COMMERCIAL APPLICATION
OKLAHOMA AUTOMOBILE INSURANCE PLAN

EASi Reference #: Transmission Date:

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

NOTICE: PRODUCER MUST READ THIS STATEMENT BEFORE PROCEEDING

Applicants requiring filings or a limit of liability in excess of $500,000 Combined Single Limit will be subject to a 15 day delay in the effective date as specified in Section 23 of the Oklahoma 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

Street Address (if different from 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. APPLICANT

Last Name	First Name	MI

DBA	Self Employed ☐ Yes ☐ No

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

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

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

Business of Applicant/Nature of Operation

SECTION 3. 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.)

President	Date in Position	Percent Ownership

Vice President		

Secretary		

Treasurer		

General Manager		

Others		

List all affiliated companies

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

SECTION 4. OPERATOR INFORMATION	(List all full time, part-time, and 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 Supplemental Operator Schedule and mailed with the original application to the Plan.

SECTION 5. ACCIDENTS

Has applicant, or anyone who usually drives the applicant's motor 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. (If necessary, use Remarks Section.)

Name of Operator	Accident Date Mo./Day/Yr./	Code No.	Place of Accident		BI or Death Amount	Prop. Damage (incl. your own) Amount	Physical Damage Amount
			City	State			
					$	$	$
					$	$	$
					$	$	$
					$	$	$

Accidents - Code No.
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. Other type of accident - non-chargeable under provisions of the Plan. Describe accident in space provided.
7. Other type of accident - chargeable under provisions of the Plan. Describe accident in space provided.

If accident code is (6) or (7) describe:

SECTION 6. CONVICTIONS

Has 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? 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 Forfeiture of Bail 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 7. 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

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

SECTION 8. 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	$	$	$	$	$

SECTION 9. VEHICLE INFORMATION AND USE

For public and long distance, list cities in which vehicles operate.

TOTAL VEHICLES

Veh. No.	Year	Vehicle Identification No.	Load Capacity	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	Radius (2) (L-I-LD)	Tank Capacity	Loss Payee Address
	Type (1)	Name of Registered Owner of Vehicle	Rating Territory	Orig. Cost New (3) / Comp. Symbol	Coll. Symbol / *Size (L-M-H-EH)	Final Rating	Purpose of Use (P-B) (S-R-C)	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
(2) For Public and Long Distance, list cities in which vehicles operate.
(3) Chassis & Body including Special Equipment

For applicants with more than five vehicles, all additional vehicles must be listed on an AIP 3500 Supplemental Vehicle Schedule and mailed with the original application to the Plan.

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

SECTION 10.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 ☐ $75,000 ☐ $125,000 ☐ $150,000 ☐ $325,000 ☐ $350,000 ☐ Other					
Uninsured Motorists Liability ☐ $50,000 ☐ $75,000 ☐ $125,000 ☐ $150,000 ☐ $325,000 ☐ $350,000 ☐ Other _____ Please check one: ☐ Stacked ☐ Non-stacked					
Medical Payments Coverage ☐ $1,000 ☐ $2,000 ☐ $5,000					
Estimated Total Premium per vehicle	$	$	$	$	$
Total Estimated Premium for vehicles 1 - 5	$				
Total Estimated Premium for supplemental vehicles	$				
Total Estimated Premium for all vehicles	$				
Nonowned Auto Liability Coverage – (Complete Section 10.b if requested)					
Hired Car Coverage – Annual Cost of Hire $_____					
Drive Other Car Coverage – (Complete Section 10.d if requested) Number of Individuals to be covered _____ Combined Single Limit					
Total Estimated Premium for all vehicles and coverages	$				

SECTION 10.b. NONOWNED AUTO LIABILITY COVERAGE

Total No. of Employees _____ What percentage of the applicant's employees operate their own vehicles in the business? _____

PREPARED FOOD DELIVERY SERVICES RISKS ONLY

Average No. of Drivers _____

Premium _____

AUTO REPAIR SHOPS, SERVICE STATIONS, STORAGE GARAGES, AND PUBLIC PARKING PLACES RISKS ONLY

Location	Address	No. of Employees	Rating Territory	Premium
1.				
2.				

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 other owned, leased or hired vehicles.

Year	Trade Make	Body Type	Vehicle Identification No.

SECTION 10.c. 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 automobiles 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 automobiles which are *not* specifically insured by the applicant as an owned automobile. (Minimum $60,000/ year per vehicle)	$	$	$	$	$
Total Long and Short Term Cost of Hire.	$	$	$	$	$

SECTION 10.d. DRIVE OTHER CAR COVERAGE For Non-Owned Automobiles – Attach applicable endorsement

Name of Individual(s).

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

SECTION 10.e. WAIVER OF SUBROGATION

Does applicant require a Waiver of Subrogation to fulfill a contractual agreement? ☐ Yes ☐ No

Name(s) and Address(es) of Person(s) or Organization(s) Requiring Waiver of Subrogation:

SECTION 11. FILINGS OR CERTIFICATES *See explanation and abbreviation guide.

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 where Filing required	Case or file No.	Reason for Filing

SECTION 12. PAYMENT PLANS

☐ Option 1 - Full Annual Premium

☐ Option 2 – Advance Premium Payment Option

☐ Option 3 - Installment Premium *

☐ Premium to be Financed – Name of Premium Finance Company**

_____

Payment by: ☐ Certified Check ☐ Bank Check ☐ Cashier's Check ☐ Money Order

Total Estimated Premium	$
Amount Submitted with Application	$

** Not Available on Premium Financed Policies.*
*** Attach a copy of Premium Finance contract.*

SECTION 13. 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:

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

SECTION 14. EVIDENCE OF INSURANCE AND REQUESTED EFFECTIVE DATE OF COVERAGE

This application shall be evidence of temporary insurance subject to the following conditions:
1. The application must be fully completed and duly executed.
2. Specific applicants requiring financial responsibility filings or a limit of liability in excess of $500,000 CSL, will be subject to a 15 day delay in the effective date as stated in Section 23 of the Oklahoma Automobile Insurance Plan. Coverage under this evidence of automobile insurance for these specific applicants is to be effective for a period not to exceed 45 days from the effective date 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, coverage 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 coverage of insurance afforded hereunder in accordance with the rules of the 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.

Applicants requiring filings or a limit of liability in excess of $500,000 Combined Single Limits will be subject to a 15 day delay in the effective date as specified in Section 23 of the Oklahoma Automobile Insurance Plan.

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.**

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

SECTION 15. PRODUCER OF RECORD STATEMENT

I hereby certify that I am a licensed agent/broker of the state to which this application applies and have read the Automobile Insurance 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. In the event of cancellation or a change to the policy resulting in the reduction of premium, I agree to return any 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.

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

SECTION 16. APPLICANT'S STATEMENT

I, the Applicant, declare and certify 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 of this insurance the Producer or firm named in the application. A substitute Producer may be designated 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 owe any insurance company for automobile insurance premiums due or contracted during the preceding months.

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.

_____	_____	_____	_____☐ A.M. ☐ P.M.
(Person Authorized to Sign for Applicant)	Title	Date	Hour

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.

_____	_____	_____	_____☐ A.M. ☐ P.M.
(Person Authorized to Sign for Additional Named Insured)	Title	Date	Hour

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 original, signed application with certified check, bank check, cashier's check, or money order and required attachments to:
Oklahoma Automobile Insurance Plan
P.O. Box 6530
Providence, RI 02940-6530

REMARKS SECTION

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