

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.

**PRIVATE PASSENGER APPLICATION
CALIFORNIA AUTOMOBILE ASSIGNED RISK PLAN**

Reference #:

Transmission Date:

EPAY:

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

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.

CONSENT TO ELECTRONIC TRANSMISSION

Your insurer is able to provide you with billing and payment reminders electronically. This reminder may be provided by email and/or text based on what you and your insurer agree.

You have the option to receive your billing and reminders electronically from your insurer. If you want to receive your billing and payment reminders electronically from your insurer, please complete the following:

☐ **Email/ Email Address:** Will be implemented later in 2024, or

☐ **Text Messaging/Cell Phone Number:** Will be implemented later in 2024

Applicant's Signature: Will be implemented later in 2024

By signing this section, you acknowledge that you have read this section and agree to electronic communication of your billing and payment reminders and that you agree to tell your insurer right away if you change your email address or cell phone number so information can be electronically transmitted to the new email address or cell phone number.

You have the option to stop receiving billing and payment reminders electronically at any time
Will be implemented later in 2024.

You will receive additional information at the time of assignment.

SECTION 1. PRODUCER OF RECORD


Producer Last Name/Agency Name		Producer First Name		MI	
DBA Name					
Mailing Address		Suite No.	City	State	Zip Code
Producer License No.		Telephone No.		Fax No.	

SECTION 2. SIGNING PRODUCER

Complete if producer completing/signing this application differs from the Producer of Record.

Last Name	First Name	MI	Producer License No.
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SECTION 3. APPLICANT																	
Last Name						First Name					MI						
Street Address						Apt. No.		City			State		Zip Code				
Mailing Address (if different from Street Address)						Apt. No.		City			State		Zip Code				
Home Telephone No. (incl. area code)				Mobile Telephone No. (incl. area code)				Business Telephone No. (incl. are code)									
Email Address																	
SECTION 4. OPERATOR INFORMATION (List all operators in household and any other drivers.)																	
Applicant's former addresses (past 3 years)																	
Street Address						City				State		Zip Code					
Applicant and other Drivers		Relationship to Applicant		% Use for Each Vehicle				Birth Date MM/DD/YYYY		MS*		Driver's License No.		State		Licensed 3 Years? If 'No', give date issued	
				V1		V2		V3		V4							
APPLICANT		APPLICANT														<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	
*MS Marital Status: S-Single, M-Married, DP-Domestic Partner, W-Widowed, D-Divorced, P- Separated																	
Applicant's Occupation				Nature of Business				Employer's Name									
Street Address						City				State		Zip Code					
Other Driver's Occupation				Nature of Business				Employer's Name									
Street Address						City				State		Zip Code					
SECTION 5. VEHICLE 1 – VEHICLE INFORMATION AND VEHICLE USE																	
Year		Make				Model				Body Style			H.P./Cu. In.CC				
Vehicle Identification No.						Registered Owner's Last Name				First Name							
Purchased Mo. Yr.		<input type="checkbox"/> New <input type="checkbox"/> Used		Cost New		Damaged* <input type="checkbox"/> Yes <input type="checkbox"/> No		Altered* <input type="checkbox"/> Yes <input type="checkbox"/> No		Damaged Glass* <input type="checkbox"/> Yes <input type="checkbox"/> No		* If yes, detail in Remarks Section					
<input type="checkbox"/> Pleasure <input type="checkbox"/> To Work/To School <input type="checkbox"/> Business <input type="checkbox"/> Commercial** <input type="checkbox"/> Farm **Applicable only for motorcycles used for commercial purposes.				Principal Address of Garaging						Miles one way to work, school or transportation			Est. Annual Mileage				
Applicant address as it appears on registration, if different from Section 3						State Registered In		Rating Band		Rate Class		Penalty Points					
SECTION 5. VEHICLE 2 – VEHICLE INFORMATION AND VEHICLE USE																	
Year		Make				Model				Body Style			H.P./Cu. In.CC				
Vehicle Identification No.						Registered Owner's Last Name				First Name							
Purchased Mo. Yr.		<input type="checkbox"/> New <input type="checkbox"/> Used		Cost New		Damaged* <input type="checkbox"/> Yes <input type="checkbox"/> No		Altered* <input type="checkbox"/> Yes <input type="checkbox"/> No		Damaged Glass* <input type="checkbox"/> Yes <input type="checkbox"/> No		* If yes, detail in Remarks Section					
<input type="checkbox"/> Pleasure <input type="checkbox"/> To Work/To School <input type="checkbox"/> Business <input type="checkbox"/> Commercial** <input type="checkbox"/> Farm **Applicable only for motorcycles used for commercial purposes.				Principal Address of Garaging						Miles one way to work, school or transportation			Est. Annual Mileage				
Applicant address as it appears on registration, if different from Section 3						State Registered In		Rating Band		Rate Class		Penalty Points					

SECTION 5. VEHICLE 3 – VEHICLE INFORMATION AND VEHICLE USE									
Year	Make			Model		Body Style		H.P./Cu. In.CC	
Vehicle Identification No.				Registered Owner's Last Name			First Name		
Purchased Mo. Yr.	<input type="checkbox"/> New <input type="checkbox"/> Used	Cost New	Damaged* <input type="checkbox"/> Yes <input type="checkbox"/> No	Altered* <input type="checkbox"/> Yes <input type="checkbox"/> No	Damaged Glass* <input type="checkbox"/> Yes <input type="checkbox"/> No	* If yes, detail in Remarks Section			
<input type="checkbox"/> Pleasure <input type="checkbox"/> To Work/To School <input type="checkbox"/> Business <input type="checkbox"/> Commercial** <input type="checkbox"/> Farm **Applicable only for motorcycles used for commercial purposes.		Principal Address of Garaging			Miles one way to work, school or transportation		Est. Annual Mileage		
Applicant address as it appears on registration, if different from Section 3.				State Registered In		Rating Band	Rate Class	Penalty Points	
SECTION 5. VEHICLE 4 – VEHICLE INFORMATION AND VEHICLE USE									
Year	Make			Model		Body Style		H.P./Cu. In.CC	
Vehicle Identification No.				Registered Owner's Last Name			First Name		
Purchased Mo. Yr.	<input type="checkbox"/> New <input type="checkbox"/> Used	Cost New	Damaged* <input type="checkbox"/> Yes <input type="checkbox"/> No	Altered* <input type="checkbox"/> Yes <input type="checkbox"/> No	Damaged Glass* <input type="checkbox"/> Yes <input type="checkbox"/> No	* If yes, detail in Remarks Section			
<input type="checkbox"/> Pleasure <input type="checkbox"/> To Work/To School <input type="checkbox"/> Business <input type="checkbox"/> Commercial** <input type="checkbox"/> Farm **Applicable only for motorcycles used for commercial purposes.		Principal Address of Garaging			Miles one way to work, school or transportation		Est. Annual Mileage		
Applicant address as it appears on registration, if different from Section 3.				State Registered In		Rating Band	Rate Class	Penalty Points	
SECTION 6. COVERAGES (As provided by the Rules of the Plan.)									
 Check appropriate boxes for coverages.					Vehicle 1 Premiums	Vehicle 2 Premiums	Vehicle 3 Premiums	Vehicle 4 Premiums	
Bodily Injury Liability <input type="checkbox"/> \$15,000 Each Person/\$30,000 Each Accident									
Property Damage Liability <input type="checkbox"/> \$5,000 Each Accident									
Medical Payments Coverage (Optional) <input type="checkbox"/> \$1,000 – Maximum Amount (Excess Coverage)									
Uninsured Motorist (UM) – Bodily Injury (Optional) <input type="checkbox"/> \$15,000 Each Person/\$30,000 Each Accident									
Uninsured Motorist (UM) – Property Damage (Optional) <input type="checkbox"/> Each Accident (Maximum \$3,500)									
Total Penalty Points Premium Surcharge (12 points max per vehicle)									
Extended NonOwned Coverage (D.O.C.) If needed complete Section 6a. <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, see Rule 25 for premium charge.)									
Financial Responsibility Certificate <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", indicate \$15.00 Filing Fee (if no penalty point surcharges)									
Estimated Total Premium per vehicle					\$	\$	\$	\$	
Total Estimated Premium for vehicles 1 – 4					\$				
SECTION 6.a. EXTENDED NON OWNED AUTO COVERAGE – PERSONAL AUTO COVERAGE									
Is the auto furnished to the individual, spouse, or resident individual for their regular use?						<input type="checkbox"/> Yes <input type="checkbox"/> No			
Is primary liability insurance in effect for the auto furnished for regular use?						<input type="checkbox"/> Yes <input type="checkbox"/> No			
Name of individual to be covered _____									

SECTION 7. FINANCIAL RESPONSIBILITY						
Is applicant or other eligible operator residing in the same household required to file evidence of financial responsibility? <input type="checkbox"/> Yes <input type="checkbox"/> No						
If "Yes", complete the following:						
Name	License No.	State where Filing required	Reason for Filing			
Type of Filing <input type="checkbox"/> SR22 Owner's (operation of owned vehicles) <input type="checkbox"/> SR22 Operator's (operation of non-owned vehicles) <input type="checkbox"/> Both						
<input type="checkbox"/> SR1P Date of Accident _____						
SECTION 8. NON-OWNER						
Complete If Application Is For a Non-Owner Policy.						
A. Type of vehicle applicant will operate. <input type="checkbox"/> Private Passenger <input type="checkbox"/> Commercial <input type="checkbox"/> Taxi/Bus <input type="checkbox"/> Other (describe)						
B. Will vehicle be operated in applicant's occupation or business? <input type="checkbox"/> Yes <input type="checkbox"/> No						
C. Is vehicle owned by applicant or member of household? <input type="checkbox"/> Yes <input type="checkbox"/> No						
D. If answer to B or C is "Yes", give name of Insurance Company providing liability coverage. _____						
E. Is applicant excluded? <input type="checkbox"/> Yes <input type="checkbox"/> No						
SECTION 9. PAYMENT PLANS						
Gross Deposit Premium Must Be Submitted With Application.						
<input type="checkbox"/> Option 1 - Full Annual Premium <input type="checkbox"/> Option 2 - Premium Deposit of \$125 or 25%, whichever is greater with Single Bill Balance to be paid in 30 days. <input type="checkbox"/> Option 3 - Installment Plan - Deposit of \$200 or 15%, whichever is greater plus 9 monthly payments with \$4.00 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:	
					<i>* Not Available on Premium Financed Policies. ** Attach a copy of Premium Finance contract.</i>	
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.						
SECTION 10. ACCIDENTS						
Has applicant, or anyone who usually drives the applicant's motor 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. (If necessary, use Remarks Section.)						
Name of Operator	Accident Date	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	\$	
If the answer to any of the following is Yes, check "Yes" box and give date of accident. 1. Applicant's motor vehicle lawfully parked. 2. Applicant reimbursed by or on behalf of person responsible for the accident or has such judgement against such person. 3. Other person involved in accident was convicted. Applicant or operator was not convicted. 4. Damaged by "Hit-and-Run" Driver and accident reported to police within 24 hours from time of accident. 5. Driving a bus for a private or municipal school bus company or as a commercial vehicle operator. 6. Driving a law enforcement agency vehicle, fire truck or ambulance on emergency call. 7. Other type of accident – non-chargeable under provisions of the Plan. If "Yes", describe in Remarks.					<input type="checkbox"/> Yes	Date(s) of Accident(s)
					<input type="checkbox"/> Yes	
					<input type="checkbox"/> Yes	
					<input type="checkbox"/> Yes	
					<input type="checkbox"/> Yes	
					<input type="checkbox"/> Yes	

SECTION 11. CONVICTIONS**(Motor Vehicle and Non-Motor Vehicle)**

Has the applicant or anyone who usually drives the applicant's motor vehicle(s) been CONVICTED or FORFEITED BAIL at any time during the immediately preceding THIRTY-SIX months? ☐ Yes ☐ No If "Yes", complete the following. (If necessary, use Remarks Section.)

NOTE: A paid ticket or fine is an admission of guilt and therefore constitutes a conviction.

Name of Operator	Conviction Date	Did Conviction Arise as a Result of an Accident?	Type of Violation	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

SECTION 12. INSURANCE RECORD

Has applicant had insurance in the past? ☐ No ☐ Yes If "Yes", complete the following.

Name of applicant's latest carrier	Policy No.	Termination date
Was coverage through Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was 3 year assignment completed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "No", give reason terminated.
Are any other vehicles owned by any member of household? <input type="checkbox"/> Yes <input type="checkbox"/> No		If "Yes", give name of insurer and attach copy of declaration page.

SECTION 13. ELIGIBILITY CERTIFICATION STATEMENT

I, (Name) _____ hereby declare under penalty of perjury that the following is true and correct:

1. A "good driver" as defined by the Insurance Code is a person licensed to drive for the previous three years who, during that time, has not; (a) had more than one violation point charged against their license; or (b) had more than one dismissal of a violation of a driving law which was not made confidential; or (c) been principally at fault for an accident resulting in bodily injury or death; or (d) [only for persons under 18 years old] have been found to have operated a motor vehicle with blood alcohol level of 0.05% or greater.

CHECK ONE: ☐ I AM NOT a "good driver" ☐ I AM a "good driver"

IF YOU CHECKED THAT YOU ARE NOT A "GOOD DRIVER", DO NOT COMPLETE THE REST OF THIS SECTION. IF YOU ARE A "GOOD DRIVER", READ AND COMPLETE ITEMS 2 - 5.

2. On (Month/Day/Year) _____, at _____ ☐ A.M. ☐ P.M., I applied to (Name of insurer) _____ Insurance Company/Group for automobile liability insurance.
3. I am eligible by reason of membership, affiliation, employment, or other such characteristic, if such is required to purchase automobile liability insurance from the insurance company/group named in Item 2.
4. On (Month/Day/Year) _____, at _____ ☐ A.M. ☐ P.M., I contacted _____ of the _____ Insurance Company/Group/Agency/Brokerage at _____ who informed me that _____ Insurance Company/Group rejected my request for insurance for the following reason(s):

IF YOU HAVE A NOTICE OF REJECTION, PLEASE INCLUDE WITH APPLICATION.

5. In the last 60 days, no other insurance company/group has agreed to sell me automobile liability insurance nor have I requested cancellation of automobile liability insurance.

SECTION 14. COVERAGE FOR ACTS OF UNINSURED MOTORISTS: CALIFORNIA

DELETION OF COVERAGE: 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, their 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.

REDUCTION OF COVERAGE: 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.

DAMAGE TO YOUR VEHICLE: 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 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. 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, with a policy effective date after January 1, 1985, shall be a valid agreement as to the amount of uninsured motorist coverage to be provided.

SECTION 15. 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 delete uninsured motorist coverage for property damage coverage, but keep uninsured motorist coverage for bodily injury.
3. ☐ I elect to delete completely uninsured motorist coverage for the following designated person(s) listed below:

4. ☐ I elect to delete uninsured motorist coverage for property damage coverage, but keep uninsured motorist coverage for bodily injury for the following designated person(s) listed below:

X _____ Date: _____ Hour: _____ ☐ AM ☐ PM
Applicant's Signature

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 with 30 days of any lapse thereof.

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

SECTION 16. EVIDENCE OF INSURANCE AND EFFECTIVE DATE OF COVERAGE

Requested Effective Date and Time:
(Not to exceed 45 days from date of application submission)

Example: 09/01/2023 11:30 AM

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.

NOTE: 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.

IN NO EVENT SHALL COVERAGE BE EFFECTIVE PRIOR TO THE DATE AND HOUR OF COMPLETION OF THIS APPLICATION.

SECTION 17. PRODUCER OF RECORD STATEMENT

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's license(s) (unless suspended or revoked), as well as each vehicle registration or proof of ownership, 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.

X _____ Date: _____ Hour: _____ ☐ A.M. ☐ P.M.
Producer's Signature

SECTION 18. APPLICANT'S STATEMENT

Your Signature On This Application Certifies The Following. Do Not Sign Without Reading.

I hereby certify under penalty of perjury that I,

1. Have been informed of my right to choose the CAARP interest-free Payment Plan option as shown in Section 9 of this application.
CHECK ONE: ☐ Yes ☐ No (If "No" please ask the producer for an explanation.)
2. Agree to pay all premiums when due and designate the individual shown above as agent/broker of record for this insurance.
3. Do not owe any insurance company for automobile insurance premiums due or contracted during the preceding two (2) years.
4. **"I understand that if I owe earned premium on a prior CAARP policy for 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. I understand a new policy will be issued and I must pay the earned premium owed for prior CAARP policy to maintain the coverage for which I am applying to be in effect. I understand that if I owe earned premium for a prior CAARP policy and the deposit accompanying this application is a premium finance company check, the insurer will issue a new CAARP policy and a cancellation notice for the earned premium owed on the prior policy."**
5. Understand the agent/broker is not acting as an agent of any company for the purposes of this insurance.
6. Agree that no coverage will be effective if my premium remittance is justifiably dishonored by the financial institution;
7. Will remit a check, money order, or a bank draft of the applicant, producer of record or financing institution, as directed by the insurer, for the balance of the full premium for the policy, within 30 days of notification or, if I have so elected in Option 3 of Section 9 of this application, to make payments as specified in the CAARP interest-free Payment Plan Regulation (Section 26).
8. Certify that this application was written and signed as of the date shown.
9. Authorize the California Automobile Risk Plan and/or assigned insurer to obtain my residence address from the California Department of Motor Vehicles pursuant to California Vehicle Code Section 1808.22.
10. **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.**
11. **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.**
12. **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.**

By affixing my initials below, I confirm I have read and understand Applicant Statements 10 through 12.

APPLICANT'S INITIALS: _____

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

X _____ Date: _____ Hour: _____ ☐ A.M. ☐ P.M.
Applicant's Signature

SECTION 19. THIRD PARTY DESIGNEE OPTION

You have the right to designate a third party, such as relative or friend, to receive notices of lapse, termination, expiration, nonrenewal, and cancellation for nonpayment of premium that you may receive for your Plan Policy. Notices sent to a third party are in addition to those provided to you and your producer of record. You have the option to designate a third party at the time of application or choose this option at any time during the policy period.

- ☐ I elect the third party designee option.
(Please complete Third Party Designee Form—AIP 1267 (1/16) and submit with this application.)

X _____ Date: _____ Hour: _____ ☐ AM ☐ PM
Applicant's Signature

- ☐ I decline the third party designee option.

NOTE – FEES ARE ILLEGAL		
<p>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.</p>		
<p>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.</p> <p>FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM.</p> <p>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.</p>		
NOTICE TO APPLICANT AND PRODUCER		
<p>In the event acknowledgement of coverage is not received with 45 days, notify the Plan at 800-622-0954.</p> <p>When a CAARP Personal 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 \$15 per vehicle or policy, whichever is greater.</p>		
<p>NOTE: For electronic applications (Regular Check/Money Order Option), following the assignment of a reference number and prior to mailing the completed, signed application, deposit, and supporting documentation to the Plan, you are not permitted to alter or in any way change any information on the application. Please refer to the Retraction Procedures outlined in the Plan manual if you need to retract an application submitted through the electronic application submission system..</p>		
DISCOUNTS AND CREDITS SECTION		
Mature Driver Improvement Course Discount	Operator Eligible <input type="checkbox"/> Op1 <input type="checkbox"/> Op2 <input type="checkbox"/> Op3 <input type="checkbox"/> Op4	Discount Applied <input type="checkbox"/> V1 <input type="checkbox"/> V2 <input type="checkbox"/> V3 <input type="checkbox"/> V4
SUPPORTING DOCUMENTATION		
<input type="checkbox"/> Copy of Vehicle Registration(s) or Proof of Ownership <input type="checkbox"/> Copy of Driver's License(s) for Applicant & Principal Operator <input type="checkbox"/> Copy of Declaration Page from any other owned vehicle(s)	<input type="checkbox"/> Deposit Premium Payment <input type="checkbox"/> Mature Driver Improvement Course Discount Certificate (if applicable) <input type="checkbox"/> Third Party Designee Form (if applicable)	
MAILING INFORMATION		
<p>Send completed application with check/money order and required documents to:</p> <p>California Automobile Assigned Risk Plan P.O. Box 6530 Providence, RI 02940-6530</p>		
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).		