COMMERCIAL APPLICATION
LOUISIANA AUTOMOBILE INSURANCE PLAN

Producer License: Applicant:	EASi Reference #: Transmission Date:

NOTICE: PRODUCER MUST READ THIS STATEMENT BEFORE PROCEEDING

CAIP applicants requiring a limit of liability in excess of $1,000,000 Combined Single Limits will be subject to a 20 day delay in the effective date as specified in Section 25 of the Louisiana Automobile Insurance Plan.

SECTION 1. PRODUCER OF RECORD

Producer Last Name/Agency Name	Producer First Name	MI

Mailing Address	Ste./Apt. No.	City	State	Zip Code

Tax ID or Social Security No.	Producer License No.	Telephone No. (incl. area code)	Fax No. (incl. area code)

SECTION 2. SIGNING PRODUCER **(Complete if the producer completing and signing this application differs from Section 1.)**

Last Name	First Name	MI	Producer License No.

SECTION 3. APPLICANT

Last Name	First Name	MI

DBA	Self Employed ☐ Yes ☐ No

Home Telephone No. (incl. area code)	Business Telephone No. (incl. area code)	Fax No. (incl. area code)	Tax ID or Social Security No.

Street Address	Ste./Apt. No.	City	State	Zip Code

Headquarters Street Address (if different from above)	Ste./Apt. No.	City	State	Zip Code

Telephone No. (incl. area code)	Fax No. (incl. area code)

Business of Applicant/Nature of Operation

SECTION 4. OWNERSHIP AND CONTROL OF APPLICANT'S ORGANIZATION

Named insured is a: ☐ Corporation ☐ Partnership ☐ Sole Proprietor ☐ Other _____	State of Incorporation	Date of Incorporation	Date actual operations commenced

Management, Ownership and Control (List names of principals and also 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

NOTE: For items where space is insufficient, use Remarks Section.

SECTION 5. OPERATOR INFORMATION	(List all full-time, part-time, and all other operators that usually drive a vehicle.)			TOTAL OPERATORS	
Last Name	First Name	MI	Birth Date Mo./Day/Yr.	Driver's License No.	State

For applicants with more than four operators, all additional operators must be listed on an AIP 3502 EASi Supplemental Operator Schedule and mailed with the original application to the Plan.

SECTION 6. ACCIDENTS

Has applicant, or anyone who usually drives the applicant's vehicle(s), been involved, either as owner or operator, in ANY motor vehicle accident during the past THIRTY-SIX months? ☐ Yes ☐ No If "Yes", complete the following.

Name of Operator	Accident Date Mo./Day/Yr.	Place of Accident		Bodily Injury or Death	Prop. Damage (incl. your own) Amount	Penalty Points
		City	State			
				☐ Yes ☐ No	$	
				☐ Yes ☐ No	$	
				☐ Yes ☐ No	$	
				☐ Yes ☐ 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 judgement 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. Accident involving damage by contact with animals or fowl.

SECTION 7. CONVICTIONS

Has the applicant or anyone who usually drives the applicant's vehicle(s) been **CONVICTED or FORFEITED BAIL** at any time during the immediately preceding THIRTY-SIX months? Convicted ☐ Yes ☐ No Forfeited Bail ☐ Yes ☐ 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		
		☐ Yes ☐ No					☐ Yes ☐ No
		☐ Yes ☐ No					☐ Yes ☐ No
		☐ Yes ☐ No					☐ Yes ☐ No
		☐ Yes ☐ No					☐ Yes ☐ No

SECTION 8. COMMODITIES TRANSPORTED

Identify any hazardous materials, waste or substances being hauled.

Identify radius of operations.

Identify routes - fixed and occasional (both outgoing and return).

Trips From Place of Origin To Place of Destination	% of Revenues	No. per Month	Principal Cities entered	Commodities Carried

SECTION 9. GROSS RECEIPTS **(Required for Motor Carriers of Property or Passengers whether or not the policy is to be written on Gross Receipts basis.)**

Gross Receipts	Current Year	1st Prior Year	2nd Prior Year	3rd Prior Year	4th Prior Year
Other than Truckers	$	$	$	$	$
Truckers excluding receipts from trip leased equipment	$	$	$	$	$

NOTE: For items where space is insufficient, use Remarks Section.

SECTION 10. VEHICLE INFORMATION AND USE

Attach copy of vehicle registration for each unit listed.
For long distance, list cities in which vehicles operate.

TOTAL VEHICLES

Veh. No.	Year	Vehicle Identification No.	Load Capacity (2)	Type of Registration	Gross Vehicle Weight (GVW) 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 (Town/State)	State of Registration	Rating Classification	Gross Comb. Weight (GCW) Trucks-Tractors only	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 pounds or less are eligible for Basic Reparations 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.

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.

NOTE: For items where space is insufficient, use Remarks Section.

SECTION 11.a. 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.
Combined Single Limits of Liability					
Uninsured Motorists Bodily Injury Liability					
*Uninsured Motorist Property Damage					
*In order to purchase this coverage, you must: 1. Accept Uninsured Motorist Bodily Injury 2. Reject Physical Damage Coverage					
Medical Payments Coverage ☐ $1,000 ☐ $2,000 ☐ $5,000					
Physical Damage - Comprehensive - Deductibles $100 $250 $500 Veh. 1 _____ Veh. 2 _____ Veh. 3 _____ Veh. 4 _____ Veh. 5 _____					
Physical Damage - Collision - Deductibles $100 $250 $500 Veh. 1 _____ Veh. 2 _____ Veh. 3 _____ Veh. 4 _____ Veh. 5 _____					
Estimated Total Premium per vehicle	$	$	$	$	$
Total Estimated Premium for vehicles 1-5	$				
Total Estimated Premium for supplemental vehicles	$				
Total Estimated Premium for all vehicles	$				
Employer's Non-Ownership Coverage – (Complete Section 11.b. if requested)					
Hired Car Coverage – (Complete Section 11.c. if requested)					
Total Estimated Premium for all vehicles and coverages	$				

For applicants with more than five vehicles, all additional vehicles must be listed on an AIP 3104 Supplemental Vehicle Schedule and mailed with the original application to the Plan.

SECTION 11.b. EMPLOYER'S NON-OWNERSHIP LIABILITY	This coverage cannot be purchased separately unless the applicant does not own or long-term lease any autos.		
Total No. Employees	What % of the applicant's employees operate their vehicles in the business?	**FAST FOOD DELIVERY ONLY ⇨**	Average No. Drivers

SECTION 11.c. HIRED CAR COVERAGE	This coverage cannot be purchased separately unless the applicant does not own or long-term lease any autos.		
☐ Check here if desired.	Estimated Annual Cost of Hire	Rates Per $100	Estimated Premium
		B.I./P.D.	B.I./P.D.
Type of coverage ☐ Primary ☐ Excess			

Certificate of Insurance must be available to verify Primary Coverage, but Certificate of Insurance will not change premium charges applicable to the Coverage on an excess basis.

SECTION 11.d. COST OF HIRE	(For policies rated under Trucker's Cost of Hire.)				
	Current Year	1st Prior Year	2nd Prior Year	3rd Prior Year	4th Prior Year
Indicate the total Cost of Hire, including wages, for vehicles leased or hired on a long term basis and specifically insured by applicant as an owned automobile.	$	$	$	$	$
Indicate the total Cost of Hire, including wages, for which are *not* 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. (minimum $60,000/year per vehicle)	$	$	$	$	$

SECTION 12. FILINGS OR CERTIFICATES

Is filing or specific limit(s) of liability needed? ☐ Yes ☐ No If "Yes" to comply with:
☐ Motor Carrier Act of 1980 Type: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Bus Regulatory Act of 1982 ☐ ICC Regulation - Docket No. _____
☐ Local Ordinance (attach copy) ☐ State Regulation ☐ U. S. DOT No. _____ ☐ 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? ☐ Yes ☐ No If "Yes", complete the following.

Last Name	First Name	MI	Tax ID or Social Security No.

Type of Filing ☐ Owner's (operation of owned vehicles) ☐ Operator's (operation of non-owned vehicles) ☐ Both

State(s) where Filing required	Case or file No.	Reason for Filing

NOTE: For items where space is insufficient, use Remarks Section.

SECTION 13. PAYMENT PLANS

☐ Premium to be Financed	Payment by: ☐ Cash ☐ Check	Check/Draft No.
Name and Address of Premium Finance Company*	Total Estimated Premium	$
	Amount of Compensation retained	$
* *Attach a copy of Premium Finance contract.*	Amount Submitted to Plan	$

SECTION 14. PREVIOUS AUTOMOBILE INSURANCE CARRIER

Information for the past three years. (If a fleet, information for the past five years required.) Attach loss statements from previous carrier.

Name of latest carrier	Policy No.	Termination date
Was coverage through Plan? ☐ Yes ☐ No	If "Yes", give reason terminated.	

Complete the following for Carriers of property and passengers.

Year	Policy No.	Policy Period From	To	Name of Insurance Company
1st Prior				
2nd Prior				
3rd Prior				
4th Prior				

SECTION 15. EVIDENCE OF INSURANCE AND REQUESTED EFFECTIVE DATE OF COVERAGE

This application shall be evidence of temporary insurance subject to the accuracy of the Applicant's Statement and the following conditions:
1. The application must be fully completed and duly executed.
2. CAIP applicants requiring a limit of liability in excess of $1,000,000 will be subject to a twenty (20) day delay in the effective date as stated in Section 25 of the Louisiana Automobile Insurance Plan Manual. Coverage under this evidence of automobile insurance quote for these applicants is to be effective for a period not to exceed thirty (30) days from the effective day of coverage.
3. Otherwise, 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 Louisiana Automobile Insurance Plan.
4. A premium charge will be made in accordance with the Plan for these coverages if the policy is not accepted.
5. The insurance afforded hereunder shall be subject to all the terms and conditions of the Plan and the Policy Form prescribed for use.
6. If local, state or federal motor carrier filings are requested, certified funds must accompany this application for coverage.
7. If any supplement to the application is not attached as required by approved Plan regulation or rules.

NOTE: In the event there is no U.S. postmark (a metered mail stamp, electronic stamp, or other postage service or stamp are not considered a U.S. postmark), coverage will become effective no earlier than 12:01 a.m. on the day following receipt in the Plan Office.

Sugar Cane Haulers and Carnival Parade Autos
Period of Coverage (Pursuant to Rules 73 and 142) _____ days

Requested Effective Date and Time: _____ Example: 09/ 01/2002 11:30 AM	**IN NO EVENT SHALL COVERAGE BE EFFECTIVE PRIOR TO THE DATE AND HOUR OF COMPLETION OF THIS APPLICATION.**

SECTION 16. PRODUCER OF RECORD STATEMENT

I hereby certify that I am a licensed agent/broker of the state to which this application applies. 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. In the event of cancellation or 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.

My signature hereon represents certification of the Producer of Record Statement AND I certify this application is submitted pursuant to the effective date provisions contained in the Automobile Insurance Plan of this state.

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

NOTE: For items where space is insufficient, use Remarks Section.

SECTION 17. APPLICANT'S STATEMENT

The Applicant, declares and certifies that:
1. It has duly authorized the undersigned to execute this application on its behalf if the Applicant is not a natural person.
2. The Applicant has tried without success to obtain automobile insurance in this state within the preceding 60 days.
3. To the best of the Applicant's knowledge and belief that all statements contained in this application are true and that these statements are offered as an inducement to issue the policy for which the Applicant is applying.
4. The Applicant realizes that any misleading information or failure to disclose required information will be considered lack of good faith on the Applicant's part and may void the application or cause cancellation of the Applicant's coverage.
5. The Applicant agrees that no coverage will be in effect if the premium remittance, which accompanies this application, is justifiably dishonored by any financial institution.
6. The Applicant understands 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, whenever applicable.
7. The Applicant will pay all premiums when due.
8. The Applicant designates as Producer of Record for this insurance the producer or firm named in this application. A substitute producer may be designed by the Applicant at any time and, upon designation, shall be the Producer of Record. The Applicant understands that any designated producer cannot act as an agent of the Automobile Insurance Plan or any carrier for the purpose of this insurance and that the producer has no authority to establish, alter or amend terms or conditions of coverage.
9. The Applicant hereby certifies that it does not own any insurance company for automobile insurance premiums due or contracted during the preceding 12 months.
10. The Applicant agrees to provide all information relative to any farm labor contractor operation on the approved commercial application supplement so titled.

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

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

If additional named insureds are to be covered under a policy issued to the Applicant, authorized signatures for each such additional named insured shall be provided below. Such additional named insureds agree to be bound by the statements made by the Applicant in this form.

_____ Date: _____ Hour: _____ ☐ A.M. ☐ P.M.
(Person authorized to sign for Applicant)

FRAUD STATEMENT

In accordance with LRS 40:1424B, any **person who knowingly presents** a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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.

NOTICE TO APPLICANT AND PRODUCER

In the event acknowledgement of coverage is not received within 45 days, notify the Plan Office, 302 Central Avenue, Johnston, RI 02919-4932.

MAILING INFORMATION

Staple check here: ➔	Send original, signed application, with check/money order and required attachments to: Louisiana Automobile Insurance Plan 302 Central Avenue Johnston, RI 02919-4932

REMARKS SECTION

NOTE: For items where space is insufficient, use Remarks Section.