

# 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.

# PRIVATE PASSENGER/MOTORCYCLE APPLICATION DELAWARE AUTOMOBILE INSURANCE PLAN

Reference #:

Transmission Date:

EPAY:

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
Tax ID No.	Producer License No.	Telephone No.	Fax No.	

## SECTION 2. APPLICANT AND REGISTERED OWNER

Last Name	First Name	MI	Home Telephone No.	Business Telephone No.
Co-Applicant's Last Name (if applicable)	First Name	MI		
Street Address	Ste./Apt. No.	City	State	Zip Code
Mailing Address (if different from above)	Ste./Apt. No.	City	State	Zip Code

## SECTION 3. OPERATOR INFORMATION

(List all operators in household and any other drivers.)

Applicant's former addresses (past 3 years)											
Street Address						City		State	Zip Code		
Applicant and other Drivers	Relationship to Applicant	% Use of Vehicles				Birth Date Mo./Day/Yr.	Sex M/F	*MS	Driver's License No.	State	Licensed 3 Years? If "No", give date issued
		V1	V2	V3	V4						
APPLICANT	APPLICANT										<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 _____
*MS Marital Status: S-Single, M-Married, W-Widowed, D-Divorced, P-Separated, CU-Civil Union											
Applicant's Occupation		Nature of Business				Employer's Name					
Employer's Street Address						City		State	Zip Code		

## SECTION 4. FINANCIAL RESPONSIBILITY

Is applicant or other eligible operator residing in the same household required to file evidence of financial responsibility? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", complete the following:				
Name	License No.	State where Filing required	Type of Filing	Reason for Filing

## SECTION 5. INSURANCE RECORD

Name of applicant's latest carrier		Policy No.	Termination date
Was coverage through Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was 3 year assignment completed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "No", give reason terminated.	
Are any other vehicles owned by any member of household? <input type="checkbox"/> Yes <input type="checkbox"/> No		If "Yes", give name of insurer.	Policy No.

SECTION 6. NAMED NON-OWNER			Complete if applicant is for a named nonowner policy.				
A. Individual(s)	B. Exclusion for Furnished auto or available for regular use applies?	C. Type of vehicle individual will operate (priv. passenger, comm. or public)	D. Will vehicle be operated in occupation or business?	E. Is vehicle owned by member of insured's household?	F. If yes, to E., give name of company providing liability coverage		G. Is individual excluded?
	<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
	<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 7. VEHICLE 1 – VEHICLE INFORMATION AND VEHICLE USE									
Year	Make		Model		Body Style		H.P./Cu. In/CC		
Vehicle Identification No.			State Registered In	Territory	Rate Class	Penalty Points	Symbols Comp. Coll.		Miles to Work or Transportation
Purchased Mo / Yr.	<input type="checkbox"/> New <input type="checkbox"/> Used	Cost New	ACV (for camper bodies and trailers)	Damaged* <input type="checkbox"/> Yes <input type="checkbox"/> No	Altered* <input type="checkbox"/> Yes <input type="checkbox"/> No	Damaged Glass* <input type="checkbox"/> Yes <input type="checkbox"/> No		* If yes, detail in Remarks Section	
<input type="checkbox"/> Loss Payee <input type="checkbox"/> Lessor	Name		Street Address		City		State		Zip Code
<input type="checkbox"/> Pleasure <input type="checkbox"/> To Work\ School <input type="checkbox"/> Business <input type="checkbox"/> Commercial** <input type="checkbox"/> Farm **Applicable only for motorcycles used for commercial purposes.				Principal Address of Garaging					Cyls.
				Address of Applicant as Appears on Registration					

  

SECTION 7. VEHICLE 2 – VEHICLE INFORMATION AND VEHICLE USE									
Year	Make		Model		Body Style		H.P./Cu. In/CC		
Vehicle Identification No.			State Registered In	Territory	Rate Class	Penalty Points	Symbols Comp. Coll.		Miles to Work or Transportation
Purchased Mo / Yr.	<input type="checkbox"/> New <input type="checkbox"/> Used	Cost New	ACV (for camper bodies and trailers)	Damaged* <input type="checkbox"/> Yes <input type="checkbox"/> No	Altered* <input type="checkbox"/> Yes <input type="checkbox"/> No	Damaged Glass* <input type="checkbox"/> Yes <input type="checkbox"/> No		* If yes, detail in Remarks Section	
<input type="checkbox"/> Loss Payee <input type="checkbox"/> Lessor	Name		Street Address		City		State		Zip Code
<input type="checkbox"/> Pleasure <input type="checkbox"/> To Work\ School <input type="checkbox"/> Business <input type="checkbox"/> Commercial** <input type="checkbox"/> Farm **Applicable only for motorcycles used for commercial purposes.				Principal Address of Garaging					Cyls.
				Address of Applicant as Appears on Registration					

  

SECTION 7. VEHICLE 3 – VEHICLE INFORMATION AND VEHICLE USE									
Year	Make		Model		Body Style		H.P./Cu. In/CC		
Vehicle Identification No.			State Registered In	Territory	Rate Class	Penalty Points	Symbols Comp. Coll.		Miles to Work or Transportation
Purchased Mo / Yr.	<input type="checkbox"/> New <input type="checkbox"/> Used	Cost New	ACV (for camper bodies and trailers)	Damaged* <input type="checkbox"/> Yes <input type="checkbox"/> No	Altered* <input type="checkbox"/> Yes <input type="checkbox"/> No	Damaged Glass* <input type="checkbox"/> Yes <input type="checkbox"/> No		* If yes, detail in Remarks Section	
<input type="checkbox"/> Loss Payee <input type="checkbox"/> Lessor	Name		Street Address		City		State		Zip Code
<input type="checkbox"/> Pleasure <input type="checkbox"/> To Work\ School <input type="checkbox"/> Business <input type="checkbox"/> Commercial** <input type="checkbox"/> Farm **Applicable only for motorcycles used for commercial purposes.				Principal Address of Garaging					Cyls.
				Address of Applicant as Appears on Registration					

SECTION 7. VEHICLE 4 – VEHICLE INFORMATION AND VEHICLE USE												
Year		Make		Model		Body Style		H.P./Cu. In/CC				
Vehicle Identification No.				State Registered In		Territory	Rate Class	Penalty Points	Symbols Comp. Coll.		Miles to Work or Transportation	
Purchased Mo / Yr.		<input type="checkbox"/> New <input type="checkbox"/> Used	Cost New	ACV (for camper bodies and trailers)		Damaged* <input type="checkbox"/> Yes <input type="checkbox"/> No		Altered* <input type="checkbox"/> Yes <input type="checkbox"/> No		Damaged Glass* <input type="checkbox"/> Yes <input type="checkbox"/> No		* If yes, detail in Remarks Section
<input type="checkbox"/> Loss Payee <input type="checkbox"/> Lessor		Name		Street Address			City			State	Zip Code	
<input type="checkbox"/> Pleasure <input type="checkbox"/> To Work\ School <input type="checkbox"/> Business <input type="checkbox"/> Commercial** <input type="checkbox"/> Farm **Applicable only for motorcycles used for commercial purposes.				Principal Address of Garaging						Cyls.		
				Address of Applicant as Appears on Registration								
SECTION 8. EXTENDED NON OWNED AUTO COVERAGE												
Is the auto furnished to an individual, spouse, or resident individual for their regular use?						<input type="checkbox"/> Yes		<input type="checkbox"/> No				
Is primary liability insurance in effect for the auto furnished for regular use?						<input type="checkbox"/> Yes		<input type="checkbox"/> No				
Name of individual to be covered: _____												
Is the auto furnished used as a public or livery conveyance?						<input type="checkbox"/> Yes		<input type="checkbox"/> No				
SECTION 9. COVERAGES				As provided by the Rules of the Plan. Same limits of liability must be purchased for all vehicles.								
Check appropriate box for coverage. (If special limits are required by law, complete premium section and indicate required limits in Remarks Section.)						Vehicle 1 Premiums	Vehicle 2 Premiums	Vehicle 3 Premiums	Vehicle 4 Premiums			
Bodily Injury Liability <input type="checkbox"/> \$25/50,000 <input type="checkbox"/> \$50/100,000 <input type="checkbox"/> \$100/300,000												
Property Damage Liability <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000												
Personal Injury Protection (PIP) Deductible <input type="checkbox"/> Applicable to named insured only <input type="checkbox"/> Applicable to named insured and members of household  Basic <input type="checkbox"/> \$15/\$30,000  Additional PIP <input type="checkbox"/> \$25/50,000 <input type="checkbox"/> \$50/100,000 <input type="checkbox"/> \$100/300,000												
Private Passenger and miscellaneous non-fleet risks (Excluding Motorcycles) <input type="checkbox"/> Full Coverage or Deductible <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000												
Restricted Coverage (Motorcycles Only) <input type="checkbox"/> Full Coverage or Deductible <input type="checkbox"/> \$100 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$3,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000												
Unrestricted Coverage (Motorcycles Only) <input type="checkbox"/> Full Coverage or Deductible <input type="checkbox"/> \$100 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$3,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000												
Uninsured Motorist (UM) – (Available Up to Policy Limits)  Bodily Injury <input type="checkbox"/> \$25/50,000 <input type="checkbox"/> \$50/100,000 <input type="checkbox"/> \$100/300,000  Property Damage <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000  <input type="checkbox"/> I Accept <input type="checkbox"/> Reject Uninsured / Underinsured Motorist Coverage												
Physical Damage – Comprehensive and Collision Deductible \$100 \$250 \$500 \$1,000 Veh. 1 _____ Veh. 2 _____ Veh. 3 _____ Veh. 4 _____												
Customized Equipment Stated Amount Veh. 1 _____ Veh. 2 _____ Veh. 3 _____ Veh. 4 _____												
Extended Nonowned Auto - If requested, complete Section 8.												
Estimated Total Premium per vehicle												
Total Estimated Premium for vehicles 1 – 4												

<b>SECTION 10. PAYMENT PLANS</b>		<b>Premium deposit may be electronically transmitted, or paid by check or money order. The electronic payment option is not available if the full premium payment or any portion of the deposit is financed.</b> <b>Method of payment:</b> <input type="checkbox"/> Electronic payment option <input type="checkbox"/> Check or money order			
<input type="checkbox"/> Option 1 - Full Annual Premium <input type="checkbox"/> Option 2 - Installment Premium Payment* (25% Downpayment, 5 installments, \$4.00 per installment charge) <input type="checkbox"/> Option 3 - Advance Premium Payment Option (30% Downpayment, balance of total annual premium due within 30 days of receipt of policy) <input type="checkbox"/> Premium to be Financed**		Total Estimated Premium Amount Submitted with Application		* Not Available on Premium Financed Policies. ** Attach a Copy of Premium Finance Contract.	
_____ (Name of Premium Finance Company)					
<b>SECTION 11. CONVICTIONS</b>		<b>(Motor Vehicle and Non-Motor Vehicle)</b>			
Has the applicant or anyone who usually drives the applicant's motor vehicle(s) been CONVICTED or FORFEITED BAIL at any time during the immediately preceding THIRTY-SIX months? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", complete the following. (If necessary, use Remarks Section.) NOTE: A paid ticket or fine is an admission of guilt and therefore constitutes a conviction.					
Name of Operator	Date of Conviction	Did Conviction Arise as a Result of an Accident?	Type of Violation	Place of Conviction	
		<input type="checkbox"/> Yes <input type="checkbox"/> No		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			
<b>SECTION 12. ACCIDENTS</b>					
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 immediately preceding THIRTY-SIX months? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", complete the following. (If necessary, use Remarks Section.)					
Name of Operator	Accident Date	Place of Accident		Bodily Injury or Death	Prop. Damage Amount (incl. your own)
		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	
If the answer to any of the following is Yes, check "Yes" box and give date of accident. 1. Applicant's motor vehicle lawfully parked. 2. Applicant reimbursed by or on behalf of person responsible for the accident or has judgment against such person. 3. Other person involved in accident was convicted. Applicant or operator was not convicted. (See NOTE under Sect. 10) 4. Damaged by "Hit-and-Run" driver and accident reported to police within 24 hours from time of accident. 5. Other type accident – non-chargeable under provisions of the Plan. (If "Yes", describe accident in Remarks Section.)					<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes
					Date(s) of Accident(s) _____ _____ _____ _____
<b>SECTION 13. CERTIFICATION – EVIDENCE OF INSURANCE AND EFFECTIVE DATE OF COVERAGE</b>					
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: 1. <b>Electronic Application Submission Private Passenger Application with Electronic Payment Option:</b> The completed signed application must be electronically transmitted to the Plan no later than two working days following the transmittal of the application and deposit to the Plan. 2. <b>Electronic Application Submission Private Passenger Application with Regular Check or Money Order Option:</b> The original completed signed application and deposit must be forwarded to the Plan and received by the Plan no later than 15 calendar days following the date of transmission of the application. 3. <b>Alternate Application Submission Procedure Applications:</b> The producer must forward the original, completed, signed application and deposit check to the Plan no later than the second working day after the date the application is written which is not a Saturday, Sunday, or Legal Holiday. 4. 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. 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 coverages of insurance afforded hereunder in accordance with the rules of the Automobile Insurance Plan. 5. A premium charge will be made for these coverages if the policy, when and as issued, is not accepted by the insured. 6. 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 Automobile Insurance Plan.					
Requested Effective Date and Time: Example: 09/01/2019 11:30 AM		<b>IN NO EVENT SHALL COVERAGE BE EFFECTIVE PRIOR TO THE DATE AND HOUR OF COMPLETION OF THIS APPLICATION.</b>			
<b>PRODUCER OF RECORD STATEMENT:</b> I do hereby certify that I am a licensed broker, 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. In the event of cancellation or a policy change resulting in a reduction of premium, I agree to return any compensation that has been paid which is in excess of the compensation due on the earned premium received by the company.					
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: _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.			

**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.

**NOTICE TO APPLICANT AND PRODUCER**

In the event acknowledgement of coverage is not received within 45 days, notify the DE Plan, P O Box 3530, Johnston, RI 02940-6530.

**SECTION 14. CERTIFICATION - APPLICANT'S STATEMENT****I, the Applicant, declare and certify that:**

1. I have tried and failed to obtain automobile insurance in this state within the preceding 60 days and have been unable to obtain such insurance at rates not exceeding those applicable under the Plan.
2. To the best of my knowledge and belief all statements contained in this application are true and that these statements are offered as an inducement to the Company to issue the policy for which I am applying.
3. I will pay all premiums when due.
4. I hereby certify that I do not owe any insurance company for automobile insurance premiums due.
5. I designate as Producer of Record for this insurance the producer or firm named in this application and I understand he / she is not acting as an agent of any company for the purposes of this insurance.
6. 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.

\_\_\_\_\_  
(Applicant's Signature) Date: \_\_\_\_\_ Hour: \_\_\_\_\_ ☐ A.M. ☐ P.M.

**DISCOUNTS AND CREDITS SECTION**

Multi Car Discount		Discount Applied <input type="checkbox"/> V1 <input type="checkbox"/> V2 <input type="checkbox"/> V3 <input type="checkbox"/> V4
Motor Vehicle Accident Prevention Course Discount	Course Taken <input type="checkbox"/> Op1 <input type="checkbox"/> Op2 <input type="checkbox"/> Op3 <input type="checkbox"/> Op4 Refresher Taken <input type="checkbox"/> Op1 <input type="checkbox"/> Op2 <input type="checkbox"/> Op3 <input type="checkbox"/> Op4 Instructor <input type="checkbox"/> Op1 <input type="checkbox"/> Op2 <input type="checkbox"/> Op3 <input type="checkbox"/> Op4	Credit Applied <input type="checkbox"/> V1 <input type="checkbox"/> V2 <input type="checkbox"/> V3 <input type="checkbox"/> V4
Limited Drive to Work Discount		Discount Applied <input type="checkbox"/> V1 <input type="checkbox"/> V2 <input type="checkbox"/> V3 <input type="checkbox"/> V4
Travellink Car Pool Discount	Operator Eligible <input type="checkbox"/> Op1 <input type="checkbox"/> Op2 <input type="checkbox"/> Op3 <input type="checkbox"/> Op4	Discount Applied <input type="checkbox"/> V1 <input type="checkbox"/> V2 <input type="checkbox"/> V3 <input type="checkbox"/> V4

**MAILING INFORMATION**

**Delaware Automobile Insurance Plan**  
**P O Box 6530**  
**Providence, RI 02940-6530**

**REMARKS SECTION**