commit the Company to policy issuance.

NOTICE TO APPLICANTS (EXCEPT CO & NY):

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 or confinement in prison.

NOTICE TO COLORADO APPLICANTS:

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 claiming with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

NOTICE TO NEW YORK APPLICANTS:

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 also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Applicant Name	Applicant Signature	Date
Producer Name	Producer Signature	Date