

ILLINOIS AUTOMOBILE INSURANCE PLAN ALTERNATE APPLICATION REPORT FORM

(FOR USE WHEN A PRODUCER IS UNABLE TO USE EASI)

SECTION 1. TYPE OF APPLICATION (Check appropriate box)

☐ PRIVATE PASSENGER

☐ COMMERCIAL

SECTION 2. PRODUCER/APPLICANT INFORMATION

a.	Producer Last Name/Agency Name	Telephone Number (include area code)	Extension	
	Signing Producer (If different from Producer of Record)	License Number		
	Mailing Address	City	State	Zip Code
b.	Applicant Name	Applicant's Date of Birth (mm/dd/yyyy)		
	DBA Name			
	Street Address	City	State	Zip Code
	Mailing Address	City	State	Zip Code

SECTION 3. DATE AND TIME ALTERNATE APPLICATION PROCEDURE WAS USED

Date: _____ Hour: _____ ☐ A.M. ☐ P.M.

SECTION 4. REASON(S) ALTERNATE APPLICATION SUBMISSION PROCEDURE WAS USED

- ☐ Unable to connect with the internet. Internet-ISP Service provider: _____
- ☐ Other service provider had technical difficulties (Specify difficulties in Section 5.) Service provider: _____
- ☐ Severe weather conditions affected access/transmit data. (Specify location in Section 5.)
- ☐ EASI website unavailable. Provide error message given. _____
- ☐ Computer difficulties (Specify difficulties in Section 5.)
- ☐ Other (Specify in Section 5.)

SECTION 5. SPECIFY REASON(S) ALTERNATE APPLICATION SUBMISSION PROCEDURE WAS USED (Include specific details regarding incident which prohibited use of EASI. If necessary, attach separate sheet of paper.)

SECTION 6. PRODUCER STATEMENT AND SIGNATURE

I hereby certify that the above information is true and accurate to the best of my knowledge and belief. In the event the aforementioned information is found to be inaccurate, the producer/signing producer may be referred to the Illinois Plan Governing Committee and/or the Illinois Department of Insurance for appropriate action.

Producer Signature

Date

SECTION 7. PRODUCER INSTRUCTIONS

Attach this form to the paper application completed for the aforementioned applicant and mail or deliver both forms to the Plan Office in accordance with the applicable Alternate Application Submission Procedures in the Illinois AIP.

COMMERCIAL APPLICATION ILLINOIS AUTOMOBILE INSURANCE PLAN

NOTICE: PRODUCER MUST READ THIS STATEMENT BEFORE PROCEEDING

Applicants requiring filings or a limit of liability in excess of \$350,000 Combined Single Limits will be subject to a 15 day delay in the effective date as specified in Section 23 of the Illinois 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	Tax ID or Social Security No.	Producer License No.
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SECTION 3. 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	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 4. 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
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			

Staple check here:



Include the following attachments, if applicable:

1. Check/Money Order payable to: Illinois Automobile Insurance Plan
2. Copy of Foreign Driver's License
3. Copy of Finance Contract
4. Proof of purchase of: Customized Auto Equipment and Anti-theft Equipment
5. Copy of Defensive Driving Course Certificate
6. Additional Vehicle Schedule
7. Additional Operator Schedule

Send the **original** of the completed application with check/money order and required attachments to:

**Illinois Automobile Insurance Plan
PO Box 6530
Providence, RI 02940-6530**

SECTION 5. OPERATOR INFORMATION		(List all full-time, part-time, and all other operators that usually drive a vehicle.)				
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 <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.	Code*	Place of Accident		Bodily Injury or Death Amount	Property Damage Amount	Physical Damage Amount
			City	State			
					\$	\$	\$
					\$	\$	\$
					\$	\$	\$
					\$	\$	\$

*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 judgment 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.
7. Other type of accident - chargeable under provisions of the Plan.
If accident code is (6) or (7) describe accident in space provided below.

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 <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 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	\$	\$	\$	\$	\$	

SECTION 10. 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		For Size Bus, Rad. (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-HT-EHT)	Final Rating		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) For public automobiles, use the highest rated territory where the vehicles operate.
(3) Chassis and Body including Special Equipment.

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

SECTION 11a. COVERAGES (As provided by the Rules of the Plan.)		Premiums for Vehicles or Non-Owner Applicant(s)				
Same limits of liability must be purchased for all vehicles. Limits shown are Combined Single Limits. Check appropriate box for limits/deductibles.		Vehicle 1 Est. Prem.	Vehicle 2 Est. Prem.	Vehicle 3 Est. Prem.	Vehicle 4 Est. Prem.	Vehicle 5 Est. Prem.
Bodily Injury Liability: <input type="checkbox"/> \$70,000 <input type="checkbox"/> \$75,000 <input type="checkbox"/> \$125,000 <input type="checkbox"/> \$150,000 <input type="checkbox"/> \$325,000 <input type="checkbox"/> \$350,000 <input type="checkbox"/> Other _____(as required by law)						
Medical Payments Coverage (available only with respect to four-wheel vehicles classified and rated as private passenger automobiles) <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$5,000						
Physical Damage: Note – Coverage is available for comprehensive (including collision coverage) on an Actual Cash Value basis subject to a maximum loss payable of \$50,000 applicable to each loss and each automobile.						
Physical Damage: For Vehicles where Cost New is \$30,000 or less:	Physical Damage: For Vehicles where Cost New is over \$30,000:					
Veh 1 Comprehensive: <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000	Comprehensive: <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000					
Collision: <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000	Collision: <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000					
Customized Equipment: Stated Amt. Indicate Value \$ _____	Customized Equipment: Stated Amt. Indicate Value \$ _____					

Physical Damage: For Vehicles where Cost New is \$30,000 or less:	Physical Damage: For Vehicles where Cost New is over \$30,000:	Vehicle 1 Est. Prem.	Vehicle 2 Est. Prem.	Vehicle 3 Est. Prem.	Vehicle 4 Est. Prem.	Vehicle 5 Est. Prem.
Veh 2 Comprehensive: <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000	Comprehensive: <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000					
Collision: <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000	Collision: <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000					
Customized Equipment: Stated Amt. Indicate Value \$ _____	Customized Equipment: Stated Amt. Indicate Value \$ _____					
Veh 3 Comprehensive: <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000	Comprehensive: <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000					
Collision: <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000	Collision: <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000					
Customized Equipment: Stated Amt. Indicate Value \$ _____	Customized Equipment: Stated Amt. Indicate Value \$ _____					
Veh 4 Comprehensive: <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000	Comprehensive: <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000					
Collision: <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000	Collision: <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000					
Customized Equipment: Stated Amt. Indicate Value \$ _____	Customized Equipment: Stated Amt. Indicate Value \$ _____					
Veh 5 Comprehensive: <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000	Comprehensive: <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000					
Collision: <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000	Collision: <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000					
Customized Equipment: Stated Amt. Indicate Value \$ _____	Customized Equipment: Stated Amt. Indicate Value \$ _____					
Uninsured Motorist (UM) (Cannot exceed BI limits) Bodily Injury – Basic Limit: <input type="checkbox"/> \$50,000 ¹ Optional Limits: <input type="checkbox"/> \$55,000 <input type="checkbox"/> \$75,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$125,000 <input type="checkbox"/> \$150,000 <input type="checkbox"/> \$200,000 <input type="checkbox"/> \$300,000 <input type="checkbox"/> \$325,000 <input type="checkbox"/> \$350,000 <input type="checkbox"/> Other _____ (as required by law) <input type="checkbox"/> I Accept <input type="checkbox"/> I Reject increased limits for Uninsured Motorists Insurance _____ (initial) ¹ (applicant must initial if increased limits for Uninsured Motorists Ins is rejected)						
² Property Damage Limit: <input type="checkbox"/> \$15,000 with \$250 deductible <input type="checkbox"/> I Accept <input type="checkbox"/> I Reject Uninsured Motorists Ins Property Damage Coverage ² (Not offered if Physical Damage Coverage is carried.)						
Underinsured Motorist (UIM) – Basic Limits: \$50,000 (included in UM) ¹ Optional Limits: <input type="checkbox"/> \$55,000 <input type="checkbox"/> \$75,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$125,000 <input type="checkbox"/> \$150,000 <input type="checkbox"/> \$200,000 <input type="checkbox"/> \$300,000 <input type="checkbox"/> \$325,000 <input type="checkbox"/> \$350,000 <input type="checkbox"/> Other _____ (as required by law) <input type="checkbox"/> I Accept <input type="checkbox"/> I Reject increased limits for Underinsured Motorists Insurance _____ (initial) ¹ (applicant must initial if increased limits for Underinsured Motorists Ins is rejected)						
Sub-Total Estimated Premium per vehicle:						
Total Estimated Premium for vehicles 1– 5:		\$ _____				
Total Estimated Premium for supplemental vehicles:		\$ _____				
Total Estimated Premium for all vehicles:		\$ _____				
Drive Other Car Coverage: Number of individuals to be covered: _____ <input type="checkbox"/> \$70,000 <input type="checkbox"/> \$75,000 <input type="checkbox"/> \$125,000 <input type="checkbox"/> \$150,000 <input type="checkbox"/> \$325,000 <input type="checkbox"/> \$350,000 <input type="checkbox"/> Other _____ (as required by law)						
Nonowned Auto Liability Coverage – (Complete Section 11.b.) <input type="checkbox"/> \$70,000 <input type="checkbox"/> \$75,000 <input type="checkbox"/> \$125,000 <input type="checkbox"/> \$150,000 <input type="checkbox"/> \$325,000 <input type="checkbox"/> \$350,000 <input type="checkbox"/> Other _____ (as required by law)						
Hired Auto Coverage (Complete Section 11.c.and 11.d.) <input type="checkbox"/> \$70,000 <input type="checkbox"/> \$75,000 <input type="checkbox"/> \$125,000 <input type="checkbox"/> \$150,000 <input type="checkbox"/> \$325,000 <input type="checkbox"/> \$350,000 <input type="checkbox"/> Other _____ (as required by law)						
Registration Plates Not Issued for a Specific Auto: Number of sets of plates: _____ <input type="checkbox"/> \$70,000 <input type="checkbox"/> \$75,000 <input type="checkbox"/> \$125,000 <input type="checkbox"/> \$150,000 <input type="checkbox"/> \$325,000 <input type="checkbox"/> \$350,000 <input type="checkbox"/> Other _____ (as required by law)						

	Vehicle 1 Est. Prem.	Vehicle 2 Est. Prem.	Vehicle 3 Est. Prem.	Vehicle 4 Est. Prem.	Vehicle 5 Est. Prem.	
Repossessed Autos: (Applies only to repossessing autos by driving away under their own power.) Estimated Number of Auto Years: _____ <input type="checkbox"/> \$70,000 <input type="checkbox"/> \$75,000 <input type="checkbox"/> \$125,000 <input type="checkbox"/> \$150,000 <input type="checkbox"/> \$325,000 <input type="checkbox"/> \$350,000 <input type="checkbox"/> Other _____ (as required by law)						
Other Coverage – Not Specified Above: Describe: <input type="checkbox"/> \$70,000 <input type="checkbox"/> \$75,000 <input type="checkbox"/> \$125,000 <input type="checkbox"/> \$150,000 <input type="checkbox"/> \$325,000 <input type="checkbox"/> \$350,000 <input type="checkbox"/> Other _____ (as required by law)						
Total Estimated Premium for All Vehicles and Coverages:	\$ _____					
SECTION 11.b. NONOWNED AUTO LIABILITY COVERAGE						
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 <i>not</i> to be insured.						
Year	Trade Make	Body Type	Vehicle Identification No.			
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 AUTO COVERAGE						
<input type="checkbox"/> Check here if desired. (Must also complete Cost of Hire Section 11.d.)		Estimated Annual Cost of Hire	Rates Per \$100		Estimated Premium	
			B.I.	P.D.	B.I.	P.D.
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 vehicles which are <i>not</i> specifically insured by the applicant as an owned vehicle. (Minimum \$60,000/yr per vehicle.).		\$	\$	\$	\$	\$
Total Long and Short Term Cost of Hire.		\$	\$	\$	\$	\$
SECTION 12. FILINGS OR CERTIFICATES						
Is filing or specific limit(s) of liability needed? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" to comply with: <input type="checkbox"/> Motor Carrier Act of 1980 Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> Bus Regulatory Act of 1982 <input type="checkbox"/> ICC Regulation - Docket No. _____ <input type="checkbox"/> Local Ordinance (attach copy) <input type="checkbox"/> State Regulation <input type="checkbox"/> U. S. DOT No. _____ <input type="checkbox"/> 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 insurance for any driver with any state? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", complete the following.						
Last Name		First Name		MI	Tax ID or Social Security No.	
Type of Filing <input type="checkbox"/> Owner's (operation of owned vehicles)		<input type="checkbox"/> Operator's (operation of non-owned vehicles)		<input type="checkbox"/> Both		
State where Filing required	Case or file No.	Reason for Filing				
Are any other vehicles owned or leased by the applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No						

SECTION 13. PAYMENT PLANS			
<input type="checkbox"/> Option 1 - Full Annual Premium <input type="checkbox"/> Option 2 - 30% Premium Deposit with Single Bill Balance <input type="checkbox"/> Option 3 - Installment Premium Payments* ⇒ \$4.00 per installment charge <input type="checkbox"/> Premium to be Financed – Name of Premium Finance Company** _____		Payment by: <input type="checkbox"/> Check <input type="checkbox"/> Money Order	Check/Money Order No.
		Total Estimated Premium	\$
		Amount Submitted with Application	\$
		* Not Available on Premium Financed Policies. ** Attach a copy of Premium Finance contract.	
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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 following conditions: 1. The application must be fully completed and duly executed. 2. Applicants requiring financial responsibility filings, or limits of liability in excess of \$350,000 CSL, will be subject to a fifteen (15) day delay in the effective date as specified in Section 23 of the Illinois Automobile Insurance Plan. The delay period shall run from the Plan assignment date shown on the Plan's Notice of Designation issued to the Producer. Coverage under this evidence of automobile insurance for these specific applicants is to be effective for a period not to exceed thirty (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 thirty (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. 6. The Producer of Record must forward this application to the Plan Office no later than the first working day after the application is written.			
Applicants requiring filings or a limit of liability in excess of \$350,000 Combined Single Limits will be subject to a 15 day delay in the effective date as specified in Section 23 of the Illinois 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.	
In no event shall coverage be effective earlier than 12:01 A.M. on the day following the date of mailing of the application to the Plan as shown by the postmark of the transmittal envelope accompanied by the prescribed deposit. The postmark date that the Plan recognizes is the postmark of the US Postal Service. A metered mail postmark, electronic stamp, or other postage service or stamp, shall not be considered a postmark of the US Postal Service for the purpose of effecting coverage. If there is not a postmark of the US Postal Service or if the postmark is not legible, or if the application is hand delivered, the coverage will be effective at 12:01 A.M. on the day following receipt by the Plan Office. Applicants requiring financial responsibility filings or a limit of liability in excess of \$350,000 CSL, will be subject to a 15 day delay in the effective date as specified in Section 23 of the Illinois Automobile Insurance Plan.			
_____ (Person Authorized to Sign for Applicant)		_____ (Title)	_____ (Date)
		_____ (Hour)	<input type="checkbox"/> A.M. <input type="checkbox"/> 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 Applicant)		_____ (Title)	_____ (Date)
		_____ (Hour)	<input type="checkbox"/> A.M. <input type="checkbox"/> P.M.

SECTION 16. PRODUCER OF RECORD STATEMENT

PRODUCER OF RECORD STATEMENT: I hereby certify that I am a licensed Producer of Record in the State of Illinois. I have read the Illinois Automobile Insurance Plan, 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 policy change resulting in a 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. I understand that the alternate procedure for private passenger application submission contained in the Appendix of the Illinois Automobile Insurance Plan may only be used when authorized 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.

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 and failed to obtain automobile insurance in this state within the preceding 60 days.
3. To the best of the Applicant's knowledge and belief, all statements contained in this application are true and 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 premiums due or contracted during the preceding 36 months.
10. With respect to past due premium the Applicant may owe for coverage obtained through the Plan within the preceding 36 months, the Applicant acknowledges and agrees that any premium currently paid may be applied against any such past due premium and, if so, the Applicant will be billed for additional premium to place or maintain its currently applied for coverage in effect.
11. If there are filings, all vehicles owned or leased by the insured are to be covered under this policy.

(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 address on front of this application.

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