

GEORGIA AUTOMOBILE INSURANCE PLAN ALTERNATE APPLICATION REPORT FORM

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

SECTION 1. PRODUCER/APPLICANT INFORMATION				
a.	Agency Name (if applicable)	Telephone Number (include area code)	Extension	
	Producer Name	License Number		
	Mailing Address	City	State	Zip Code
b.	Applicant Name	Applicant's Date of Birth (mm/dd/yyyy)		
	Address	City	State	Zip Code

SECTION 2. DATE AND TIME ALTERNATE APPLICATION PROCEDURE WAS USED	
Date: _____	Hour: _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.

SECTION 3. REASON(S) ALTERNATE APPLICATION SUBMISSION PROCEDURE WAS USED
<input type="checkbox"/> Unable to connect with the internet. Internet-ISP Service provider: _____
<input type="checkbox"/> Other service provider had technical difficulties (Specify difficulties in Section 4.) Service provider: _____
<input type="checkbox"/> Severe weather conditions affected access/transmit data. (Specify location in Section 4.)
<input type="checkbox"/> EASI website unavailable. Provide error message given. _____
<input type="checkbox"/> Computer difficulties (Specify difficulties in Section 4.)
<input type="checkbox"/> Other (Specify in Section 4.)

SECTION 4. 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 5. 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 Governing Committee and/or the Insurance Department for appropriate action.	
_____ Producer Signature	_____ Date

SECTION 6. 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 AUTOMOBILE/MOTORCYCLE APPLICATION GEORGIA AUTOMOBILE INSURANCE PLAN

EASi Reference #:

Transmission Date:

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

**PRIVATE PASSENGER APPLICATION
GEORGIA AUTOMOBILE INSURANCE PLAN**
MAIL TO: P.O. Box 6530, Providence, RI 02940-6530
THIS APPLICATION MUST BE SIGNED BY THE
APPLICANT AND PRODUCER.

The Applicant should understand that this is an application for insurance to be written through the Georgia Automobile Insurance Plan, and the applicant may be able to obtain insurance coverage in the voluntary market by making inquiry of more than one source.

FOR PLAN USE ONLY
Postmark Date: _____
Effective Date: _____
Money: \$ _____
Initials: _____

SECTION 1. PRODUCER OF RECORD

Producer Last Name/Agency Name		Producer First Name			MI
Mailing Address		Ste./Apt. No.	City	State	Zip Code + 4
Tax ID or Social Security No.	Producer License No.	Telephone No.	Fax No.		

SECTION 2. APPLICANT

Last Name		First Name		MI	Applicant's Home Telephone No	
Co-Applicant's Last Name (if applicable)		First Name		MI	Applicant's Business Telephone No.	
Mailing Address		Ste./Apt. No.	City	State	Zip Code + 4	County
Street Address (If different than above)		Ste./Apt. No.	City	State	Zip Code + 4	County
Address Is : <input type="checkbox"/> Inside City Limits <input type="checkbox"/> Outside City Limits						

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 + 4					
DOES ANYONE IN THE HOUSEHOLD HAVE A PROBATIONARY OR LIMITED DRIVER'S LICENSE? <input type="checkbox"/> YES <input type="checkbox"/> NO If "Yes", give name of person(s).											
Applicant, and Other Drivers	Relationship to Applicant	% Use of each Vehicle				Birth Date Mo./Day/Yr.	Sex M/F	*MS	Driver's License No. or Permit No.	State	Licensed 3 Years? If "No", give date Issued
APPLICANT	APPLICANT	V1	V2	V3	V4						<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

Applicant's Occupation		Nature of Business		Employer's Name	
Employer's Street Address		City		State	Zip Code + 4
Other Driver's Occupation		Nature of Business		Employer's Name	
Employer's Street Address		City		State	Zip Code + 4

PRODUCER MUST INCLUDE ALL ESTIMATED PREMIUMS ON THE APPLICATION. IF NOT INCLUDED APPLICATION WILL BE REJECTED.

SECTION 4. VEHICLE 1 – VEHICLE INFORMATION AND VEHICLE USE										
Year		Make		Model			Body Style		H.P./Cu. In.CC	
Vehicle Identification No.				Registered Owner's Last Name			First Name			
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, give details			
<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"/> Farm <input type="checkbox"/> Business		Principal Address of Garaging				Miles one way to work, school or transportation		Est. Annual Mileage		
Applicant address as it appears on registration, if different from Section 2.				State Registered In	Territory	Rate Class	Penalty Points	Symbols Comp. Coll.		Age Group
SECTION 4. VEHICLE 2 – VEHICLE INFORMATION AND VEHICLE USE										
Year		Make		Model			Body Style		H.P./Cu. In.CC	
Vehicle Identification No.				Registered Owner's Last Name			First Name			
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, give details			
<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"/> Farm <input type="checkbox"/> Business		Principal Address of Garaging				Miles one way to work, school or transportation		Est. Annual Mileage		
Applicant address as it appears on registration, if different from Section 2.				State Registered In	Territory	Rate Class	Penalty Points	Symbols Comp. Coll.		Age Group
SECTION 4. VEHICLE 3 – VEHICLE INFORMATION AND VEHICLE USE										
Year		Make		Model			Body Style		H.P./Cu. In.CC	
Vehicle Identification No.				Registered Owner's Last Name			First Name			
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, give details			
<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"/> Farm <input type="checkbox"/> Business		Principal Address of Garaging				Miles one way to work, school or transportation		Est. Annual Mileage		
Applicant address as it appears on registration, if different from Section 2.				State Registered In	Territory	Rate Class	Penalty Points	Symbols Comp. Coll.		Age Group

SECTION 4. VEHICLE 4 – VEHICLE INFORMATION AND VEHICLE USE										
Year		Make		Model			Body Style		H.P./Cu. In.CC	
Vehicle Identification No.				Registered Owner's Last Name			First Name			
Purchase d 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, give details			
<input type="checkbox"/> Loss Payee <input type="checkbox"/> Lessor	Name		Street Address			City		State	Zip Code	
<input type="checkbox"/> Pleasure <input type="checkbox"/> Farm	<input type="checkbox"/> To Work\School <input type="checkbox"/> Business	Principal Address of Garaging				Miles one way to work, school or transportation		Est. Annual Mileage		
Applicant address as it appears on registration, if different from Section 2.				State Registered In	Territory	Rate Class	Penalty Points	Symbols Comp Coll.		Age Group

SECTION 4.a. TRANSPORTATION NETWORK COMPANY USE									
Does the applicant or anyone who usually drives the applicant's vehicle(s) work as a driver for a transportation network (ride-sharing) company? <input type="checkbox"/> Yes <input type="checkbox"/> No									

SECTION 5. COVERAGES					(As provided by the Rules of the Plan.)				
Same limits of liability must be purchased for all vehicles Check appropriate box for coverage					Vehicle 1 Estimated Premium	Vehicle 2 Estimated Premium	Vehicle 3 Estimated Premium	Vehicle 4 Estimated Premium	
Bodily Injury Liability <input type="checkbox"/> \$25,000/50,000 <input type="checkbox"/> \$50,000/100,000 <input type="checkbox"/> \$100,000/300,000									
Property Damage Liability <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000									
Medical Payments Coverage (Available for 4 wheel vehicles only) <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000									
Physical Damage - Comprehensive Full Deductibles: \$100 \$250 \$500 \$1,000 Veh. 1 _____ Veh. 2 _____ Veh. 3 _____ Veh. 4 _____									
Physical Damage - Collision Full Deductibles: \$100 \$250 \$500 \$1,000 Veh. 1 _____ Veh. 2 _____ Veh. 3 _____ Veh. 4 _____									
Loss of Use Veh. 1 _____ Veh. 2 _____ Veh. 3 _____ Veh. 4 _____									
Custom Equipment (other than original manufacturer equipment) (attach list) Actual Cash Value Above \$1,500 Veh. 1 _____ Veh. 2 _____ Veh. 3 _____ Veh. 4 _____									
Uninsured Motorist <input type="checkbox"/> \$25,000/50,000/25,000 <input type="checkbox"/> \$50,000/100,000/25,000 <input type="checkbox"/> \$100,000/300,000/25,000 <input type="checkbox"/> \$100,000/300,000/50,000									

If UM is accepted, all applicants must read and sign the GA UM Coverage Notice 01.09 (Eff. 01.01.2009) – found at <https://www.aipso.com/Plansites/Georgia.aspx>. This notice must be submitted with this application.

Uninsured Motorist - Property Damage Deductibles: <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000				
Estimated Total Premium Per Vehicle	\$	\$	\$	\$
Total Estimated Premium For Vehicles 1 – 4	\$			

NOTE: If Limits, Deductibles and Premiums are not shown on "Coverage" lines above, NO Coverage will be provided.

SECTION 5a. PROTECTION AGAINST UNINSURED MOTORISTS	
<p>In keeping with the provisions of the laws of the State of Georgia, I/(WE) hereby request that the Service Center on behalf of the assigned company proceed as indicated as respects the policy of bodily injury/property damage liability insurance on the described motor vehicle(s) and of such policy or policies to be issued.</p> <p><input type="checkbox"/> I/we reject UM coverage entirely - protection for bodily injury and protection for property damage caused by an uninsured or an unidentified motorist.</p> <p><input type="checkbox"/> I/we reject UM coverage added on to at-fault liability limits and elect UM coverage reduced by at - fault liability limits.</p> <p><input type="checkbox"/> I/we elect coverage for protection for bodily injury and property damage caused by an uninsured or an unidentified motorist with Limits of liability of \$ _____ / \$ _____ / \$ _____ and reject all higher limits.</p> <p>It is understood that if I/we reject Uninsured Motorists coverage as indicated above, the rejection applies on a continuing basis to policy renewals, policy replacements, and additional or replacement vehicle(s) insured under this policy or subsequently issued policies. Coverage may be added at any time by completing a Policy Change request form.</p>	
APPLICANT'S SIGNATURE _____	DATE _____

SECTION 6. FINANCIAL RESPONSIBILITY			Is the applicant or other eligible operator required to file evidence of financial responsibility? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Name	Resides with Applicant	State where Filing Required	Case or File No.	Reason for Filing	Type of Filing	Do you own any other vehicles?	If "Yes", give Name of Ins. Co.	Policy No.		
	<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Owner* <input type="checkbox"/> Operator** <input type="checkbox"/> Both	<input type="checkbox"/> Yes <input type="checkbox"/> No				
	<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Owner* <input type="checkbox"/> Operator** <input type="checkbox"/> Both	<input type="checkbox"/> Yes <input type="checkbox"/> No				
	<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Owner* <input type="checkbox"/> Operator** <input type="checkbox"/> Both	<input type="checkbox"/> Yes <input type="checkbox"/> No				
	<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Owner* <input type="checkbox"/> Operator** <input type="checkbox"/> Both	<input type="checkbox"/> Yes <input type="checkbox"/> No				
SECTION 7. PAYMENT PLANS										
<input type="checkbox"/> Option 1 - Full Annual Premium <input type="checkbox"/> Option 2 - Advanced Premium Payment *+ <input type="checkbox"/> Option 3 - Installment Premium Payments*+ <input type="checkbox"/> Option 4 - Premium to be Financed+ Name of Premium Finance Company**			Total Estimated Premium \$ Amount Submitted with Application \$			<i>* Not Available on Premium Financed Policies. + Not Available for SR-22. ** Attach a copy of Premium Finance contract.</i>				
DISCOUNTS AND CREDITS SECTION										
Discounts and Credits by Operator (must submit proof of eligibility)				Operator 1		Operator 2		Operator 3		Operator 4
Good Student Driver Discount				<input type="checkbox"/> Yes		<input type="checkbox"/> Yes		<input type="checkbox"/> Yes		<input type="checkbox"/> Yes
Defensive Driving Course Credit				<input type="checkbox"/> Yes		<input type="checkbox"/> Yes		<input type="checkbox"/> Yes		<input type="checkbox"/> Yes
SECTION 8. INSURANCE RECORD			Has applicant had insurance in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes If "Yes", complete the following.							
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.						
Does applicant (or anyone who usually drives the applicant's motor vehicles) owe any insurance company for any automobile premium? (If "Yes", give details)										
SECTION 8a. ADDITIONAL INSURANCE INFORMATION										
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 9. 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", complete the following. (If necessary, use Remarks Section.)										
Name of Operator	Accident Date Mo./Day/Yr.	Place of Accident		Bodily Injury or Death	Amount of Property Damage (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. See manual for exception. 1. Applicant's motor vehicle lawfully parked. 2. Applicant reimbursed by or on behalf of person responsible for the accident or has such judgment against such person. 3. Other person involved in accident was convicted. Applicant or operator was not convicted. 4. Damaged by "Hit-and-Run" Driver and accident reported to police within 24 hours from time of accident. 5. Involved in accident in which only a first party Medical Coverage Claim was made. 6. Other type of accident -- non-chargeable under provisions of the Plan. If "Yes", describe in Remarks Section				<input type="checkbox"/> Yes <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) _____ _____ _____ _____ _____					

SECTION 10. CONVICTIONS (Motor Vehicle and Non-Motor Vehicle)

Has the applicant or anyone who usually drives the applicant's motor vehicle(s) been CONVICTED or FORFEITED BAIL or a DETERMINATION BY A JUVENILE COURT AUTHORITY at any time during the immediately preceding **THIRTY-SIX** months? Convicted: Yes No Forfeited Bail: Yes No Juvenile Court Authority: Yes No If "Yes", for either item, 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 or Forfeiture of Bail or a Juvenile Court Authority	Did Conviction Arise as a Result of Accident?	Nature of Violation	Place of Conviction		Penalty Points	Was License Suspended or Revoked?
				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
		<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 11. NON-OWNER Complete if application is for a non-owner policy.

Applicant elects coverage for vehicles furnished or available for regular use. Yes No

Operator 1	Type of vehicle that will be operated. <input type="checkbox"/> Priv Pass <input type="checkbox"/> Comm <input type="checkbox"/> Taxi/Bus <input type="checkbox"/> Other (describe) _____
	Will vehicle be operated in applicant's occupation or business? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of Insurance Company providing liability coverage. _____
	Is vehicle owned by applicant or member of household? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of Insurance Company providing liability coverage. _____
	Is applicant excluded? <input type="checkbox"/> Yes <input type="checkbox"/> No
Operator 2	Type of vehicle that will be operated. <input type="checkbox"/> Priv Pass <input type="checkbox"/> Comm <input type="checkbox"/> Taxi/Bus <input type="checkbox"/> Other (describe) _____
	Will vehicle be operated in applicant's occupation or business? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of Insurance Company providing liability coverage. _____
	Is vehicle owned by applicant or member of household? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of Insurance Company providing liability coverage. _____
	Is applicant excluded? <input type="checkbox"/> Yes <input type="checkbox"/> No
Operator 3	Type of vehicle that will be operated. <input type="checkbox"/> Priv Pass <input type="checkbox"/> Comm <input type="checkbox"/> Taxi/Bus <input type="checkbox"/> Other (describe) _____
	Will vehicle be operated in applicant's occupation or business? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of Insurance Company providing liability coverage. _____
	Is vehicle owned by applicant or member of household? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of Insurance Company providing liability coverage. _____
	Is applicant excluded? <input type="checkbox"/> Yes <input type="checkbox"/> No
Operator 4	Type of vehicle that will be operated. <input type="checkbox"/> Priv Pass <input type="checkbox"/> Comm <input type="checkbox"/> Taxi/Bus <input type="checkbox"/> Other (describe) _____
	Will vehicle be operated in applicant's occupation or business? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of Insurance Company providing liability coverage. _____
	Is vehicle owned by applicant or member of household? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of Insurance Company providing liability coverage. _____
	Is applicant excluded? <input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 12. EXTENDED NONOWNED

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

PRODUCER OF RECORD STATEMENT I do hereby certify that I am a licensed broker or agent of the State of Georgia and that I hold a Certificate of Authority from at least one Insurance Company licensed to write automobile liability and physical damage insurance in the State. (Name Company below.) I have read the Georgia 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 made 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 Service Center on behalf of the assigned company. I certify this application is submitted pursuant to the effective date provisions contained in the Automobile Insurance Plan of this State.

Name of Company _____

List reason why applicant is applying for coverage through the Plan _____

PRODUCER CANNOT BIND COVERAGE

A copy of the current producer's license must be attached

Producer must Submit Gross Premium and Not Withhold Commission

Date: _____

Print Producer's Name

Date: _____

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 assigned company or Service Center on behalf of the assigned company may have an investigative consumer report made including information obtained from various sources bearing on character, general reputation, personal characteristics or mode of living and, upon the individual's written request, will provide a copy of such report to the applicant if such a report is procured. The applicant has the further right to a personal interview with regard to such report if requested.

FRAUD WARNING

A person commits a fraudulent insurance act if he or she knowingly and with intent to defraud presents, causes to be presented, or prepares with knowledge or belief that it will be presented, to or by an insurer, purported insurer, broker, or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of, an insurance policy, or a claim for payment or other benefit pursuant to an insurance policy, which he or she knows to contain materially false information concerning any fact material thereto or if he or she conceals, for the purpose of misleading another, information concerning any fact material thereto.

APPLICANT'S STATEMENT

IMPORTANT: READ CAREFULLY BEFORE SIGNING

I declare and certify that:

1. Within the past sixty (60) days I have tried and failed to obtain automobile insurance from the following two Insurance Companies
(Company 1) _____
(Company 2) _____

Reason for which coverage was declined

2. To the best of my knowledge and belief that all statements contained in the application are true and that these statements are offered as an inducement to the Service Center on behalf of the assigned company to issue the policy for which I am applying.
3. I realize that any misleading information or failure to disclose required information will be considered lack of good faith on my part, and may cause cancellation of my coverage.
4. I will pay all premiums when due.
5. I designate as Producer of Record of this insurance the Producer or firm named in this application and I understand that he/she is not acting as a Producer of the Automobile Insurance Plan or Service Center or any assigned Company for the purpose of this insurance.
6. I certify that I do not owe any insurance company for automobile premiums due or contracted during the preceding 12 months.
7. I understand that no coverage will be afforded during any period of time any vehicle(s) is used by an applicant or anyone who usually drives the applicant's vehicle(s) while logged into a transportation network platform (ride-sharing application).

AUTHORIZATION FOR DRIVER'S OPERATING RECORDS: I hereby authorize the Service Center on behalf of the assigned company to obtain from the Georgia Department of Public Safety a copy of my Motor Vehicle Report for the use in rating and/or underwriting the insurance for which I do hereby apply, and any renewal thereof. I understand that in obtaining a Motor Vehicle Report, a consumer reporting agency may be used by the Service Center on behalf of the assigned company and I do hereby authorize such use. I hereby certify that the drivers in my household named in Section 3 of this application have authorized me to consent on their/his/her behalf for the Service Center on behalf of the assigned company to obtain Motor Vehicle Report(s) for rating and/or underwriting.

EFFECTIVE DATE I am aware that I am applying for insurance through the Georgia Automobile Insurance Plan and I understand that I am not covered immediately for insurance.

NOTE: In the event there is no U.S. postmark, or the postmark is not legible, is a metered mail postmark, electronic stamp, or any other postage service or stamp, the coverage will be effective at 12:01 A.M. on the day of receipt by the Plan Office. In the event an application is hand delivered, coverage will be effective at 12:01 A.M. on the day following receipt by the Plan Office.

Desired Effective date and time:

Example: 09/ 01/2012 11:30 AM

PREMIUM DETERMINATION I understand that the premium shown on this application is an estimated premium. The Service Center on behalf of the assigned company reserves the right to adjust the premium either prior to or after the issuance of the Policy, whenever applicable.

X _____
APPLICANT'S SIGNATURE

DATE

NOTICE TO APPLICANT AND PRODUCER

In the event acknowledgement of coverage is not received within 30 days, notify the Plan Office, P.O. Box 6530, Providence, Rhode Island 02940-6530

MAILING INFORMATION

Send completed application with check, money order, (Financial Responsibility Filings require a cashier's check or money order) and required attachments to:

Georgia Automobile Insurance Plan
P.O. Box 6530
Providence, Rhode Island 02940-6530

Remarks:

Empty box for Remarks.