

COMMERCIAL APPLICATION RHODE ISLAND 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 \$550,000 Combined Single Limits will be subject to a 15 day delay in the effective date as specified in Section 31 of the Rhode Island 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. APPLICANT

Last Name		First Name		MI
DBA			Self Employed <input type="checkbox"/> Yes <input type="checkbox"/> 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	State Zip Code
Headquarters Street Address (if different from above)		Ste./Apt. No.	City	State Zip Code

Business of Applicant/Nature of Operation

SECTION 3. OWNERSHIP AND CONTROL OF APPLICANT'S ORGANIZATION

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
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Management, Ownership and Control (List names of principals and also anyone with more than a 10% ownership interest.)

Name	Date in Position	Percent Ownership
President		
Vice President		
Secretary		
Treasurer		
General Manager		
Others		

List all affiliated companies

SECTION 4. 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 AIP3502 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 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 Mo./Day/Yr.	Place of Accident		Bodily Injury or Death	Prop. Damage Amount	Phys. Damage Amount	Penalty Points	Code*
		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, owner or other resident operator was determined to be 50% or less negligent or reimbursed for 50% or more of his or her damages, by or on behalf of, persons in the accident. 4. Other person involved in accident was convicted. Applicant or operator was not convicted. 5. Driving a bus for RIPTA. 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. Describe accident in space provided below. 8. Other type of accident - chargeable under provisions of the Plan. Describe accident in space provided below.								
SECTION 6. CONVICTIONS								
Has the applicant or anyone who usually drives the applicant's motor vehicle(s) been CONVICTED or FORFEITED BAIL 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	
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		

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 **TOTAL VEHICLES**

Veh. No.	Year	Vehicle Identification No.	Load Capacity	Type of Registration		Gross Vehicle Weight (GVW) Trucks only		Special Industry (T-FD-SD-WD-F-D-C-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 Class (L-I-LD)	Tank Capacity	Loss Payee Address
	Type (1)	Name of Registered Owner of Vehicle	Rating Territory (2)	Orig. Cost New (3)	Comp. Symbol	Coll. Symbol	Size (L-M-H-EH)	Purpose Of Use (P or B) (S-R-C)	Final Rating	Loss Payee City, State, Zip Code
List where vehicle is permitted to operate.				For Public and Long Distance, 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) For public automobiles, use the highest rated territory where the vehicles pick up or discharge passengers.
 (3) Chassis and Body including Special Equipment.

For applicants with more than five vehicles, all additional vehicles must be listed on an AIP3500 Supplemental Vehicle Schedule and mailed with the original application to the Plan.

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 <input type="checkbox"/> \$75,000 <input type="checkbox"/> \$110,000 <input type="checkbox"/> \$125,000 <input type="checkbox"/> \$150,000 <input type="checkbox"/> \$350,000 <input type="checkbox"/> \$550,000 <input type="checkbox"/> Other _____ (as required by law)						
Protection Against Uninsured Motorists Bodily Injury <input type="checkbox"/> \$ _____ <input type="checkbox"/> I reject the limits of UMBI equal to the limits of BI and select the above. X _____ (APPLICANT'S SIGNATURE) If rejecting UMBI coverage, attach AIP-4556 UMBI Rejection Notice and Warning form.						
Protection Against Uninsured Motorists Property Damage <input type="checkbox"/> \$ _____ <input type="checkbox"/> I reject this coverage for all vehicles. OR I reject this coverage for the following vehicle(s) <input type="checkbox"/> Veh. 1 <input type="checkbox"/> Veh. 2 <input type="checkbox"/> Veh. 3 <input type="checkbox"/> Veh. 4 <input type="checkbox"/> Veh. 5 X _____ (APPLICANT'S SIGNATURE)						
Medical Payments Coverage <input type="checkbox"/> \$2,500 <input type="checkbox"/> I reject this coverage. X _____ (APPLICANT'S SIGNATURE)						
Physical Damage - Comprehensive - Deductibles \$100 \$200 \$500 Veh. 1 _____ Veh. 2 _____ Veh. 3 _____ Veh. 4 _____ Veh. 5 _____						
Physical Damage - Collision - Deductibles \$100 \$200 \$500 Veh. 1 _____ Veh. 2 _____ Veh. 3 _____ Veh. 4 _____ Veh. 5 _____						
Pollution Liability <input type="checkbox"/> \$75,000 <input type="checkbox"/> \$110,000 <input type="checkbox"/> \$125,000 <input type="checkbox"/> \$150,000 <input type="checkbox"/> \$350,000 <input type="checkbox"/> \$550,000 <input type="checkbox"/> Other _____ (as required by law)						
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 – If requested, Complete Section 10.b.						
Garagekeepers Coverage – If requested, Complete Section 10.c.						
Cost of Hire – If requested, Complete Section 10.d.						
Hired Auto Coverage – Annual Cost of Hire– If requested, Complete Section 10.e.						
Drive Other Car Coverage No. of individuals to be covered _____ <input type="checkbox"/> \$75,000 <input type="checkbox"/> \$110,000 <input type="checkbox"/> \$125,000 <input type="checkbox"/> \$150,000 <input type="checkbox"/> \$350,000 <input type="checkbox"/> \$550,000 <input type="checkbox"/> Other _____ (as required by law)						
Registration Plates Not Issued for a Specific Auto No. of sets of plates _____ <input type="checkbox"/> Dealer's Plates <input type="checkbox"/> Transporter or Bailee Plates <input type="checkbox"/> \$75,000 <input type="checkbox"/> \$110,000 <input type="checkbox"/> \$125,000 <input type="checkbox"/> \$150,000 <input type="checkbox"/> \$350,000 <input type="checkbox"/> \$550,000 <input type="checkbox"/> Other _____ (as required by law)						
Partnership as the Named Insured Non-Ownership Liability No. of active and inactive partners _____						
Total Estimated Premium for all vehicles and coverages	\$					

SECTION 10.b. NONOWNED AUTO LIABILITY COVERAGE

Total No. Employees _____	What percentage of the applicant's employees operate their vehicles in the business? _____				
PREPARED FOOD DELIVERY SERVICES ONLY	AUTO REPAIR SHOPS AND AUTOS HELD FOR INSPECTION BY AN OFFICIAL INSPECTION STATION				
	Location	Address	No. of Employees	Rating Territory	Premium
	1.				
Average No. Drivers _____	2.				

Are any other vehicles owned by the Applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" complete the following.		Are any vehicles hauling exclusively for one firm/carrier? <input type="checkbox"/> Yes <input type="checkbox"/> 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.	Carrier	Policy No.	Expiration Date

SECTION 10.c. GARAGEKEEPERS COVERAGE Applicable only to auto repair shops and autos held for inspection by an official inspection station.

Locations	Total Value Per Location	Specified Causes of Loss Deductible	Specified Causes of Loss Premium	Collision Deductible	Collision Premium
Location No. 1					
Location No. 2		Same		Same	
All Locations					

SECTION 10.d. COST OF HIRE For policies rated under Trucker's Cost of Hire. Minimum of \$60,000 per year per vehicle.

	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 short term basis and specifically insured by applicant as an owned automobile.	\$	\$	\$	\$	\$
Indicate the total Cost of Hire, including wages, for 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.	\$	\$	\$	\$	\$

SECTION 10.e. HIRED AUTO COVERAGE

<input type="checkbox"/> Check here if desired.	Estimated Annual Cost of Hire	Rates Per \$100	Estimated Premium
		B.I. & P.D.	B.I. & P.D.
	\$		

SECTION 10.f. WAIVER OF SUBROGATION

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:	

SECTION 11. 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.
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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
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SECTION 12. PAYMENT PLANS

<input type="checkbox"/> Option 1 - Full Annual Premium <input type="checkbox"/> Option 2 - Advance premium payment option <input type="checkbox"/> Option 3 - Installment Premium Payments* <input type="checkbox"/> Premium to be Financed – Name of Premium Finance Company** _____	Payment by Check Total Estimated Premium (all units and coverages) Deposit Premium Amount Submitted with Application	Check No. \$ \$ \$
* 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. Attach loss statements from previous carrier.

Name of latest carrier	Policy No.	Termination Date
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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 and Address of Insurance Company
1st Prior			
2nd Prior			
3rd 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 filings or a limit of liability in excess of \$550,000 Combined Single Limits will be subject to a 15 day delay in the effective date as specified in Section 31 of the Rhode Island Automobile Insurance 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.
 3. Otherwise, coverage under this evidence of automobile insurance is to be effective for a period not to exceed 30 days from the effective date and time stated herein. Within such 30 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 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.

NOTE: In the event there is no U.S. postmark (a metered mail postmark, 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.

Applicants requiring filings or a limit of liability in excess of \$550,000 Combined Single Limits will be subject to a 15 day delay in the effective date as specified in Section 31 of the Rhode Island Automobile Insurance Plan.

Requested Effective Date and Time: _____ Example: 09/ 01/2002 11:30 AM	<p style="text-align:center">IN NO EVENT SHALL COVERAGE BE EFFECTIVE PRIOR TO THE DATE AND HOUR OF COMPLETION OF THIS APPLICATION.</p>
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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.

(Person authorized to sign for applicant) Title: _____ Date: _____ Hour: _____ A.M. P.M.

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.

(Person authorized to sign for additional named insured) Title: _____ Date: _____ Hour: _____ A.M. P.M.

SECTION 15. PRODUCER OF RECORD STATEMENT

I hereby certify that I am a licensed broker/agent of the State of Rhode Island. I have read the Rhode Island 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 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.

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

FRAUD WARNING

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.

SECTION 16. APPLICANT'S STATEMENT IMPORTANT READ BEFORE SIGNING

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. Applicant has tried without success to obtain automobile insurance in this state within the preceding 60 days.
3. To the best of 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 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.
6. The Applicant will pay all premiums when due.
7. The Applicant designates as Producer of Record of this insurance the producer or firm named in this 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 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.
8. The Applicant hereby certifies that it does not owe any insurance company for any automobile insurance premiums due or contracted during the preceding 12 months.
10. I understand and agree that if I owe earned premium to an assigned company for prior RIAIP coverage and I am reassigned to the same company, the assigned company may: a) apply my deposit premium to that outstanding balance prior to applying my deposit premium to this new application and bill me or send a notice of cancellation for any additional deposit needed on this application or, b) return this application and deposit without providing any coverage if my deposit is in the form of a premium finance company check. I further understand and agree that if my deposit premium is insufficient to cover the outstanding earned premium for prior coverage the assigned company may apply the entire deposit premium to that outstanding balance and return this application without providing any coverage.
11. I understand that if my installment, additional premium or renewal check is justifiably dishonored by the bank, I will be billed for the resulting bank fee incurred.

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

This section must be signed or no Physical Damage Coverage will be provided.

I understand that the requested collision and/or comprehensive coverage for my auto will not be effective unless the vehicle is properly registered to me at the time of loss, as required by the provisions of the Rhode Island Automobile Insurance Plan and the policy contract.

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

NOTICE TO APPLICANT AND PRODUCER

In the event acknowledgement of coverage is not received within 30 days, notify the Plan Office at (401) 946-2600.

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.

REMARKS SECTION

ATTACHMENTS

Did you remember to sign the application where required and include the following, if applicable?

Copy of Premium Finance Contract.

Deposit Premium.

Copy of Foreign Driver's License.

Copy of International Driving Permit, or other acceptable English translation of the foreign license.

Send original, signed application with check/money order and required attachments to:

Rhode Island Automobile Insurance Plan

PO Box 6530

Providence, RI 02940-6530