COMMERCIAL APPLICATION
INDIANA AUTOMOBILE INSURANCE PLAN

EASi Reference #: Transmission Date:

OFFICE USE ONLY – DO NOT WRITE OR ALTER INFORMATION IN THIS BLOCK

SECTION 1. PRODUCER OF RECORD

Producer Last Name/Agency Name			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 2. APPLICANT AND REGISTERED OWNER

Last Name		First Name		MI
Home Telephone No. (incl. area code)	Business Telephone No. (incl. area code)	Tax ID No.		
Street Address	Ste./Apt. No.	City	State	Zip Code
Headquarters Street Address (if different from above)	Ste./Apt. No.	City	State	Zip Code

SECTION 3. OWNERSHIP AND CONTROL OF APPLICANT'S ORGANIZATION

Named insured is a: ☐ Individual ☐ 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		

Business of Applicant/Nature of Operation (describe)

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 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 AIP 3502 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 motor 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. (If necessary, use Remarks Section.)

Name of Operator	Accident Date	Place of Accident		Bodily Injury	Death	Property Damage (Including your own)	Penalty Points	Accident 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 reimbursed by or on behalf of person responsible for the accident or has judgement against such person.
4. Other person involved in accident was convicted of a moving traffic violation.
5. Damage by contact with animals or fowl.

SECTION 6. 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 ☐ 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/Town	State		
		☐ Yes ☐ No					☐ Yes ☐ No
		☐ Yes ☐ No					☐ Yes ☐ No
		☐ Yes ☐ No					☐ Yes ☐ No
		☐ Yes ☐ No					☐ Yes ☐ No

SECTION 7. COMMODITIES TRANSPORTED

COMMERCIAL TRUCKERS ONLY

List all commodities hauled and 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.										
Veh. No.	Year	Vehicle Identification No.	Load Capacity (2)	Type of Registration		Gross Vehicle Weight (GVW) Trucks only		Purpose of Use (P or B) (S-R-C)	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		Bus. Rad. (L-I-LD)	Tank Capacity	Loss Payee Address
	Type (1)	Name of Registered Owner of Vehicle	Rating Territory (3)	Orig. Cost New (4)	Comp. Symbol	Coll. Symbol	Size (L-M-H-EH)	Spec. Industry (M-T-FD-SD-WD-F-D-O)	Final Rating	Loss Payee City, State, Zip Code
	List where vehicle is permitted to operate			For public and long distance, list cities 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) Truck-Type vehicles with Private Passenger or Combination registration and load capacities of 1500 pounds or less are eligible for Basic Reparations Benefits coverage. (3) For public automobiles, use the highest rated territory where the vehicles pick up or discharge passengers. (4) 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.

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

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 Limit of Liability ☐ Basic Limit Other Limits (as required by law) ☐ $100,000 ☐ $125,000 ☐ $200,000 ☐ $250,000 ☐ $300,00 ☐ $350,000 ☐ $500,000 ☐ $750,000 ☐ $1,000,000 ☐ $1,500,000 ☐ $5,000,000					
Medical Payments Coverage ☐ $500 ☐ $1,000					
Physical Damage Coverage Comprehensive and Collision ☐ $100 ☐ $250 ☐ $500 ☐ $1,000 Comprehensive ☐ $100 ☐ $250 ☐ $500 ☐ $1,000					
Uninsured Motorist UMBI ☐ Basic Limit UMPD* ☐ Basic Limit no deductible ☐ Basic Limit and $300 deductible * Only available if UMBI coverage elected					
Underinsured Motorists ☐ I reject UM coverage** ☐ I reject UMPD coverage only** ☐ I reject UIM coverage**					
Estimated Total Premium per vehicle	$	$	$	$	$
Total Estimated Premium for vehicles 1 - 5					$
Total Estimated Premium for supplemental vehicles					$
Total Estimated Premium for all vehicles					$
Waiver of Subrogation Premium (Complete Section 10.e. if requested.)					$
Total Estimated Premium for all vehicles and all coverages					$

** I understand and agree that any rejection of the above coverages shall apply to this policy and to any renewal, reinstatement, substitute, amended, or replacement policy until I request such coverage or coverages in writing.

X____ (Applicant's Signature/Date)

SECTION 10.b. NONOWNED AUTO LIABILITY COVERAGE

☐ Check here if desired ☐ Primary Coverage ☐ Excess Coverage

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

Total No. Employees	What % of the applicant's employees operate their vehicles in the business?	**FAST FOOD DELIVERY ONLY ⇨**	Average No. Drivers

SECTION 10.c. HIRED AUTO COVERAGE

☐ Check here if desired. ☐ Primary Coverage ☐ Excess Coverage	Estimated Annual Cost of Hire	Rates Per $100		Estimated Premium	
		B.I.	P.D.	B.I.	P.D.

SECTION 10.d. DRIVE OTHER CAR COVERAGE

For Non-Owned Automobiles

Name of Individual (s) (If necessary, Use Remarks Section)

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

SECTION 10.e. 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:

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 (to allow for operation of owned vehicles) ☐ Operator's (to allow for operation of non-owned vehicles) ☐ Both

State(s) where Filing required	Case or file No.	Reason for Filing

SECTION 12. PAYMENT PLANS

Must be purchased in conjunction with collision coverage.
☐ Option 1 - Full Annual Premium
☐ Option 2 - Advance Premium Payment Option (submit 40% of annual premium as a deposit, balance due in 30 days)
☐ Option 3 - Installment Premium Payment Option (submit 40% of annual premium as a deposit plus $4 installment charge)*
30% of the premium plus a $4 installment charge due no later than three months after effective date of policy
Balance plus $4 installment charge due no later than six months after effective date of policy
☐ Premium to be Financed – Name of Premium Finance Company**

____

Payment by: ☐ Certified Check ☐ Bank Check ☐ Money Order	Check/Draft No.
Total Estimated 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. (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? ☐ Yes ☐ 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 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, duly executed.
2. Specific applicants requiring financial responsibility filings or limits of liability in excess of $500,000 CSL will be subject to a 25 day delay in the effective date as stated in Section 23 of the Indiana 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 45 days from the effective date and time stated herein. Within such 45 day period coverage 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 coverage of insurance afforded hereunder in accordance with the rules of the Indiana 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 of the policy form described for use.

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

Requested Effective Date and Time will be in accordance with Section 23 of the Manual. _______________________________ Example: 10/ 01/2016 11:30 AM	**IN NO EVENT SHALL COVERAGE BE EFFECTIVE PRIOR TO THE DATE AND HOUR OF COMPLETION OF THIS APPLICATION.**

SECTION 15. PRODUCER OF RECORD STATEMENT

I hereby certify that I am a licensed broker/agent of 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 of the policy is cancelled or a change is made resulting in a return premium to the insured, I agree to return the unearned commission portion of such premium.

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)

SECTION 16. 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 without success to obtain automobile insurance in this state within the preceding 60 days. If written declination was received, attached copies. If no written declination was received, provide name of company, contact name and telephone number of each company.

	Company Name	Contact Name	Telephone Number
1.			
2.			
3.			

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.

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.
(Applicant's Signature)

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 the form.

____ Title:_________________ Date:___________ Hour: __________ ☐ A.M. ☐ P.M.
(Person Authorized to Sign for Applicant)

NOTICE TO APPLICANT AND PRODUCER

In the event acknowledgement of coverage is not received within 45 days, notify the Indiana Automobile Insurance Plan Office, 302 Central Avenue, Johnston, RI 02919-4932.

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.

FRAUD NOTICE

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.

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

Send original, signed application, with money order, bank check, or certified check and required attachments to:
Indiana Automobile Insurance Plan
P.O. Box 6530
Providence, RI 02940-6530

REMARKS SECTION

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