# 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 ☐ 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 | 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: ☐ 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 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 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 Amount | Phys. Damage Amount | Penalty Points | Code* |
|---|---|---|---|---|---|---|---|---|
| | | 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, 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 ☐ 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 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

**TOTAL VEHICLES**

| Veh. No. | Year / Trade Name/ Model No. / Type (1) | Vehicle Identification No. / Garage Location (Town/State) / Name of Registered Owner of Vehicle | Load Capacity / State of Registration / Rating Territory (2) | Type of Registration / Rating Classification / Orig. Cost New (3) / Comp. Symbol | Gross Vehicle Weight (GVW) Trucks only / Gross Comb. Weight (GCW) Trucks-Tractors only / Coll. Symbol / Size (L-M-H-EH) | Special Industry (T-FD-SD-WD-F-D-C-O) / Radius Class (L-I-LD) / Purpose Of Use (P or B) (S-R-C) | Seating Capacity / Tank Capacity / Final Rating | Loss Payee Name / Loss Payee Address / 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.



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

**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<br>☐ $75,000 ☐ $110,000 ☐ $125,000 ☐ $150,000 ☐ $350,000 ☐ $550,000<br>☐ Other __________________ (as required by law) | | | | | |
| Protection Against Uninsured Motorists Bodily Injury ☐ $ ________________<br>☐ I reject the limits of UMBI equal to the limits of BI and select the above.<br>X________________________________________ (APPLICANT'S SIGNATURE)<br>**If rejecting UMBI coverage, attach AIP-4556 UMBI Rejection Notice and Warning form.** | | | | | |
| Protection Against Uninsured Motorists Property Damage ☐ $ ______________<br>☐ I reject this coverage for all vehicles.<br>**OR**<br>I reject this coverage for the following vehicle(s)<br>☐Veh. 1 ☐ Veh. 2 ☐Veh. 3 ☐Veh. 4 ☐Veh. 5<br>X________________________________________ (APPLICANT'S SIGNATURE) | | | | | |
| Medical Payments Coverage ☐ $2,500<br>☐ I reject this coverage.<br>X________________________________________ (APPLICANT'S SIGNATURE) | | | | | |
| Physical Damage - Comprehensive - Deductibles $100 $200 $500<br>Veh. 1 _______ Veh. 2 _______ Veh. 3 _______ Veh. 4 _______ Veh. 5_______ | | | | | |
| Physical Damage - Collision - Deductibles $100 $200 $500<br>Veh. 1 _______ Veh. 2 _______ Veh. 3 _______ Veh. 4 _______ Veh. 5_______ | | | | | |
| Pollution Liability<br>☐ $75,000 ☐ $110,000 ☐ $125,000 ☐ $150,000 ☐ $350,000 ☐ $550,000<br>☐ 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 _______________<br>☐ $75,000 ☐ $110,000 ☐ $125,000 ☐ $150,000 ☐ $350,000 ☐ $550,000<br>☐ Other __________________ (as required by law) | | | | | |
| Registration Plates Not Issued for a Specific Auto No. of sets of plates __________<br>☐ Dealer's Plates ☐ Transporter or Bailee Plates<br>☐ $75,000 ☐ $110,000 ☐ $125,000 ☐ $150,000 ☐ $350,000 ☐ $550,000<br>☐ Other __________________ (as required by law) | | | | | |
| Partnership as the Named Insured Non-Ownership Liability<br>No. of active and inactive partners ____________________ | | | | | |
| Total Estimated Premium for all vehicles and coverages | $ | | | | |



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

## 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**

Average No. Drivers _____________

AUTO REPAIR SHOPS AND AUTOS HELD FOR INSPECTION BY AN OFFICIAL INSPECTION STATION

| 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.

| Name of Insurance Company | Policy No. |
|---|---|
| | |

Address of Insurance Company

Are any vehicles hauling exclusively for one firm/carrier? ☐ Yes ☐ No
If "Yes", complete the following.

Name of Firm/Carrier

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 *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. | $ | $ | $ | $ | $ |

## SECTION 10.e. HIRED AUTO COVERAGE

| ☐ Check here if desired. | Estimated Annual Cost of Hire | Rates Per $100 B.I. & P.D. | Estimated Premium B.I. & P.D. |
|---|---|---|---|
| | $ | | |

## SECTION 10.f. 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:

**When a Waiver of Subrogation Endorsement is requested, a copy of the agreement between the applicant and the person(s) or organization(s) requiring the endorsement must accompany the application.**



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

## SECTION 10.g. PRIMARY AND NONCONTRIBUTORY—OTHER INSURANCE CONDITION

Does applicant require a Primary and Noncontributory—Other Insurance Condition to fulfill a contractual agreement? ☐ Yes ☐ No

Name(s) and Address(es) of Person(s) or Organization(s) Requiring Primary and Noncontributory—Other Insurance Condition:

**When a Primary and Noncontributory–Other Insurance Condition Endorsement is requested, a copy of the agreement between the applicant and the person(s) or organization(s) requiring the endorsement must accompany the application.**

## 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. |
|---|---|---|---|
| | | | |

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

_______________________________________________

| Payment by Check | Check No. |
|---|---|
| Total Estimated Premium (all units and coverages) | $ |
| Deposit 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. 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 | Policy Period 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.**



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

| Requested Effective Date and Time:<br><br>______________________________<br>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.** |
|---|---|

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.

__________________________________________ Title: _____________________ Date: ____________ Hour: ______ ☐ A.M. ☐ P.M.
(Person authorized to sign for applicant)

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.

__________________________________________ Title: _____________________ Date: ____________ Hour: ______ ☐ A.M. ☐ P.M.
(Person authorized to sign for additional named insured)

## 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.

_______________________________________________ Date: _________________________ Hour: ___________ ☐ A.M. ☐ P.M.
(Producer's Signature)

## 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.

_______________________________________________ Date: ____________________________ Hour: __________ ☐ A.M. ☐ P.M.
(Applicant's Signature)

**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.

_______________________________________________ Date: ____________________________ Hour: __________ ☐ A.M. ☐ P.M.
(Applicant's Signature)

## 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.

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

## 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.
Copy of Agreement with Person(s) or Organization(s), if Waiver of Subrogation Endorsement is requested.
Copy of Agreement with Person(s) or Organization(s), if Primary and Noncontributory – Other Insurance Condition Endorsement is requested.

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

Rhode Island Automobile Insurance Plan
PO Box 6530
Providence, RI 02940-6530



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