

# CALIFORNIA AUTOMOBILE ASSIGNED RISK PLAN (CAARP) CALIFORNIA LOW COST AUTOMOBILE INSURANCE PROGRAM (LCA) ALTERNATE APPLICATION REPORT FORM

(FOR USE WHEN A PRODUCER IS UNABLE TO USE EASi)

## SECTION 1. PLAN (Check appropriate box)

CALIFORNIA AUTOMOBILE ASSIGNED RISK PLAN  
☐ PRIVATE PASSENGER    ☐ COMMERCIAL

CALIFORNIA LOW COST AUTOMOBILE INSURANCE PROGRAM  
☐ LOW COST APPLICATION

## SECTION 2. PRODUCER/APPLICANT INFORMATION

a.	Producer Last Name/Agency Name	Telephone Number (include area code)	Extension	
	Signing Producer (If different from Producer of Record)	License Number		
	Mailing Address	City	State	Zip Code
b.	Applicant Name	Applicant's Date of Birth (mm/dd/yyyy)		
	DBA Name			
	Street Address	City	State	Zip Code
	Mailing Address	City	State	Zip Code

## SECTION 3. DATE AND TIME ALTERNATE APPLICATION PROCEDURE WAS USED

Date: \_\_\_\_\_ Hour: \_\_\_\_\_ ☐ A.M. ☐ P.M.

## SECTION 4. REASON(S) ALTERNATE APPLICATION SUBMISSION PROCEDURE WAS USED

- ☐ Unable to connect with the internet. Internet-ISP Service provider: \_\_\_\_\_
- ☐ Other service provider had technical difficulties (Specify difficulties in Section 5.) Service provider: \_\_\_\_\_
- ☐ Severe weather conditions affected access/transmit data. (Specify location in Section 5.)
- ☐ EASi website unavailable. Provide error message given. \_\_\_\_\_
- ☐ Computer difficulties (Specify difficulties in Section 5.)
- ☐ Other (Specify in Section 5.)

## SECTION 5. SPECIFY REASON(S) ALTERNATE APPLICATION SUBMISSION PROCEDURE WAS USED (Include specific details regarding incident which prohibited use of EASi. If necessary, attach separate sheet of paper.)


## SECTION 6. PRODUCER STATEMENT AND SIGNATURE

I hereby certify that the above information is true and accurate to the best of my knowledge and belief. In the event the aforementioned information is found to be inaccurate, the producer/signing producer may be referred to the CAARP Advisory Committee and/or Department of Insurance for appropriate action.

\_\_\_\_\_  
 Producer Signature

\_\_\_\_\_  
 Date

## SECTION 7. PRODUCER INSTRUCTIONS

Attach this form to the paper application completed for the aforementioned applicant and mail or deliver both forms to the Plan Office in accordance with the applicable Alternate Application Submission Procedures in the CAARP or Low Cost Plan of Operation.

**COMMERCIAL APPLICATION  
CALIFORNIA AUTOMOBILE ASSIGNED RISK PLAN**

Reference #:

Transmission Date:

OFFICE USE ONLY – DO NOT WRITE OR ALTER INFORMATION IN THE BLOCK

**NOTICE: PRODUCER MUST READ THIS STATEMENT BEFORE PROCEEDING**

**IMPORTANT NOTICE**

**This policy is not effective until your application is electronically transmitted to the Plan by your agent or broker. The following conditions must also be met: (1) Both you and your agent or broker must sign and date a properly completed application. (2) Your agent or broker must transmit your application to the Plan within two working days of its completion.**

**You may request that your agent or broker transmit the documents in your presence to ensure immediate coverage, provided the above requirements are met. If the above requirements are not met, the effective date of your coverage may be delayed.**

**Applicants requiring filings or a limit of liability in excess of \$750,000 combined single limit will be subject to a 15-day delay in the effective date as specified in Section 46 of the California Automobile Assigned Risk Plan.**

**SECTION 1. PRODUCER OF RECORD**

Producer Last Name/Agency Name		Producer First Name		MI	
Producer DBA Name					
Mailing Address		Ste./Apt. No.	City	State	Zip Code
Producer License No.		Telephone No. (incl. area code)		Fax No. (incl. area code)	

**SECTION 2. SIGNING PRODUCER**

**(If the producer completing and signing this application is the producer of record, indicate SAME.)**

Last Name	First Name	MI	Signing Producer License No.
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**SECTION 3. APPLICANT NAME**

Last Name		First Name		MI	
DBA Name			Self Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Street Address		Ste./Apt. No.	City	State	Zip Code
Mailing Address		Ste./Apt. No.	City	State	Zip Code
Home Telephone No. (incl. area code)		Mobile Telephone No. (incl. area code)		Business Telephone No. (incl. area code)	
Tax ID or SS No.			Headquarters of Operation		
Business of Applicant/Nature of Operation					

<b>SECTION 4. OWNERSHIP AND CONTROL OF APPLICANT'S ORGANIZATION</b>										
Named insured is a: <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Other _____				State of Incorporation		Date of Incorporation		Date actual operations commenced		
Management, Ownership and Control (List names of principals and anyone with more than a 10% ownership interest.)						Date in Position		Percent Ownership		
President:										
Vice President:										
Secretary:										
Treasurer:										
General Manager:										
Others:										
List all affiliated companies:										
<b>SECTION 5. OPERATOR INFORMATION</b>				List all full-time, part-time, and any other operator that usually drives a vehicle.				TOTAL NO of OPERATORS:		
Last Name			First Name		MI	Birth Date MM/DD/YYYY		Driver's License No.		State
Are there any principal operators 55 years of age or older who have successfully completed a Mature Driver Improvement Course approved by the California DMV? <input type="checkbox"/> Yes <input type="checkbox"/> No    If "Yes" include a copy of the certificate attesting to such successful completion.										
<b>For applicants with more than four operators, all additional operators must be listed on an AIP 3502 Supplemental Operator Schedule and mailed with the original application to the Plan.</b>										
<b>SECTION 6. ACCIDENTS</b>										
Has applicant, or anyone who usually drives the applicant's vehicle(s), been involved, either as owner or operator, in <u>ANY</u> motor vehicle accident during the past THIRTY-SIX months? <input type="checkbox"/> Yes <input type="checkbox"/> No    If "Yes", complete the following.										
Name of Operator		Accident Date MM/DD/YYYY	Code*	Place of Accident		Bodily Injury or Death		Prop. Damage (incl. your own) Amount	Penalty Points	
				City	State					
						<input type="checkbox"/> Yes <input type="checkbox"/> No		\$		
						<input type="checkbox"/> Yes <input type="checkbox"/> No		\$		
						<input type="checkbox"/> Yes <input type="checkbox"/> No		\$		
						<input type="checkbox"/> Yes <input type="checkbox"/> No		\$		
*Accident Codes 1. Applicant's motor vehicle lawfully parked. 2. Damaged by "Hit and Run" driver and accident reported to police within 24 hours from time of accident. 3. Applicant reimbursed by or on behalf of person responsible for the accident or has judgment against such person. 4. Other person involved in accident was convicted. Applicant or operator was not convicted. 5. Police or Fire Department or First Aid Squad responding to an emergency call. 6. Other type of accident - non-chargeable under provisions of the Plan. Describe accident in space provided below.										
<b>SECTION 7. CONVICTIONS</b>										
Has the applicant or anyone who usually drives the applicant's vehicle(s) been <b>CONVICTED or FORFEITED BAIL</b> at any time during the immediately preceding THIRTY-SIX months?    Convicted <input type="checkbox"/> Yes <input type="checkbox"/> No    Forfeited Bail <input type="checkbox"/> Yes <input type="checkbox"/> No    If "Yes", for either item, complete the following.    NOTE: A paid ticket or fine is an admission of guilt and therefore constitutes a conviction.										
Name of Operator		Date of Conviction or bail forfeiture Mo./Day/Yr.	Did Conviction Arise as a Result of an Accident?	Nature of Conviction	Place of Conviction		Penalty Points	Was License Suspended or Revoked?		
					City	State				
			<input type="checkbox"/> Yes <input type="checkbox"/> No					<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> Yes <input type="checkbox"/> No					<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> Yes <input type="checkbox"/> No					<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> Yes <input type="checkbox"/> No					<input type="checkbox"/> Yes <input type="checkbox"/> No		

<b>SECTION 8. COMMODITIES TRANSPORTED</b>										
Specify goods transported in all vehicles:										
Identify any hazardous materials, waste or substances being hauled:										
Identify radius of operations. Number of straight-line, air miles from garaging to furthest destination to which vehicle travels in one direction. Include the % of trips in each radius class (Must equal 100%).										
0 – 50 Miles _____ %      51 – 200 Miles _____ %      201 + Miles _____ %										
Routes (both outgoing and return):										
Trips From Place of Origin To Place of Destination			% of Revenues		No. of Trips per Vehicle per Month		Principal Cities entered		Commodities Carried	

<b>SECTION 9. VEHICLE INFORMATION AND USE</b>					<b>For long distance, list cities in which vehicles operate</b>					<b>TOTAL VEHICLES</b>	
Veh No.	Year	Vehicle Identification No.	Load Capacity (2)	Type of Registration	Gross Vehicle Weight Rating (GVWR) TRUCKS ONLY		Spec Industry (M-T-FD-SD-WD-F-D-C-L-O)	Seating Capacity	Loss Payee Name		
	Trade Name Model No.	Garage Location (City/State/Zip Code)	State of Registration	Rating Classification	Gross Comb. Weight (GCW) Trucks- Tractors only		For Size Bus. Rad. (L-I-LD)	Tank Capacity	Loss Payee Address		
	Type (1)	Name of Registered Owner of Vehicle	Rating Territory (3)	Orig. Cost New (4)	Comp. Symbol	Coll. Symbol	Size (L-M-H-EH-HT-EHT)	Final Rating	How veh. is licensed	Loss Payee City, State, Zip Code	
Where vehicle is permitted to operate.				List all cities through and in which vehicles operate.							
Veh 1											
Veh 2											
Veh 3											
Veh 4											
Veh 5											

(1) Type - Truck=T, Truck-Tractor=TT, Trailer=TR, Semi-Trailer=ST, Public Auto=PA

(2) Truck-Type vehicles with Private Passenger or Combination registration and load capacities of 1500 pound or less are eligible for Basic Reparatons Benefits coverage.

(3) For public automobiles, use the highest rated territory where the vehicles pick up or discharge passengers.

(4) Chassis and Body including Special Equipment.

**For applicants with more than five vehicles, all additional vehicles must be listed on a Supplemental Vehicle Schedule and mailed with the original application to the Plan.**

SECTION 10. COVERAGES AND PREMIUMS		(As provided by the Rules of the Plan.)				
All vehicles written under the same policy shall have the same Limits of Liability. Check appropriate boxes to indicate limits/deductibles.		Vehicle 1 Est. Prem.	Vehicle 2 Est. Prem.	Vehicle 3 Est. Prem.	Vehicle 4 Est. Prem.	Vehicle 5 Est. Prem.
Bodily Injury/Property Damage Combined (CSL) _____						
Bodily Injury <input type="checkbox"/> \$15,000/\$30,000 <input type="checkbox"/> Other _____						
Property Damage <input type="checkbox"/> \$5,000 <input type="checkbox"/> Other _____						
Uninsured Motorists – BI <input type="checkbox"/> \$15,000/\$30,000 <input type="checkbox"/> Other _____						
Uninsured Motorists - PD (PPA's only) <input type="checkbox"/> \$3,500 <input type="checkbox"/> Other _____						
Nonowned Auto Liability Coverage – (Complete Section 10.c. if requested)						
Hired Car Coverage – Annual Cost of Hire: \$ _____						
Medical Payments (PPA's only) <input type="checkbox"/> \$1,000						
Estimated Total Premium per vehicle		\$	\$	\$	\$	\$
Total Estimated Premium for vehicles 1–5					\$	
Total Estimated Premium for supplemental vehicles					\$	
Total Estimated Premium for all vehicles					\$	
<b>NOTE: BI AND PD LIMITS WILL BE ISSUED AT MINIMUM FINANCIAL RESPONSIBILITY LIMITS AS REQUIRED BY LAW FOR THE RISK INSURED.</b>						
<b>SECTION 10.a. COVERAGE FOR ACTS OF UNINSURED MOTORISTS: CALIFORNIA</b>						
<p><b>DELETION OF COVERAGE:</b> 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 such 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.</p> <p><b>REDUCTION OF COVERAGE:</b> The Uninsured Motorists 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.</p> <p><b>DAMAGE TO YOUR VEHICLE: (This provision Applies Only to Private Passenger Vehicles That Are Subject to Commercial Assignment)</b> In addition, the California Insurance Code requires insurers to offer coverage for damage to your vehicle caused by an uninsured motor vehicle to the extent that you, the insured party, are legally entitled to recover from the owner or operator of the uninsured motor vehicle. Such property damage coverage will either: (1) pay the collision deductible on the insured motor vehicle, if it is covered by collision insurance, or (2) pay for damage to the insured motor vehicle, if it is not covered by collision insurance. This coverage will not pay for damage to personal property other than the vehicle or for loss of use of the vehicle, and it will not exceed the smallest of any of the following: (1) The amount of the collision deductible; (2) the actual cash value of the insured motor vehicle; or (3) \$3,500. You may reject uninsured motorist coverage completely or reject it only when an insured motor vehicle is operated by a natural person or persons that you designate by name. If you reject uninsured motorist coverage for bodily injury, you must also reject uninsured motorist coverage for property damage; however, you may elect to obtain uninsured motorist bodily injury coverage without obtaining uninsured motorist property damage coverage.</p> <p><b>ALL RISKS:</b> It shall be presumed that an application for a policy of bodily injury liability insurance containing uninsured motorist coverage, if an amount less than that required by Insurance Code Section 11580.2, Subdivision (m), signed by you (the named insured) and approved by the insurer, shall be a valid agreement as to the amount of uninsured motorist coverage to be provided.</p>						

**SECTION 10.b. REJECTION OF UNINSURED MOTORIST COVERAGE**

I understand that if I reject uninsured motorist coverage, and if I am injured by a person driving without motor vehicle insurance, I may be unable to recover any significant amount of money to cover the costs of my injuries or of damage to my motor vehicle. I have applied this day for coverage under an automobile liability insurance policy, and the company providing such coverage and I have agreed as follows to delete uninsured motorist coverage from that insurance policy:

1. ☐ I elect to delete completely uninsured motorist coverage for all insureds.
2. ☐ I elect to retain uninsured motorist coverage at reduced limits of \$15,000 per person or \$30,000 per accident.
3. ☐ I elect to retain uninsured motorist coverage at reduced limits of \$25,000 per person or \$50,000 per accident.

The following elections apply to applicants wishing to insure at least one private passenger vehicle that is subject to commercial assignment:

4. ☐ I elect to delete uninsured motorist coverage for property damage coverage but retain uninsured motorist coverage for bodily injury.
5. ☐ I elect to delete uninsured motorist coverage for property damage but retain uninsured motorist coverage for bodily injury at reduced limits of \$15,000 per person or \$30,000 per accident.
6. ☐ I elect to delete uninsured motorist coverage for property damage but retain uninsured motorist coverage for bodily injury at reduced limits of \$25,000 per person or \$50,000 per accident.

Applicant's Signature **X** \_\_\_\_\_ Date \_\_\_\_\_ Hour \_\_\_\_\_ ☐ A.M. ☐ P.M.

The rejection of insurance indicated by the above agreement shall be binding upon every insured to whom such policy or endorsement provisions apply while such policy is in force, and it shall continue to be so binding with respect to any continuation, renewal or replacement of such policy by the named insured, or with respect to reinstatement of such policy within 30 days of any lapse thereof.

**DO NOT SIGN THIS AGREEMENT UNLESS YOU READ AND UNDERSTAND IT.**

**SECTION 10.c. NONOWNED AUTO LIABILITY COVERAGE**

If filings are requested, this coverage must be added.

☐ Check here to add coverage. ☐ Primary ☐ Excess

Are any other vehicles owned by the Applicant? ☐ Yes ☐ No  
If "Yes" complete the following.

Are any vehicles hauling exclusively for one firm/carrier? ☐ Yes ☐ No  
If "Yes", complete the following.

Name of Insurance Company

Policy No.

Name of Firm/Carrier

Address of Insurance Company

Type of Business

Description of any owned, leased, hired, and non-owned vehicles, which are *not* to be insured.

Year	Trade Make	Body Type	Vehicle Identification No.

Total No. Employees \_\_\_\_\_

The number of employees that use their own (unspecified) vehicles in the applicant's business? \_\_\_\_\_

Prepared Food Delivery Operations: Estimated Total Delivery Sales for Policy Period: \$ \_\_\_\_\_.

**Application must be accompanied by certificates of insurance from a California-admitted insurer for each delivery-driver.**

**SECTION 10.d. HIRED CAR COVERAGE**

If filings are requested, this coverage must be added.

<input type="checkbox"/> Check here if <b>desired</b> . <b>Cost of Hire section (10.e.) must be completed.</b>	Estimated Annual Cost of Hire	Rates Per \$100		Estimated Premium	
		B.I.	P.D.	B.I.	P.D.
<input type="checkbox"/> Primary <input type="checkbox"/> Excess					

**This application MUST be accompanied by a copy of the truckers written agreement with their hired carriers that complies with the requirements outlined in Rule 75 in order to receive EXCESS coverage.**

1. Does each hired carrier have their own coverage? ☐ Yes ☐ No
2. Are there Certificates of Insurance or Additional Insured Endorsements on file with the insured? ☐ Yes ☐ No
3. Is there any interstate travel? ☐ Yes ☐ No

<b>SECTION 10.e. COST OF HIRE</b>		<b>(For policies rated under Trucker's Cost of Hire.) All risks for which a broad form filing or MCS-90 endorsement has been issued</b>				
	Current Year	1st Prior Year	2nd Prior Year	3rd Prior Year	4th Prior Year	
Indicate the total Cost of Hire, including cost and wages, for vehicles leased or hired on a long-term basis (over 6 months) and specifically insured by applicant as an owned automobile.	\$	\$	\$	\$	\$	
Indicate the total Cost of Hire, including cost and wages, for automobiles, which are <i>not</i> specifically insured by the applicant as an owned vehicle but are to be insured as hired automobiles.	\$	\$	\$	\$	\$	
Cost of Hire – Represents Total Long and Short Term Cost of Hire.	\$	\$	\$	\$	\$	
<b>SECTION 10.f. WAIVER OF SUBROGATION</b>						
Does applicant require a Waiver of Subrogation to fulfill a contractual agreement? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Name(s) and Address(es) of Person(s) or Organization(s) Requiring Waiver of Subrogation:						
<b>When a Waiver of Subrogation Endorsement is requested, a copy of the agreement between the applicant and the person(s) or organization(s) requiring the endorsement must accompany the application.</b>						
<b>SECTION 11.g. PRIMARY AND NONCONTRIBUTORY—OTHER INSURANCE CONDITION</b>						
Does applicant require a Primary and Noncontributory—Other Insurance Condition to fulfill a contractual agreement? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Name(s) and Address(es) of Person(s) or Organization(s) Requiring Primary and Noncontributory—Other Insurance Condition:						
<b>When a Primary and Noncontributory—Other Insurance Condition Endorsement is requested, a copy of the agreement between the applicant and the person(s) or organization(s) requiring the endorsement must accompany the application.</b>						
<b>SECTION 11. GROSS RECEIPTS</b>		<b>(Required for Motor Carriers of Property or Passengers whether or not the policy is to be written on Gross Receipts basis.)</b>				
Gross Receipts	Current Year	1st Prior Year	2nd Prior Year	3rd Prior Year	4th Prior Year	
Other than Truckers	\$	\$	\$	\$	\$	
Truckers	\$	\$	\$	\$	\$	
<b>SECTION 12. PUBLIC AUTOS</b>						
List all cities through and in which vehicles operate:						
Where is vehicle permitted to operate?			How is vehicle licensed?			
<b>SECTION 13. FILINGS OR CERTIFICATES</b>						
<b>NOTE:</b> Producers completing this application and section must be guided by the following: (a) All owned and operated vehicles must be described in this application. (b) All risks for which a filing has been made (except SR-22s) are subject to cost of hire rating and nonowned auto liability coverages. (c) If a filing is requested in this Section, the Cost of Hire (Sections 10.d and 10.3) and Nonowned Auto Liability (Section 10.c) Coverage Sections must be completed. (d) The applicant's name must be identical to the name as it appears on the Department of Transportation (DOT) or Department of Public Safety (DPS) permit to avoid rejection. (e) A CAIP Inspected Units Form must be completed, signed, and submitted for all applicants who require a Federal Highway Administration (FHWA) or Federal Motor Carrier Safety Administration (FMCSA) filings or endorsements.						
Is filing or specific limit(s) of liability needed? <input type="checkbox"/> Yes <input type="checkbox"/> No    If "Yes" to comply with:						
<input type="checkbox"/> Motor Carrier Act of 1980 Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> Bus Regulatory Act of 1982 <input type="checkbox"/> Motor Carrier No. _____						
<input type="checkbox"/> Local Ordinance (attach copy) <input type="checkbox"/> State Regulation <input type="checkbox"/> U. S. DOT No. _____ <input type="checkbox"/> DMV-MCP No. _____						
<input type="checkbox"/> PUC No. _____ <input type="checkbox"/> Other _____						
If block(s) are checked, list state(s) and city(ies) requiring filings or limits of liability required by law.						
Is applicant required to file evidence of financial responsibility (SR-22)? <input type="checkbox"/> Yes <input type="checkbox"/> No    If "Yes", complete the following.						
Last Name		First Name		MI	License No.	
Type of Filing <input type="checkbox"/> Owner's (operation of owned vehicles) <input type="checkbox"/> Operators (operation of non-owned vehicles) <input type="checkbox"/> Both						
State where Filing required	Case or file No.	Reason for Filing				
Name of any party requiring a Certificate of Insurance or Additional Insured Endorsement.						
<b>When an "Additional Applicant Endorsement" is requested a copy of the agreement between the applicant and the additional interested party must accompany the application.</b>						

<b>SECTION 14. PAYMENT PLANS</b>		<b>GROSS DEPOSIT PREMIUM MUST BE SUBMITTED WITH APPLICATION.</b>	
<b>40% of total estimated premium or minimum deposit per vehicle, whichever is greater, is required as a DEPOSIT.</b>			
<b>Payment must be submitted in the form of a producer's trust account check, certified check, bank check, money order, or premium finance company check or draft. The application will be rejected if paid by personal check.</b>			
<input type="checkbox"/> Option 1 - Full Annual Premium <input type="checkbox"/> Option 2 - Premium Deposit with Single Bill Balance <input type="checkbox"/> Option 3 - Installment Premium Payments - Deposit plus 5 monthly payments No interest charge - \$4.00 per installment charge* <input type="checkbox"/> Option 4 - Installment Premium Payments - Deposit plus 9 monthly payments No interest charge - \$4.00 per installment charge* <input type="checkbox"/> Premium to be Financed – Name of Premium Finance Company**	Check/Money Order/Draft No.:		
	Total Estimated Premium:	\$	
	Amount Submitted with Application:	\$	
* Not Available on Premium Financed Policies. ** Attach a copy of Premium Finance contract.			
<b>NOTICE TO PREMIUM FINANCE COMPANY – Unearned Premium is based on actual premium, not estimated premium.</b>			
<b>SECTION 15. PREVIOUS AUTOMOBILE INSURANCE CARRIER</b>			
Information for the past three years. (If a fleet, information for the past five years is required.) <b>Loss statements from and basic premiums paid by previous carrier must accompany this application. Indicate if risk is a new venture.</b>			
Name of latest carrier	Policy No.	Termination date	
Was coverage through Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No    If "Yes", give reason terminated.			
Complete the following for Carriers of property and passengers.			
	Policy No.	Policy Period From      To	Name of Insurance Company
1st Prior			
2nd Prior			
3rd Prior			
4th Prior			
<b>SECTION 16. EVIDENCE OF INSURANCE AND REQUESTED EFFECTIVE DATE OF COVERAGE</b>			
The Applicant hereby authorizes any insurer that may previously have provided coverage to the Applicant or to additional named insureds to provide records, data or information concerning prior coverage to the Plan or any carrier designated by the Plan. The Applicant agrees that a reproduction of this authorization shall be considered as effective and valid as the original.			
<ol style="list-style-type: none"> <li>1. <b>Specific applicants requiring filings or a limit of liability in excess of \$750,000 combined single limit will be subject to a 15-day delay in the effective date as specified in Section 46 of the California Automobile Assigned Risk Plan. Coverage under this evidence of automobile insurance for these specific applicants is to be effective for a period not to exceed 30 days from the effective date of coverage.</b></li> <li>2. Coverage under this evidence of automobile insurance is to be effective for a period not to exceed 45 days from the effective date and time stated herein. Within such 45 day period coverages under this evidence of automobile insurance will terminate immediately upon: (a) the issuance of the policy applied for, (b) the issuance of any policy affording similar insurance, or (c) the cancellation of the coverages of insurance afforded hereunder in accordance with the rules of the California Automobile Assigned Risk Plan.</li> <li>3. The application must be fully completed and duly executed.</li> <li>4. A premium charge will be made for these coverages if the policy, when and as issued, is not accepted by the insured.</li> <li>5. The insurance afforded hereunder shall be subject to all the terms and conditions of the Plan and the Policy Form prescribed for use.</li> <li>6. The Producer of Record must forward this application to the Plan in accordance with Plan rules.</li> </ol>			
<b>NOTE:</b> Electronic Applications (Regular check/Money Order Option): If the paper application, deposit, and supporting documentation are received by the Plan more than 15 calendar days following the date of transmittal of the online application, coverage will become effective on 12:01 A.M. on the day following the date of mailing as evidenced by the postmark on the envelope accompanying the application or hand delivery (including delivery by means of overnight mail, courier, or other delivery service). If the postmark is illegible, the envelope does not contain a postmark or the envelope is stamped by postage meter and does not contain a postmark, coverage will be effective at 12:01 A.M. on the day following receipt by the Plan. If the applicant requests a future effective date or there is an in-force policy terminating on a later date, coverage will be effective on the future effective date or the termination date of the in-force policy or at 12:01 A.M. on the day following receipt by the Plan, whichever is later. The postmark to be recognized by the Plan is the postmark of the United States Postal Service. A metered mail stamp (without a USPS postmark), computer-generated electronic stamp, or other postage service or stamp will not be considered a postmark of the USPS for the purposes of effecting coverage.			
<b>Applicants requiring filings or a limit of liability in excess of \$750,000 combined single limit will be subject to a 15-day delay in the effective date as specified in Section 46 of the California Automobile Assigned Risk Plan.</b>			
Requested Effective Date and Time: (Not to exceed 45 days from date of application submission)  Example: 09/ 01/2021 11:30 AM		For risks not subject to the 15-day delay in effective date, if the application is NOT submitted electronically, the effective date of coverage will be 12:01 A.M. on the day following receipt by the Plan, unless a future date is requested.	
<b>IN NO EVENT SHALL COVERAGE BE EFFECTIVE PRIOR TO THE DATE AND HOUR OF COMPLETION OF THIS APPLICATION.</b>			



**SECTION 17. PRODUCER OF RECORD STATEMENT**

I hereby certify that I am a licensed broker/agent of the State of California. I have read the California Automobile Assigned Risk Plan and have explained the provisions to the applicant. I acknowledge that I am acting on behalf of the applicant in submitting this application and have no authority to establish or revise the terms or conditions of coverage. This application includes all required information given to me by the applicant. If the applicant requires federal filings or endorsements, I must complete and submit a CAIP Inspected Units Form with this application. I understand that failure to include a completed CAIP Inspected Units Form will result in rejection of the application and no coverage is in effect. In the event of cancellation or a change to the policy resulting in a reduction of premium, I agree to return the unearned premium to the insured (net of any minimum premium due the carrier) and also to return to the carrier unearned compensation for this insurance received by me as required by the Plan. I have explained the terms of this coverage applied for to the applicant and to any finance company utilized.

I certify, under penalty of perjury, that I have personally asked the applicant every question on this application and accurately noted each of the applicant's responses. In addition, I certify that legible copies of the applicant's and principal operator's driver license(s) (unless suspended or revoked), as well as each vehicle registration, accompany this application. I certify that this application is submitted pursuant to the effective date provisions of the California Automobile Assigned Risk Plan. In the event the policy is cancelled or a change is made resulting in a return premium to the insured, I agree to return the unearned commission portion of such premium. The information contained herein is accurate to the best of my knowledge.

Date: \_\_\_\_\_ Hour: \_\_\_\_\_ ☐ AM ☐ PM

\_\_\_\_\_  
Producer's Signature

**SECTION 18. NOTE – FEES ARE ILLEGAL**

Section 11624.5 of the California Insurance Code provides: No insurance agent, broker or solicitor shall make any charge to the applicant, directly or indirectly, for furnishing any person the necessary application forms, technical assistance and services necessary to perfect an application through the Plan other than such commission as is paid by the insurer pursuant to the provisions of such Plan.

**SECTION 19.**

**ANY PERSON WHO KNOWINGLY MAKES AN APPLICATION FOR MOTOR VEHICLE INSURANCE COVERAGE CONTAINING ANY STATEMENT THAT THE APPLICANT RESIDES OR IS DOMICILED IN THIS STATE WHEN, IN FACT, THE APPLICANT RESIDES OR IS DOMICILED IN A STATE OTHER THAN THIS STATE, IS SUBJECT TO CRIMINAL PENALTIES.**

**FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM.**

**ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDULENT INFORMATION TO OBTAIN OR AMEND INSURANCE COVERAGE OR TO MAKE A CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.**

**SECTION 20. APPLICANT'S STATEMENT**

I hereby certify under penalty of perjury that I,

1. have been informed of my right to choose the CAARP interest-free Payment Plan options as shown in Section 14 of this application  
CHECK ONE: ☐ Yes ☐ No – If "No" please ask the producer for an explanation.
2. have duly authorized the undersigned to execute this application on my behalf if the Applicant is not a natural person.
3. has tried without success to obtain automobile insurance in this state within the preceding 60 days, and that the Applicant has been unable to obtain such insurance through ordinary methods.
4. agree that no coverage will be in effect if my premium remittance, which accompanies this application, is justifiably dishonored by any financial institution.
5. understand that the premium shown on this application is an estimated premium. The carrier reserves the right to adjust the premium either prior to or after the issuance of the policy. I agree to pay the adjusted/developed premium which may be higher than the original estimate.
6. will pay all premiums when due.
7. designate as Producer of Record of this insurance the Producer or firm named in this application. A substitute Producer may be designated by me at any time and, upon designation shall be the Producer of Record. I understand that any designated Producer cannot act as an agent of the California Automobile Assigned Risk Plan or any servicing carrier for the purpose of this insurance and that the Producer has no authority to establish, alter or amend terms or conditions of coverage.
8. do not owe any insurance company for automobile insurance premiums due or contracted during the preceding 36 months.
9. understand that if I owe money for a prior CAARP policy which I have not formally appealed to the California Insurance Commissioner, the money I submit with this application for a new CAARP policy will be applied to that prior policy, and I am not entitled to a refund of the money I have submitted with this application, even if coverage for this new policy is terminated, until I pay the full amount owed for all current and prior CAARP policies.
10. understand that the agent/broker is not acting as an agent of any company for the purposes of this insurance.
11. will remit payment as directed by the insurer for the balance of the full premium for the policy within 30 days of notification or, if I have elected an interest-free Installment Payment Option in Section 14 of this application, I will make payments as specified in CAARP Plan of Operation Section 44. Payments will be submitted in the form of a certified check, bank check, money order, or premium finance company check or draft (if applicable).
12. that this application was written and signed as of the date shown.
13. that when the insurance is to be written on a basis requiring final adjustment of the premium after expiration of the policy, I will maintain a complete record of all financial transactions in any reasonable form and manner as the insurer may require. I will also make this record available for inspection by the insurer at a designated place and at all reasonable times.
14. authorize the California Automobile Assigned Risk Plan and/or assigned servicing carrier to obtain my residence address from the California Department of Motor Vehicles pursuant to California Vehicle Code Section 1808.22.

15. to the best of my knowledge and belief all statements contained in this application are true and all these statements are provided as an inducement to issue to the policy for which I am applying.
16. realize that failure to disclose pertinent eligibility information or failure to remedy and defects in the application may result in rejection of my application for insurance or cancellation of my coverage.
17. realize that any misleading information or failure to disclose required information will be considered lack of good faith on my part and will be grounds for rejection of my application for insurance or cause cancellation of my coverage.
18. acknowledge that if I require federal filings or endorsements and a CAIP Inspected Units Form is not completed and submitted with my application, my application for insurance will be rejected and no coverage is in effect.

By affixing my initials below, I confirm I have read and understand Applicant Statements 15 through 18.

APPLICANT'S INITIALS REQUIRED: \_\_\_\_\_

19. certify that, to the best of my knowledge and belief, all statements contained in this application are correct.

I hereby authorize any insurer that may previously have provided coverage to me or to additional named insureds to provide records, data or information concerning prior coverage to the Plan or any servicing carrier designated by the Plan. I agree that a reproduction of this authorization shall be considered as effective and valid as the original.

X \_\_\_\_\_ Date: \_\_\_\_\_ Hour: \_\_\_\_\_ ☐ AM ☐ PM

Named Applicant's or Corporate Officer's Signature

#### NOTICE TO APPLICANT AND PRODUCER

In the event acknowledgement of coverage is not received within 45 days, notify the Plan at 800-622-0954

When a CAARP Commercial Auto Insurance policy is cancelled, the premium refund determined in accordance with Plan rules may be based on .90 of the pro rata unearned premium for the period of coverage, subject to a minimum premium of \$250 per policy, whichever is greater.

#### FAIR CREDIT REPORTING ACT NOTICE

In addition to routine verification of information pertinent to the insurance applied for, if the application is by an individual for insurance primarily for personal or family purposes, the insurer to which it is assigned may have an investigative consumer report made including information bearing on character, general reputation, personal characteristics or mode of living and, upon the individual's written request, will disclose in writing the nature and scope of the investigation requested, if such report is procured.

#### MAILING INFORMATION

Send completed application with certified funds and required documents within 24 hours to:  
California Automobile Assigned Risk Plan  
PO Box 6530  
Providence, RI 02940-6530

#### SUPPORTING DOCUMENTATION

- |   |   |
|---|---|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Copy of Vehicle Registration(s) or Proof of Ownership</li> <li><input type="checkbox"/> Copy of Driver's License(s) for Applicant and Principal Operator(s)</li> <li><input type="checkbox"/> Deposit Premium Payment</li> <li><input type="checkbox"/> Supplemental Operator Schedule (if applicable)</li> <li><input type="checkbox"/> Supplemental Vehicle Schedule (if applicable)</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Copy of Agreement with Additional Interested Party, if Additional Applicant Endorsement is requested</li> <li><input type="checkbox"/> Copy of Agreement with Person(s) or Organization(s), if Waiver of Subrogation Endorsement is requested</li> <li><input type="checkbox"/> Copy of Agreement with Person(s) or Organization(s), if Primary and Noncontributory-Other Insurance Condition Endorsement is requested</li> <li><input type="checkbox"/> CAIP Inspected Units Form</li> </ul> |
|---|---|

#### REMARKS SECTION

Complaints about insurance companies or agents/brokers can be directed to the California Department of Insurance Consumer Services Division at 800-927-HELP(4357).

Note: Following Electronic Application Submission, mail the signed application, certified funds and required documents within 24 hours to the address in the Mailing Information section listed above.