MID-ATLANTIC REGION
ALTERNATE APPLICATION REPORT FORM

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

SECTION 1. PLAN (Check appropriate box)

☐ DELAWARE ☐ DISTRICT OF COLUMBIA ☐ VIRGINIA ☐ WEST VIRGINIA

SECTION 2. PRODUCER/APPLICANT INFORMATION

a.	Agency Name (if applicable)	Telephone Number (include area code)	Extension	
	Signing Producer	License Number	Certification Number	
	Mailing Address	City	State	Zip Code
b.	Applicant Name	Applicant's Date of Birth (mm/dd/yyyy)		
	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 agency/signing producer may be referred to the Plan Board of Governors/Governing Committee and/or the Insurance Department for appropriate action.

_____ _____

Producer Signature Date

SECTION 7. PRODUCER INSTRUCTIONS

Attach this form to the paper application completed for the aforementioned applicant and mail both forms to the Plan as required by Plan language.

COMMERCIAL/TRUCKERS/AUTO DEALER APPLICATION
DELAWARE 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 Limits will be subject to a 15-day delay in the effective date of coverage as specified in Section 23 of the Delaware 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 Identification or Social Security No.	Producer License No.	Business No. (incl. area code)	Fax No. (incl. area code)	Email Adress

SECTION 2. APPLICANT

Last Name	First Name	MI

DBA	Self Employed ☐ Yes ☐ No

Cell Phone No.(incl. area code)	Business Telephone No. (incl. area code)	Email Address	Tax Identification or Social Security No.

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

Mailing Address (if different from above)	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.)

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

SECTION 4. FILINGS OR CERTIFICATES

NOTE: Producers completing this application and section must be guided by the following:
(a) If a filing is requested in this Section, the Cost of Hire (Sections 8 and 10.c) and Nonowned Auto Liability (Section 10.b) Coverage Sections of this application must be completed. (b) The applicant's name must be identical to the name as it appears on the Department of Transportation (DOT) or Department of Public Safety (DPS) permit. (c) A CAIP Inspected Units Form must be completed, signed, and submitted for any applicant who requires a Federal Highway Administration (FHWA) or Federal Motor Carrier Safety Administration (FMCSA) filing or endorsement.

Is a federal filing or specific limit(s) of liability needed? ☐ Yes ☐ No If "Yes" to comply with:

(Answering "Yes" to any of the 4 filings below will require completion of the CAIP Inspected Units form.)

☐ Motor Carrier Act of 1980 Type: ☐ 1 ☐ 2 ☐ 3 ☐ 4

☐ Bus Regulatory Act of 1982 ☐ Motor Carrier No. _____

☐ U. S. DOT No. _____

Is a state or local filing or specific limit(s) of liability needed? ☐ Yes ☐ No If "Yes" to comply with:

☐ Local Ordinance (attach copy) ☐ State Regulation

☐ (Insert state specific item)_____

☐ PUC No._____ ☐ Other _____

If block(s) are checked, list state(s) and city(ies) requiring filings or limits of liability required by law.

Is applicant or other eligible operator required to file evidence of financial responsibility? ☐ Yes ☐ No If "Yes", complete the following.

Last Name	First Name	MI	License 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 5. OPERATOR INFORMATION

List all full-time, part-time, and all other operators that usually drive a vehicle. Total Operators

Last Name	First Name	MI	Date of Birth 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 6. 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 7. 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 8. 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 short term basis and specifically insured by applicant as an owned vehicle.	$	$	$	$	$
Indicate the total Cost of Hire, including wages, for vehicles which are *not* specifically insured by the applicant as an owned vehicle but are to be insured as hired vehicles. (See Rule 75 for minimum Cost of Hire per vehicle.)	$	$	$	$	$
Cost of Hire – Represents Total Cost of Hire	$	$	$	$	$

SECTION 9. PREVIOUS AUTOMOBILE INSURANCE CARRIER

Name of latest carrier	Policy No.	Termination Date

Was coverage through Plan? ☐ Yes ☐ No	If "Yes", give reason terminated.

SECTION 10. AUTO DEALER GENERAL INFORMATION

(1) Location No.1_____

Location No.2_____

Location No.3_____

(2) How many sets of plates does the applicant have? Dealers_____ Repairer_____ Transporter_____ Other_____

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

(4) Does the applicant have a tow truck that at any time crosses a state line when used in towing operations? ☐ Yes ☐ No
(If "Yes," the vehicle is subject to the liability limits required by MCA 1980.)

(5) No. of passenger elevators _____ No. of landings _____

No. of other elevators _____ No. of landings _____

No. of escalators _____ No. of landings _____

A. AUTO DEALER

Description of Operation:

☐ Franchised Private Passenger Auto Dealer
☐ Franchised Motorcycle Dealer (including all two wheeled cycle autos)
☐ Other Franchised Self-Propelled Land Motor Vehicle Dealer
☐ Franchised Truck or Truck-tractor Dealer
☐ Franchised Recreational Vehicle Dealer
☐ Non-Franchised Dealer

(1)

Location	CLASS I No. of Employees				CLASS II No. of Non-Employees	
	Regular		All Other		Under the Age of 25	All Other
	Full Time	Part Time	Full Time	Part Time		
No.1						
No.2						
No.3						

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

(3) Does applicant, if a non-franchised dealer, pick up or deliver automobiles beyond a 50-mile radius? ☐ Yes ☐ No

No. of trips 51-200 miles _____ No. of trips over 200 miles _____

(4) Does applicant engage in "drive-away" or "haul-away" operations? ☐ Yes ☐ No

(5) Schedule of automobiles furnished to someone other than a "Class I" or "Class II" operator - List individuals to whom such autos are furnished and the number furnished for each.

Name and Address of Person/Organization	Occupation	No. of Autos	Vehicle Description
1.			
2.			
3.			

(6) Physical Damage (Nonreporting Basis) ☐ Franchised Dealer ☐ Nonfranchised Dealer

		Comprehensive	Blanket Collision
	Total Value To Be Insured	Deductible	Deductible
Location 1			
Location 2			
Location 3			

B. SPECIFICALLY REGISTERED AUTOS OR TRAILERS: Complete Section 11

TRAILER DEALER

☐ Franchised or Non-Franchised Residence Trailer Dealer ☐ Franchised or Non-Franchised Commercial Trailer Dealer

☐ Other Franchised or Non-Franchised Trailer Dealer

(1) Estimated Payroll Location No. 1 _____ Location No. 2 _____ Location No. 3 _____

No. of employees Location No. 1 _____ Location No. 2 _____ Location No. 3 _____

SECTION 11. VEHICLE INFORMATION AND USE **TOTAL VEHICLES**

Veh. No.	Year	Vehicle Identification No.	Load Capacity	Type of Registration		Gross Vehicle Weight Rating (GVWR) Trucks only		Spec. Industry (T-FD-SD-WD-F-D-C-AO)	Seating Capacity	Loss Payee Name
	Trade Name/ Model No.	Garage Location (City/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	Purp of Use (S-R-C)	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.

SECTION 12.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 ☐ $60,000 ☐ $100,000 ☐ $125,000 ☐ $150,000 ☐ $325,000 ☐ $350,000 ☐ Other _____					
Uninsured/Underinsured Motorists Liability ☐ I accept ☐ I reject ☐ $25/50,000/10,000 ☐ $50/100,000/25,000 ☐ $100/300,000/25,000 ☐ $100/300,000/50,000 ☐ Other _____					
Auto Dealers Liability Coverage (Complete Section 10 if requested) ☐ $60,000 ☐ $100,000 ☐ $125,000 ☐ $150,000 ☐ $325,000 ☐ $350,000 ☐ Other					

Dealer Plates – (Complete Section 10 If requested) No. of Sets of Plates _____					
Elevators – Escalators (Complete Section 10 if requested)					
Nonowned Auto Liability Coverage – (Complete Section 12.b. if requested)					
Hired Auto Coverage – (Complete Section 12.c. if requested) Truckers – If vehicle hired without operators, include wages to $100 weekly per operator in cost.					
Drive Other Car Coverage					
Partnership as the Named Insured					
Personal Injury Protection (PIP) Deductible: ☐ Applicable to named insured only ☐ Applicable to named insured and members of household ☐ Basic $15/30,000 ☐ Additional PIP ☐ $25/50,000 ☐ $50/100,000 ☐ $100/300,000 School Buses under contract with school districts only - ☐ $100/300,000 ☐ Full Coverage or Deductible ☐ $250 ☐ $500 ☐ $1,000					
Physical Damage Coverages–Comp & Collision Deductibles $100 $250 $500 $1000 Veh. 1 _____ Veh. 2 _____ Veh. 3 _____ Veh. 4 _____ Veh. 5_____					
Customized Equipment - Stated Amount: (Priv Pass Vehicles Only) Veh. 1 _____ Veh. 2 _____ Veh. 3 _____ Veh. 4 _____ Veh. 5_____					
Sound Receiving and Transmitting Equipment - Cost New: Veh. 1 _____ Veh. 2 _____ Veh. 3 _____ Veh. 4 _____ Veh. 5_____					
Extended Transportation Expense ☐ I accept ☐ I reject					
Auto Dealers Transportation Expense ☐ I accept ☐ I reject (Complete Section 10 if requested)					
Estimated Total Premium Per Vehicle	$	$	$	$	$
Total Estimated Premium for vehicles 1 – 5				$	
Total Estimated Premium for supplemental vehicles				$	
Total Estimated Premium for all vehicles and coverages				$	

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.

Are any other vehicles owned by the Applicant? ☐ Yes ☐ No If "Yes", give name of insurer Policy No.

Are any vehicles hauling exclusively for one firm/carrier? ☐ Yes ☐ No If "Yes" give name of firm/carrier _____
Address _____ Type of Business _____
TOW TRUCK OPERATORS: Do you have a tow truck that at any time crosses a state line when used in towing operations? ☐ Yes ☐ No
(If "Yes", the vehicle is subject to the liability limits required by The Motor Carrier Act of 1980.)

SECTION 12.b. NONOWNED AUTO LIABILITY COVERAGE

Total No. Employees	What % of the applicant's employees operate their vehicles in the business?	**FAST FOOD DELIVERY ONLY ⇨**	Average No. Employees	Determine the average number of employees by dividing the estimated average weekly number of hours worked for all employees who operate their autos in the insured's business by **56**.

Estimated Premium	$

SECTION 12.c. HIRED AUTO COVERAGE Motor Carriers must have Hired Car Coverage for any vehicle which will come under the Motor Carrier Act.

Types Hired	Principal Garaging or Locations Where Vehicles Will Be Used	Estimated Annual Cost of Hire	Rates Per $100 BI and PD	Estimated Premiums
		$	$	$
		$	$	$
		$	$	$

SECTION 12.d. 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.

SECTION 12.e. 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 13. PAYMENT PLANS

☐ Option 1 - Full Annual Premium
☐ Option 2 - Premium Deposit with Single Bill Balance
☐ Option 3 Installment Premium Payments* – 5 Monthly Payments**
☐ Premium to be Financed – Name of Premium Finance Company***

_____
Name of Premium Finance Company

Payment by: ☐ Check ☐ Money Order	Check/Money Order No.
Total Estimated Premium	$
Amount Submitted with Application	$

**Not Available on Premium Financed Policies.*
***$4.00 per installment charge*
****Attach a copy of Premium Finance contract.*

SECTION 14. 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 (incl. your own)	Penalty Points
		City	State			
				☐ Yes ☐ No	$	
				☐ Yes ☐ No	$	
				☐ Yes ☐ No	$	
				☐ Yes ☐ No	$	

If the answer to any of the following questions is "Yes", so state and give date of accident:	Yes	Accident Date
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. Conviction for failure to report accident where there was no bodily injury or death and property damage did not exceed $500.	☐	_____
4. Applicant reimbursed by or on behalf of person responsible for the accident or has judgement against such person.	☐	_____
5. Other person involved in accident was convicted. Applicant or operator was not convicted.	☐	_____
6. Any claim paid arose from a not at-fault accident.	☐	_____
7. Involvement in accident which occurred while vehicle was being operated by the applicant or any other person who usually drives the vehicle that resulted in no payment by an insurer.	☐	_____

SECTION 15. CONVICTIONS Motor Vehicle and Non-Motor Vehicle

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 ☐ 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 Violation	Place of Conviction		Penalty Points
				City	State	
		☐ Yes ☐ No				
		☐ Yes ☐ No				
		☐ Yes ☐ No				
		☐ Yes ☐ No				

SECTION 16. EVIDENCE OF INSURANCE AND REQUESTED EFFECTIVE DATE OF COVERAGE

This application having been fully completed and duly executed, shall be, from the effective date and time shown below, evidence of insurance in the limits and coverages specified, subject to the following conditions:

1. Specific applicants requiring filings and limits 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 Delaware 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.
2. For EASi applications requiring immediate coverage, the producer must forward the original application to the Plan to be received by the Plan no later than 15 calendar days following the date of transmittal of the EASi application. For plain paper applications not submitted by EASi requiring immediate coverage, the producer must mail or deliver the original application to the Plan no later than two working days after the date the application is written.
3. For CAIP applicants requesting limits of $500,000 Combined Single Limit Coverage or less not subject to the 15 day delay in effective date, 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 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, when and as issued, is not accepted by the insured.
5. The insurance afforded hereunder shall be subject to all the terms and conditions of the Plan and the policy form prescribed for use in accordance with the rules of the Automobile Insurance Plan.

NOTE: In the event there is no U.S. postmark (a metered mail stamp, electronic stamp, or other postage service or stamp are not considered a U.S. postmark), coverage will become effective per Plan rules.

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 of coverage as specified in Section 23 of the Delaware Automobile Insurance Plan.

Requested Effective Date and Time:

IN NO EVENT SHALL COVERAGE BE EFFECTIVE PRIOR TO THE DATE AND HOUR OF SIGNATURE AS SHOWN IN SECTION 18.

_____

Example: 09/01/2023 11:30 AM

SECTION 17. PRODUCER OF RECORD STATEMENT

I hereby certify that I am a licensed agent, of the State of Delaware. I have read the Delaware Automobile Insurance Plan, have explained the provisions to the applicant, and have included in this application all required information given to me by 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. In the event of cancellation or a change to the policy 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 the 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)

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 a report is procured.

NOTICE TO APPLICANT AND PRODUCER

In the event acknowledgement of coverage is not received within 45 days, notify the DE Plan, PO Box 6530, Johnston, RI 02940-6530.

SECTION 18. APPLICANT'S 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 his/her 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 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 Automobile Insurance Plan or any company 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.

10. I understand and agree that if I owe earned premium to a servicing carrier for prior coverage, the servicing carrier 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 me 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 servicing carrier may apply the entire deposit premium to that outstanding balance and return this application without providing any coverage.

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

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

MAILING INFORMATION

Send original, signed application with check/money order and required attachments to:
Delaware Automobile Insurance Plan
PO Box 6530
Providence, RI 02940-6530

REMARKS SECTION