



APPLICATION FORM Automobile Insurance

Date: _____ Customer Code _____ Policy No. _____

NAME OF APPLICANT _____ SOCIAL SECURITY NO. _____

MAILING ADDRESS _____

PHYSICAL ADDRESS _____

CONTACT NO. (WORK) _____ (Home) _____ (Other) _____

COVERAGE PERIOD Effective Date _____ Expiration Date _____

COVERAGE DETAILS:

| VEHICLE DESCRIPTION: | | VEHICLE DESCRIPTION: | | VEHICLE DESCRIPTION: | |
|----------------------------------|-----------------|----------------------------------|-----------------|----------------------------------|-----------------|
| AGREED VALUE: | | AGREED VALUE: | | AGREED VALUE: | |
| VIN: | | VIN: | | VIN: | |
| LICENSE PLATE NO.: | | LICENSE PLATE NO.: | | LICENSE PLATE NO.: | |
| Comprehensive (Deductible) | \$ | Comprehensive (Deductible) | \$ | Comprehensive (Deductible) | \$ |
| Collision (Deductible) | \$ | Collision (Deductible) | \$ | Collision (Deductible) | \$ |
| Typhoon (Deductible) | \$ | Typhoon (Deductible) | \$ | Typhoon (Deductible) | \$ |
| Bodily Injury | Per Person \$ | Bodily Injury | Per Person \$ | Bodily Injury | Per Person \$ |
| | Per Accident \$ | | Per Accident \$ | | Per Accident \$ |
| Property Damage | Per Accident \$ | Property Damage | Per Accident \$ | Property Damage | Per Accident \$ |
| Uninsured Motorist Bodily Injury | Per Person \$ | Uninsured Motorist Bodily Injury | Per Person \$ | Uninsured Motorist Bodily Injury | Per Person \$ |
| | Per Accident \$ | | Per Accident \$ | | Per Accident \$ |
| Med Pay | Per Person \$ | Med Pay | Per Person \$ | Med Pay | Per Person \$ |
| Loss of Use | \$ | Loss of Use | \$ | Loss of Use | \$ |

For additional vehicles, attach "Additional Vehicles" form.

LOSS PAYEE _____ Total Premium \$

Please initial to indicate that all available coverages have been explained to you. _____

- A. Do you require Typhoon Coverage on your auto? Yes No
- B. Would you require Loss of Use Coverage? Yes No
- C. Would you require Medical Coverage? Yes No
- D. Would you require Uninsured Motorist Coverage? Yes No
- E. Does your auto have an alarm installed? Yes No
- F. Are there any full time student drivers? Yes No

G. Please indicate with whom you were previously insured: _____

LISTING OF ALL DRIVERS (Household and other members):

| NAME | RELATION TO APPLICANT | DATE OF BIRTH | SEX | OCCUPATION |
|------|-----------------------|---------------|-----|------------|
| | | | | |
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QUESTIONNAIRE

All questions must be answered. Failure to do so will result in the delay of processing your application. Please explain any 'Yes' answer in the remarks below.

- 1. Has any driver had auto insurance declined or cancelled? Yes No
- 2. Has any driver had their license revoked, suspended or refused? Yes No
- 3. Has any user been involved in an accident (as a driver) in the past 3 years? Yes No
- 4. Has any user been convicted of a moving traffic violation in the past 3 years? Yes No
- 5. Does described vehicle have any cracked / broken glass or other damage? Yes No
- 6. Do you or any driver have a physical or mental deficiency or impairment? Yes No
- 7. Would you like your policy(s) renewed automatically at expiration? Yes No

REMARKS

I hereby warrant the truth of the above statements, and I declare that I have not withheld any information whatever with night tend in any way to influence the acceptance of this application. Additionally, I warrant that only persons holding a valid drivers license will operate my automobile. Specifically, I agree to advise the Company in writing if the age of the youngest male driver will be other than as stated herein. I understand that any false statement by me will constitute a breach of warranty and cause the policy to be void. I agree that this application shall be the basis of the policy between the company and me.

Applicant's Signature _____ Authorized Representative _____

Date _____ Time _____ Date _____ Time _____