COMMERCIAL AUTOMOBILE APPLICATION
PENNSYLVANIA ASSIGNED RISK 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 calendar day delay in the effective date as specified in Section 38 of the Pennsylvania Assigned Risk Plan.

ANTIFRAUD STATEMENT

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

SECTION 1. CERTIFIED PRODUCER OF RECORD

Producer Last Name/Agency Name	Producer First Name	MI

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

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	Producer License No.

SECTION 3. APPLICANT

Last Name	First Name	MI

Signature of Applicant or Person Authorized to Sign for Applicant

DBA	Self Employed ☐ Yes ☐ No

Home Telephone No. (incl. area code)	Business Telephone No. (incl. area code)	Tax ID No. or Social Security No.

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

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

Business of Applicant/Nature of Operation

SECTION 4. 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		

List all affiliated companies

Staple check here:
➔

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

Pennsylvania Assigned Risk Plan
P.O. Box 6530
Providence, RI 02940-6530

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

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	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 6. 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 Mo./Day/Yr.	Accident Codes *	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 judgement 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.

SECTION 7. 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? NOTE: A paid ticket or fine is an admission of guilt and therefore constitutes a conviction.
Convicted: ☐ Yes ☐ No Forfeited Bail: ☐ Yes ☐ No If "Yes", for either item, complete the following. (If necessary, use Remarks Section.)

Name of Operator	Date of Conviction or Forfeiture of Bail Mo./Day/Yr.	Did Conviction Arise as a Result of an Accident?	Nature of Conviction	Place of Conviction		Additional Charge Percentage	Was License Suspended or Revoked?
				City	State		
		☐ Yes ☐ No				%	☐ Yes ☐ No
		☐ Yes ☐ No				%	☐ Yes ☐ No
		☐ Yes ☐ No				%	☐ Yes ☐ No
		☐ Yes ☐ No				%	☐ Yes ☐ 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

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

SECTION 9. 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 automobiles leased or hired on a short term basis and specifically insured by the 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 automobile but are to be insured as hired automobiles.	$	$	$	$	$
Represent Total Long and Short Term Cost of Hire	$	$	$	$	$

SECTION 10. 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 11. VEHICLE INFORMATION AND USE TOTAL VEHICLES

Veh. No.	Year	Vehicle Identification No.	Load Capacity	Type of Registration	Gross Vehicle Weight (GVW) Trucks only	Special Industry (T-FD-SD-WD-F-D-C-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	Radius Class (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)		Purpose Of Use (P or B) (S-R-C)	Final Rating	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 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.
Liability – Combined Single Limit (as required by law) ☐ $35,000 CSL ☐ $100,000 CSL ☐ $250,000 CSL ☐ $300,000 CSL ☐ $350,000 CSL ☐ Other: _____					
Medical Benefit (Required) ☐ $5,000 ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ $100,000					
Income Loss Benefit ☐ $1,000/$5,000 ☐ $1,000/$15,000 ☐ $1,500/$25,000 ☐ $2,500/$50,000					
Funeral Benefit (Optional) ☐ None ☐ $1,500 ☐ $2,500					
Accidental Death Benefit (Optional) ☐ None ☐ $5,000 ☐ $15,000 ☐ $25,000					
Combination First Party Benefit ($177,500) ☐ Yes ☐ No					
Uninsured Motorist Coverage (Optional) (Not to exceed liability limits) ☐ None ☐ $35,000 CSL ☐ $100,000 CSL ☐ $250,000 CSL ☐ $300,000 CSL ☐ $350,000 CSL					
If "None" is checked, attach a signed Rejection of Uninsured Motorist Protection statement found on current Form PA-2000A to this application. Proceed to Underinsured Motorist Coverage. Since uninsured motorist protection is selected, **does the applicant accept stacked limits of Uninsured Motorist Coverage.** ☐ Yes ☐ No **If "No" is checked, attach a signed Rejection of Stacked Uninsured Motorist Coverage Limits statement found on current Form PA-2000B to this application.**					
Underinsured Motorist Coverage (Optional) (Not to exceed liability limits) ☐ None ☐ $35,000 CSL ☐ $100,000 CSL ☐ $250,000 CSL ☐ $300,000 CSL ☐ $350,000 CSL					
If "None" is checked, attach a signed Rejection of Underinsured Motorist Protection statement found on current Form PA-3000A to this application. Proceed to the Extraordinary Medical Benefits Coverage statement. Since underinsured motorist protection is selected, **does the applicant accept stacked limits of Underinsured Motorist Coverage.** ☐ Yes ☐ No **If "No" is checked, attach a signed Rejection of Stacked Underinsured Motorist Coverage Limits statement found on current Form PA-3000B to this application.**					
EXTRAORDINARY MEDICAL BENEFIT COVERAGE (EMBC): UNLESS THE APPLICANT INITIALS THE STATEMENT PROVIDED BELOW, NO EXTRAORDINARY MEDICAL BENEFITS COVERAGE WILL BE PROVIDED. ☐ I REQUEST EXTRAORDINARY MEDICAL BENEFIT COVERAGE X _____(Applicant's Signature)					
Physical Damage Comprehensive Deductibles $100* $200* $250* $500 $1,000 $5,000** Veh. 1 _____ Veh. 2 _____ Veh. 3 _____ Veh. 4 _____ Veh. 5_____ *For, **Not for private passenger, light commercial, motorcycle and recreational trailers and camper bodies only.					
Physical Damage Collision Deductibles $100* $200* $250* $500 $1,000 $5,000** Veh. 1 _____ Veh. 2 _____ Veh. 3 _____ Veh. 4 _____ Veh. 5_____ *For, **Not for private passenger, light commercial, motorcycle and recreational trailers and camper bodies only.					
Loss Of Use* Veh. 1 ☐ Yes ☐ No, Veh. 2 ☐ Yes ☐ No, Veh. 3 ☐ Yes ☐ No, Veh. 4 ☐ Yes ☐ No, Veh. 5 ☐ Yes ☐ No *For private passenger, light commercial, motorcycle and recreational trailers and camper bodies only.					
Pollution Liability					
Total Estimated 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, select the Bodily Injury Liability Limit or Combined Single Limit above and complete Section 12.b.					
Garagekeepers Coverage – If requested, Complete Section 12.c.					
Hired Auto Coverage – If requested, select the Bodily Injury Liability Limit or Combined Single Limit above and complete Section 12.d.					
Drive Other Car Coverage - If requested, select the Bodily Injury Liability Limit or Combined Single Limit above and complete Section 12.d. Number of individuals to be covered: _____					

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

Registration Plates Not Issued For A Specific Auto Number of plates: _____ ☐ $35,000 CSL ☐ $100,000 CSL ☐ $250,000 CSL ☐ $300,000 CSL ☐ $350,000 CSL ☐ Other: _____		
Partnership As The Named Insured Nonownership Liability Select the Bodily Injury Liability Limit or Combined Single Limit above Number of active and inactive partners: _____		
Total Estimated Premium for all vehicles and all coverages		$

SECTION 12.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.	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.

SECTION 12.c. GARAGEKEEPERS COVERAGE Applicable only to official Inspection Stations approved by the PA DOT..

Total Values for All Locations	Specified Causes of Loss Deductible	Specified Causes of Loss Premium	Collision Deductible	Collision Premium

SECTION 12.d. HIRED AUTO COVERAGE

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

SECTION 12.e. DRIVE OTHER CAR COVERAGE For Non-Owned Automobiles.

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

SECTION 13. 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	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

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

SECTION 14. PAYMENT PLANS

☐ Option 1 - Full Annual Premium
☐ Option 2 – Advance Premium Payment of 30% as provided by the Rules of the Plan.
Balance of annual premium to be paid within 30 days after receipt of the policy or notice of premium due.
☐ Option 3 - Installment Premium Payments of 30% as provided by the Rules of the Plan.*
Balance of annual premium to be paid in five (5) monthly installments to be completed six (6) months after the policy effective date. A $4.00 installment charge must be paid with each installment.
In order to ensure timely and proper credit, installment premium payments should be made only to the assigned carrier. Please note that neither the Pennsylvania Assigned Risk Plan nor the producer of record are agents of the assigned carrier.
☐ 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 this Application	$

** Not Available on Premium Financed Policies.*
*** Attach a copy of Premium Finance contract.*

SECTION 15. PREVIOUS AUTOMOBILE INSURANCE CARRIER

Information for the past three years. Attach loss statements from previous carrier.

Name of latest carrier	Address of latest carrier	
Policy No.	Was coverage through Plan? ☐ Yes ☐ No	Termination Date

If "Yes", give reason terminated.

Complete the following for Motor Carriers of Property and Passengers:

	Policy No.	Policy Period From	To	Name and Address of Insurance Company
1st Prior Year				
2nd Prior Year				
3rd Prior Year				

EVERY POOLED CAP APPLICATION MUST BE ACCOMPANIED BY FOUR (4) YEARS OF THE APPLICANT'S ACCOUNT HISTORY (INCLUDING CLAIMS AND LOSS EXPERIENCE), UNLESS THE RISK HAS BEEN IN BUSINESS LESS THAN FOUR (4) YEARS, IN WHICH EVENT THE ACCOUNT HISTORY FOR THAT PERIOD MUST BE FURNISHED.

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

This application, having been 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:
IS EASi IMMEDIATE COVERAGE REQUESTED ☐ YES ☐ NO

1. If immediate coverage is requested, coverage is effective at the time and on the date shown below, provided the EASi Immediate Coverage Procedure authorized by Sections 24 and 38
of the Pennsylvania Assigned Risk Plan has been utilized. You must make proper payment in accordance with Section 14 of this application. The applicant is advised to sign this application in the presence of the producer of record. If EASi Immediate Coverage is utilized, confirmation of the effective date is established by the EASi Reference Number.

If immediate coverage is not required, or the applicant is a **Pooled CAP** risk ineligible for immediate coverage, then the effective date of Plan coverage will be as shown below in accordance with the provisions of Pennsylvania Plan Section 38 but in no event shall coverage be effective prior to 12:01 A.M. on the day following the **date of mailing** of the completed application and prescribed deposit.
2. A premium charge will be made for these coverages if the policy, when and as issued, is not accepted by the insured.
3. The insurance afforded hereunder shall be subject to all the terms and conditions of the Policy Form prescribed for use in accordance with the rules of the Pennsylvania Assigned Risk Plan.

Requested Effective Date and Time of Coverage: (Not to exceed 30 days from the date of application submission) _____ Example: 01/01/16 11:30 AM	**IN NO EVENT SHALL COVERAGE BE EFFECTIVE PRIOR TO THE DATE AND HOUR OF COMPLETION OF THIS APPLICATION.**

Applicants requiring filings or a limit of liability in excess of $350,000 Combined Single Limits will be subject to a 15 calendar day delay in the effective date as specified in Section 38 of the Pennsylvania Assigned Risk Plan.

IMPORTANT: FOR POOLED CAP RISKS REQUIRING FILINGS (ICC, PUC, etc.) OR LIMITS IN EXCESS OF $350,000 COMBINED SINGLE LIMITS, COVERAGE WILL BE EFFECTIVE ON A DATE SPECIFIED BY THE APPLICANT OR FIFTEEN (15) CALENDAR DAYS FOLLOWING THE PLAN ASSIGNMENT DATE, WHICHEVER IS LATER, UNLESS THE APPLICANT PROVIDES BOTH A DECLARATION PAGE FROM THE INSURER SHOWING COVERAGE THROUGH THE DATE OF APPLICATION, AND EITHER A NOTICE OF ESTIMATED RENEWAL PREMIUM OR A TERMINATION NOTICE PURSUANT TO ACT 86 FOR A REASON OTHER THAN NON-PAYMENT OF PREMIUM, FRAUD OR MATERIAL MISREPRESENTATION, IN WHICH CASE THE EFFECTIVE DATE OF COVERAGE SHALL BE IN ACCORDANCE WITH PENNSYLVANIA PLAN SECTION 38.

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

PREMIUM DETERMINATION

I understand that the premium shown on this application is an estimated premium. The company reserves the right to adjust the premium either prior to or after the issuance of the policy, whenever applicable, as permitted by the Rules and Rates approved by the Pennsylvania Insurance Department in accordance with the Pennsylvania Insurance Department regulations. **Cash cannot be accepted by the Producer of Record.** Premium monies to the Producer of Record shall be only in the form of a bank/postal money order, cashier's check, certified check, premium finance check or personal check made payable to the Pennsylvania Assigned Risk Plan.

By: X _____ Date_____Hour_____ ☐ AM ☐ PM
Applicant's Signature

X _____ Date_____Hour_____ ☐ AM ☐ PM
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.

X _____ Date_____Hour_____ ☐ AM ☐ PM
Person Authorized to Sign For Applicant

PRODUCER OF RECORD STATEMENT:I hereby certify that I am a licensed broker/agent of the State of Pennsylvania, and certified by the Pennsylvania Plan. I have read the Pennsylvania Assigned Risk Plan, have explained the provisions to the applicant, and have included in this application all required information given to me by the applicant. In the event 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 return premium.

My signature hereon represents certification of the Statement of the Producer of Record on this application and I certify this application is submitted pursuant to the effective date provisions contained in the Pennsylvania Assigned Risk Plan and accompanied by all coverage/acceptance rejection forms mandated by Act 6.

By: X _____ Date_____Hour_____ ☐ AM ☐ PM
Producer's Signature

IMPORTANT NOTICE

Insurance Companies operating in the Commonwealth of Pennsylvania are required by law to make available for purchase the following benefits for you, your spouse or other relatives or minors in your custody or in the custody of your relatives, residing in your household, occupants of your motor vehicle or persons struck by your motor vehicle:

(1) Medical benefits, up to a least $100,000.

(1.1) Extraordinary medical benefits, from $100,000 to $1,100,000 which may be offered in increments of $100,000.

(2) Income loss benefits, up to a least $2,500 per month up to a maximum benefit of at least $50,000.

(3) Accidental death benefits, up to a least $25,000.

(4) Funeral benefits, $2,500.

(5) As an alternative to paragraphs (1), (2), (3) and (4), a combination benefit, up to at least $177,500 of benefits in the aggregate or benefits payable up to three years from the date of the accident, whichever occurs first, subject to a limit on accidental death benefit of up to $25,000 and a limit on funeral benefit of $2,500, provided that nothing contained in this subsection shall be construed to limit, reduce, modify or change the provisions of section 1715(d) (relating to availability of adequate limits).

(6) Uninsured, underinsured and bodily injury liability coverage up to at least $100,000 because of injury to one person in any one accident and up to at least $300,000 because of injury to two or more persons in any one accident or, at the option of the insurer, up to at least $300,000 in a single limit for these coverages, except for policies issued under the Assigned Risk Plan. Also, at least $5,000 for damage to property of others in any one accident.

Additionally, insurers may offer higher benefit levels than those enumerated above as well as additional benefits. However, an insured may elect to purchase lower benefit levels than those enumerated above. Your signature on this notice or your payment of any renewal premium evidences your actual knowledge and understanding of the availability of these benefits and limits as well as the benefits and limits you have selected.

If you have any questions or you do not understand all of the various options available to you, contact your agent or company.

If you do not understand any of the provisions contained in this notice, contact your agent or company before you sign.

_____
Applicant's Signature

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

SECTION 17. APPLICANT'S STATEMENT

I DECLARE AND CERTIFY THAT: (1) I HAVE TRIED AND FAILED TO OBTAIN AUTOMOBILE INSURANCE IN THIS STATE WITHIN 60 DAYS PRIOR TO THE DATE OF APPLICATION; (2) to the best of my knowledge and belief that all statements contained in this application are true; (3) I do not owe any insurance company any automobile premiums due or contracted during the past 12 months. (4) I designated as Producer of Record for this insurance the producer named in this application and I understand he is not acting as an agent of the Pennsylvania Assigned Risk Plan or any company for the purpose of this insurance. (5) I agree that no coverage will be effective if my premium remittance, which accompanies the application, and is forwarded to the assigned carrier, is justifiably dishonored by the financial institution.

The Producer of Record has been unable to obtain coverage for you through the voluntary market. This application is for coverage through the Pennsylvania Assigned Risk Plan. Within twenty (20) days of receipt of this application, you may request in writing that the Insurance Department review the reasons why you were unable to obtain coverage through the voluntary market.

By: X _____ Date_____Hour_____ ☐ AM ☐ PM
Applicant's Signature

NOTICE TO APPLICANT AND PRODUCER

In the event acknowledgment of coverage is not received within 30 days, notify the Plan Office, P.O. Box 6510, Providence, RI 02940-6510. Please give application number.

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.

ATTACHMENTS

- ☐ Deposit Premium Payment
- ☐ Copy of Premium Finance Contract
- ☐ Premium Comparision Form (if premium is financed)
- ☐ Copy of Vehicle Registration mandatory for each vehicle
- ☐ Coverage Selection/Acceptance/Rejection Forms
- ☐ Supplemental Commercial Vehicle Schedule, if applicable
- ☐ Copy of Foreign Driver's License*
- ☐ Copy of International Driving Permit *

*If the above are checked, attach a copy of one of the following:
(1) a valid passport
(2) a valid alien registration receipt (green card)
(3) a valid employment authorization card issued by the United States Department of Homeland Security
(4) a valid proof of nonimmigrant classification issued by the United States Department of Homeland Security

REMARKS SECTION

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