AUTO DEALER SUPPLEMENT FOR THE

INDIANA AUTOMOBILE INSURANCE PLAN

P.O. Box 6530

PROVIDENCE, RI 02940-6530

THIS SUPPLEMENTAL AUTO DEALER APPLICATION MUST BE ACCOMPANIED BY A COMPLETED COMMERCIAL AUTOMOBILE APPLICATION. SUPPLEMENTAL AUTO DEALER APPLICATIONS RECEIVED BY THE PLAN WITHOUT A COMPLETED COMMERCIAL APPLICATION WILL BE RETURNED TO THE PRODUCER AND NOT ASSIGNED.

SECTION 1. PRODUCER OF RECORD

Producer Last Name/Agency	Producer First Name	MI

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

IRS No.	Producer License No.	Telephone No. (incl. area code)	Fax No. (incl. area code)

SECTION 1a. SIGNING PRODUCER Must be completed by signing producer if an agency is listed in Section 1.

Last Name	First Name	MI	License No.

APPLICANT

Applicant	Street Address	Apt. No.

City	State	Zip Code	Home Telephone No.(incl. area code)	Business Telephone No. (incl. area code)

NON-FRANCHISED AUTO DEALER Rating Territory

(1) Location No. 1 _____

Location No. 2 _____

(2) Are any other businesses operated on the premises? ☐ Yes ☐ No If "Yes", describe business.

_____

(3) No. of passenger elevators _____ No. of landings _____ Inspection Charge _____
No. of other elevators _____ No. of landings _____ Inspection Charge _____
No. of escalators _____ No. of landings _____ Inspection Charge _____
Escalator Liability: Limit _____ Premium $_____

(4) Does applicant engage in "drive away" or "haul away" operations? ☐ Yes ☐ No If "Yes", give details.

_____

(5) Does the applicant rent automobiles to customers while such customers' automobiles are temporarily left with the applicant for service, repair or sale?
☐ Yes ☐ No Rental to others? ☐ Yes ☐ No

CLASS OF OPERATIONS		LOCATION No. 1	LOCATION No. 2
CLASS I EMPLOYEES*	REGULAR OPERATORS		
	ALL OTHERS		
CLASS II NON-EMPOLYEES	UNDER AGE 25		
	ALL OTHERS		

DEFINITIONS:
CLASS I - EMPLOYEES (including part-time employees)
Proprietors, partners and officers active in the business, sales persons, general managers, service managers and any employee whose principal duty involves the operation of autos or who is furnished a covered auto. ALL OTHER EMPLOYEES
CLASS II - NONEMPLPOYEES
Inactive proprietors, partners or officers, family members of an employee, and family members of an inactive proprietor, partner and officer.
*NOTE: Part time employees working less than 20 hours a week are to be counted as ½ rating unit.

(6) How many plates does the applicant have? Dealer _____ Repairer _____ Transporter _____ Other _____

(7) No. of autos owned by applicant other than those being held for sale: Commercial _____ Private Passenger _____ Motorcycle _____ Other _____

(8) Does applicant pick-up or deliver automobiles beyond a 50 miles radius? ☐ Yes ☐ No
If "Yes", How many trips between 51-200 miles did you do last year? _____ How many do you expect to do this year? _____
If "Yes", How many trips over 200 miles did you do last year? _____ How many do you expect to do this year? _____

(9) Automobiles furnished to someone other than "Class I or Class II" operator - list individual or organization to whom such autos are furnished and the number furnished for each (Describe on Commercial Automobile Application or Supplemental Commercial Vehicle Schedule):
Name and Address of person/organization No. of Vehicles
1. _____
2. _____

(10) Estimated Annual Gross Receipts: a. Auto Sales: $ _____ b. All Other: $ _____

(11) Limit of Liability for Auto Dealer Liability: Limit: $ _____ Aggregate: $ _____ Estimated Premium: $ _____

APPLICANT STATEMENT

IMPORTANT READ BEFORE SIGNING

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 a 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 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 Indiana 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.

_____ _____ _____ ☐ A.M.
(SIGNATURE OF APPLICANT OR PERSON AUTHORIZED TO SIGN FOR APPLICANT) (TITLE) (DATE) MONTH DAY YEAR HOUR ☐ P.M.

EVIDENCE OF INSURANCE

See accompanying Commercial Automobile Application for effective date and time of coverage provisions.

In no event shall coverage be effective prior to the date and hour of completion of this application. 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.
(SIGNATURE OF APPLICANT OR PERSON AUTHORIZED TO SIGN FOR APPLICANT) (TITLE) (DATE) MONTH DAY YEAR HOUR ☐ 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.

_____ _____ _____ ☐ A.M.
(SIGNATURE OF ADDITIONAL NAMED INSURED) OR PERSON AUTHORIZED TO SIGN FOR ADDITIONAL NAMES INSURED) (TITLE) (DATE) MONTH DAY YEAR HOUR ☐ P.M.

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.

PRODUCER STATEMENT

I hereby certify that I am a licensed broker/agent in the state of Indiana. I have read the Indiana Automobile Insurance Plan, have explained the provisions to the applicant, and included in this application all required information given to me by the applicant. In the event the policy is canceled or a change is made resulting in a return premium to the insured, I agree to return any unearned commission portion of such return premium.

By_____ _____ ☐ A.M.
(PRODUCER'S SIGNATURE) (DATE) MONTH DAY YEAR HOUR ☐ P.M.