COMMERCIAL/TRUCKERS APPLICATION
KENTUCKY 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 Kentucky 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	Producer License No.

SECTION 3. APPLICANT

Owner/Contact Person - Last Name	First Name	MI

DBA	Self Employed ☐ Yes ☐ No

Business Telephone No. (incl. area code)	Alternate 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	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 certified funds/money order and required attachments to:

Kentucky Automobile Insurance Plan
10605 Shelbyville Road, Suite 100
Louisville, KY 40223

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 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 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 (incl. your own) Amount	Penalty Points	Codes *
		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. 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. Describe accident in space provided.

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 ☐ Yes ☐ No Forfeited Bail ☐ Yes ☐ No If "Yes", for either item, complete the following. NOTE: A paid ticket or fine is an admission of guilt and therefore constitutes a conviction.

Name of Operator	Date of Conviction or bail forfeiture Mo./Day/Yr.	Did Conviction Arise as a Result of an Accident?	Nature of Conviction	Place of Conviction		Penalty Points	Was License Suspended or Revoked?
				City	State		
		☐ Yes ☐ No					☐ Yes ☐ No
		☐ Yes ☐ No					☐ Yes ☐ No
		☐ Yes ☐ No					☐ Yes ☐ No
		☐ Yes ☐ No					☐ Yes ☐ No

SECTION 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	$	$	$	$	$

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

SECTION 10. VEHICLE INFORMATION AND USE — **For long distance, list cities in which vehicles operate.** — **TOTAL VEHICLES**

Veh No.	Year	Vehicle Identification No.	Load Capacity (2)	Type of Registration	Gross Vehicle Weight (GVW) Trucks only	Spec. Industry (M-T-FD-SD-WD-F-D-C-L-O)	Seating Capacity	Does unit have an extended weight decal? ☐ Yes ☐ No What is extended weight? _____ ☐ Tandem ☐ Tridem ☐ Tractor-Trailer
	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	

	Type (1)	Name of Registered Owner of Vehicle	Rating Territory (3)	Orig. Cost New (4)	Comp. Sym.	Coll. Sym.	Size (L-M-H-EH-HT-EHT)	Purpose of Use (P or B) (S-R-C)	Final Rating	
	Where vehicle is permitted to operate			List all cities through and in which vehicles operate						
Veh 1										Does unit have an extended weight decal? ☐ Yes ☐ No What is extended weight? _____ ☐ Tandem ☐ Tridem ☐ Tractor-Trailer
Veh 2										Does unit have an extended weight decal? ☐ Yes ☐ No What is extended weight? _____ ☐ Tandem ☐ Tridem ☐ Tractor-Trailer
Veh 3										Does unit have an extended weight decal? ☐ Yes ☐ No What is extended weight? _____ ☐ Tandem ☐ Tridem ☐ Tractor-Trailer
Veh 4										Does unit have an extended weight decal? ☐ Yes ☐ No What is extended weight? _____ ☐ Tandem ☐ Tridem ☐ Tractor-Trailer
Veh 5										Does unit have an extended weight decal? ☐ Yes ☐ No What is extended weight? _____ ☐ Tandem ☐ Tridem ☐ Tractor-Trailer

(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 Easi Supplemental Vehicle Schedule and mailed with the original application to the Plan.

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

SECTION 11.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 ☐ $125,000 ☐ $150,000 ☐ $325,000 ☐ $350,000 ☐ Other _____					
Uninsured Motorists Liability ☐ $60,000 ☐ $125,000 ☐ $150,000 ☐ $325,000 ☐ $350,000					
Underinsured Motorists Liability ☐ $60,000 ☐ $125,000 ☐ $150,000 ☐ $325,000 ☐ $350,000					
Basic Personal Injury Protection (PIP) $10,000 Deductible Option ☐ $250 ☐ $500 ☐ $1,000 Covered by Workers Comp? ☐ No ☐ Yes (If Yes, attach documentation) ☐ Guest PIP ☐ Motorcycle PIP ☐ Added PIP (not available on policy with Guest PIP only)					
☐ I Accept Uninsured Motorist Coverage ☐ I Reject Uninsured Motorist Coverage: ☐ I Accept Underinsured Motorist Coverage ☐ I Reject Underinsured Motorist Coverage PIP Coverage: ☐ Accepted ☐ Rejected Does Municipal Tax Apply? ☐ Yes ☐ No **City taxing authority** _____ **County taxing authority**_____ If rejecting Uninsured Motorist (UM) coverage, you must complete the Uninsured Motorist (UM) Coverage Rejection below.					
Pollution Liability					
Estimated Total Premium per vehicle	$	$	$	$	$
Total Estimated Premium for vehicles 1 - 5	$				
Total Estimated Premium for supplemental vehicles	$				
Total Estimated Premium for all vehicles	$				
Employer's Non-Ownership Coverage – (Complete Section 11.b. if requested)					
Hired Car Coverage – (Complete Section 11.c. if requested)					
Registration Plates Not Issued for a Specific Auto Number of plates: _____					
Total Estimated Premium for All Vehicles and Coverages: (KY taxes not incl.)	$				

KENTUCKY NO-FAULT REJECTION: IMPORTANT

IF ANY OTHER REGULAR OPERATOR OF THE INSURED'S VEHICLE NOT IDENTIFIED BY NAME AS AN INSURED IN ANY OTHER CONTRACT OF BASIC REPARATIONS INSURANCE, REJECTS TORT LIMITATIONS ALL OF THE FOLLOWING QUESTIONS MUST BE COMPLETED.

1. ☐ Applicant accepts Tort Limitations ☐ Applicant rejects Tort Limitations
2. ☐ Regular Operators of Insured's Vehicles accepting _____ (number) Tort Limitations
   ☐ Regular Operators of Insured's Vehicles rejecting _____ (number) Tort Limitations
3. Total Number of Regular Operators of Insured's Vehicles _____

UNINSURED MOTORIST (UM) COVERAGE REJECTION: IMPORTANT

KRS 304.20.020 provides that all motor vehicle liability insurance policies shall contain insurance, "for the protection of persons insured thereunder who are legally entitled to recover damages from owners or operators of uninsured motor vehicles because of bodily injury, sickness or disease, including death, resulting therefrom." It further provides that you have the right to reject in writing such coverage. If you desire to reject such coverage, indicate this by signing below.*

I do not desire to have insurance protection for bodily injury, sickness or disease, including death, resulting from owners or operators of uninsured motor vehicles and hereby reject Uninsured Motorist (UM) Coverage.

Signature_____ Date_____

Signature_____ Date_____

Signature_____ Date_____

*Each named insured must sign separately to reject Uninsured Motorist (UM) Coverage.

SECTION 11.b. HIRED AUTO COVERAGE

☐ 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.c. EMPLOYER'S NON-OWNERSHIP LIABILITY

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

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, which are *not* specifically insured by the applicant as an owned vehicle.	$	$	$	$	$
Cost of Hire – Represents Total Long and Short Term Cost of Hire.	$	$	$	$	$

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

SECTION 12. FILINGS OR CERTIFICATES

Commercial Auto Application Filings Supplement Required

Is filing or specific limit(s) of liability required by law? ☐ Yes***** ☐ No If "Yes" to comply with:
☐ Motor Carrier Act of 1980 (MCS-90) 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.

*** Hired auto and non-owned auto liability coverage will be added to policy.**

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

Last Name	First Name	MI	Tax ID or Social Security No.

Type of Filing ☐ Owner's (operation of owned vehicles) ☐ Operator's (operation of non-owned vehicles) ☐ Both

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

SECTION 13. ADDITIONAL INFORMATION

Are any other vehicles owned by the Applicant? ☐ Yes ☐ No
If "Yes" complete the following.

Name of Insurance Company	Policy No.

Address of Insurance Company

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

Name of Firm/Carrier

Type of Business

Description of any owned, leased, hired, and non-owned vehicles which are *not* to be insured.

Year	Trade Make	Body Type	Vehicle Identification No.

SECTION 14. PAYMENT PLANS

☐ Option 1 - Full Annual Premium
☐ Option 2 - 40% or $300, whichever is greater, Premium Deposit with Single Bill Balance
☐ Option 3 - Installment Premium Payments (40% or $300 whichever is greater)*
⇨ $4.00 per installment charge
☐ Premium to be Financed – Name of Premium Finance Company**

_____

Payment by: ☐ Certified Funds ☐ 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 15. 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	Policy Period To	Name of Insurance Company
1st Prior				
2nd Prior				
3rd Prior				
4th Prior				

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

SECTION 16. 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. 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 Plan and the Policy Form prescribed for use.

NOTE: In the event there is no U.S. postmark (a metered mail postmark, electronic stamp, or other postage service or stamp are not considered a U.S. postmark), coverage will become effective no earlier than 12:01 a.m. on the day following receipt in the Plan Office.

Applicants requiring filings or a limit of liability in excess of $350,000 Combined Single Limits will be subject to a 15 day delay in the effective date as specified in Section 23 of the Kentucky 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.**

SECTION 17. PRODUCER OF RECORD STATEMENT

I hereby certify that I am a licensed broker/agent of the State of Kentucky. I have read the Kentucky 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 change to the policy resulting in a reduction of premium, I agree to return the unearned premium to the insured (net of any minimum premium due the carrier) and also to return to the carrier unearned compensation for this insurance received by me as required by the Plan.

My signature hereon represents certification of the Producer of Record Statement AND I certify this application is submitted pursuant to the effective date provisions contained in the Automobile Insurance Plan of this state.

_____ Date: _____ Hour: _____ ☐ A.M. ☐ P.M.
(Producer's Signature)

SECTION 18. APPLICANT'S STATEMENT

I, the Applicant, declare and certify that:
1. It has duly authorized the undersigned to execute this application on its behalf if the Applicant is not a natural person.
2. 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 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 premiums 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. I hereby certify that I do not owe any insurance company for automobile premiums due or contracted.
9. The Applicant designates as Producer of Record of this insurance the Producer or firm named in this application. The Applicant understands that any designated Producer cannot act as an agent of the Automobile Insurance Plan or any carrier for the purposes of this insurance and that the Producer has no authority to establish, alter or amend terms or conditions of coverage.
10. The Applicant hereby certifies that it does not own any insurance company for any automobile insurance premiums due or contracted during the preceding 12 months.
11. I hereby certify that Kentucky No-Fault Rejection Form KY.N.F.-1 has been available.

The Applicant hereby authorizes any insurer that may previously have provided coverage to the Applicant or to an 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.

_____ Date: _____ Hour: _____ ☐ A.M. ☐ P.M.
(Person authorized to sign for Applicant)

If additional named insureds are to be covered under a policy issued to the Applicant, authorized signatures for each such additional named insured shall be provided below. Such additional named insureds agree to be bound by the statements made by the Applicant in this forms.

_____ Date: _____ Hour: _____ ☐ A.M. ☐ P.M.
(Person authorized to sign for Additional Named Insured)

NOTICE TO APPLICANT AND PRODUCER

In the event acknowledgement of coverage is not received within 30 days, notify the Plan Office, (insert Plan address).

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.

WARNING

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

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

REMARKS SECTION

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