COMMERCIAL/TRUCKERS/PUBLIC AUTOMOBILE

OHIO

AUTOMOBILE INSURANCE PLAN APPLICATION

MAIL TO: 172E. State St., Suite 201
Columbus, OH. 43215

This application must be PRINTED IN INK OR TYPED AND SIGNED BY THE APPLICANT AND PRODUCER.

STATEMENT OF THE PRODUCER OF RECORD

I do hereby certify that I am a licensed broker, agent, of the state of Ohio. I have read the Ohio 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 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 returned premium.

1. Producer	Telephone (Incl. Area Code) ( )	Producer's License No.	Producer's IRS or Soc. Sec. No.
Street	City	State	Zip Code

2. Applicant	Street Address	Apt. No.
City	County	State	Zip Code	Home ( )	Telephone (Incl. Area Code)	Business ( )
Business of Applicant (Describe)	Self Employed ☐ Yes ☐ No	Headquarters Address

☐ Individual ☐ Partnership ☐ Corporation ☐ Other _____

Loss Payee	Name	Street	City	State	Zip Code
Unit No. 1					
Unit No. 2					
Unit No. 3					
Unit No. 4					

3. OPERATOR INFORMATION: Names of Owners, Employees and Relatives who will operate owned autos:

Name	Date of Birth	Driver's License No. & State	Name	Date of Birth	Driver's License No. & State
1.			5.		
2.			6.		
3.			7.		
4.			8.		

4.a. VEHICLE DESCRIPTION:

Unit No.	Owned - O Leased - L	Year	State of Reg.	Make Trade Name	Body Type- Sedan, Truck, Tractor, Trailer, Bus, Etc.	Weight or Seating Capacity	Dual Rear Axles or Equipped to Haul Trailer	Vehicle Identification No.	Place of Principal Garaging	Radius of Operations (miles)	Pubic Auto/Truckman Territory(s) in and through which vehicle customarily operated (zones)
1											
2											
3											
4											

4.b. VEHICLE CLASSIFICATION:

Unit No.	Commodities Carried	Territory	Rate Class	Purchased	Original Cost New	Vehicle Damaged or Altered
1				☐ New ☐ Used Mo. Yr.	$	☐ Yes ☐ No
2				☐ New ☐ Used Mo. Yr.	$	☐ Yes ☐ No
3				☐ New ☐ Used Mo. Yr.	$	☐ Yes ☐ No
4				☐ New ☐ Used Mo. Yr.	$	☐ Yes ☐ No

4.c. USE OF VEHICLE:

Is transportation of Materials or Commodities for ☐ Self ☐ Others

Is hauling done exclusively for one concern? ☐ Yes ☐ No

Retail Deliveries ☐ Yes ☐ No

Wholesale Deliveries ☐ Yes ☐ No

Indicate which type of description applies to operations:

☐ Private ☐ Common ☐ Contract ☐ Exempt

If "Yes", name and address _____

Concern's type of business _____

Public Automobiles:
Specify Type: _____
(i.e. Bus, Taxi, Private Livery, Etc.)

Indicate commodities hauled: _____

Indicate hazardous commodities hauled (check applicable box):

☐ Explosives ☐ Gasoline ☐ LPG ☐ Anhydrous ammonia ☐ Chemicals ☐ Other (specify) _____

5. COVERAGES AND PREMIUMS: (As provided by the Rules of the Plan) Same Limits of Liability Must Be Purchased for All Vehicles

Covered Auto Symbols		Unit No. 1		Unit No. 2		Unit No. 3		Unit No. 4	
		Limits Deductibles	Premiums	Limits Deductibles	Premiums	Limits Deductibles	Premiums	Limits Deductibles	Premiums
	Bodily Injury Liability….....								
	Property Damage Liability…….....								
	Physical Damage Coverage* Comprehensive and Collision…….……								
	Uninsured/Underinsured Motorist Coverage……								
(For Company Use Only)	Total Estimated Premium	$		$		$		$	

Total Estimated Premium All Vehicles $ _____

*For private passenger, light commercial, motorcycles and recreational trailers and camper bodies only. (Deductibles $100, $250, $500)

Check One Of The Following Blocks If Applicable:

☐ I accept the Uninsured/Underinsured limit(s) shown on the schedule above even though I understand I am entitled to purchase an amount of Uninsured/Underinsured Motorist Coverage equal to my Automobile Bodily Injury Coverage.

☐ I reject Uninsured Motorist and Underinsured Motorist Coverage in their entirety.

6. HIRED AUTO COVERAGE:

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

7. NONOWNED AUTO LIABILITY:

Total Number of Employees _____ Estimated Premium $ _____

8. WAIVER OF SUBROGATION:

Does applicant require a Waiver of Subrogation to fulfill a contractual agreement? ☐ Yes ☐ No Estimated Premium $ _____

Name(s) and Address(es) of Person(s) or Organization(s) Requiring Waiver of Subrogation:

9. TOTAL ESTIMATED ANNUAL PREMIUMS (ALL UNITS & COVERAGES):

Total Estimated Premium $ _____ Amount submitted with this application $ _____ (minimum deposit — 40% of estimated annual premium)

10. FILINGS OR SPECIFIC LIMITS OF LIABIILTY:

Is filing or specific limits of liability to comply with:

☐ Motor Carrier Act of 1980 ☐ Bus Regulatory Act of 1982 ☐ I.C.C. regulation ☐ State regulation ☐ Local ordinance (attach copy)

Docket No._____ Docket No._____

If block(s) checked, list state(s) and cities requiring filings and limits of liability required by law _____

11. PUBLIC AUTO:

Use of Vehicle: _____ Seating Capacity (excluding drivers): _____

Territory(s) in which or through which vehicle is customarily operated: _____

Radius Class (check one): ☐ Local ☐ Intermediate ☐ Long distance

12. RADIUS OF OPERATIONS (ZONE RATED VEHICLES): ROUTES—Fixed and Occasional (both outgoing and return). Give complete information.

Unit No.	From (Terminal)	To (Furthest Terminal)	Commodities Carried
1			
2			
3			
4			

Haul exclusively for one firm? ☐ Yes ☐ No If "Yes", enter name and address in Remarks.

13. INSURANCE RECORD:

Name of latest carrier: _____ Policy No.: _____ Termination Date: _____

Was coverage through Plan? ☐ Yes ☐ No Was 3-year assignment completed? ☐ Yes ☐ No

If "No", Reason Terminated: _____

Are any other vehicles owned by the applicant? ☐ Yes ☐ No

If "Yes", give name of insurer: _____ Policy No.: _____

14. FINANCIAL RESPONSIBILITY:

Is applicant or other eligible operator required to file evidence of financial responsibility? ☐ Yes ☐ No

Name: _____ Social Security Number: _____ Relationship to applicant: _____

Resides with applicant? ☐ Yes ☐ No Case or File Number: _____ Reason for Filing: _____ State where Filing required: _____

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

15. ACCIDENTS:

Has the 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 separate sheet).

Name of Operator	Accident Date	Place of Accident		Bodily Injury or Death		Property Damage
		Town	State	Yes	No	Amount
						$
						$
						$

If the answers to any of the following are "Yes", so state and give date of accident:	YES	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……	☐	
4. Damaged by "Hit-and-run" driver and accident reported to police within 24 hours from time of accident……..	☐	
5. Other type of accident — non-chargeable under provisions of the Plan……..	☐	

If answer to 5. Is "Yes", describe accident on separate sheet.

16. CONVICTIONS:

Has 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? ☐ Yes ☐ No If "Yes", complete the following: (If necessary, use separate sheet).

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 Accident (Yes or No)	Nature of Violation	Place of Conviction	
				Town	State

16.a. Has operator's license or registration of applicant, or anyone who usually drives the applicant's motor vehicle(s), been suspended or revoked?

☐ Yes ☐ No If "Yes", give details _____

REMARKS: _____

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 a report is procured.

EVIDENCE OF INSURANCE AND 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:

1. Coverage under this evidence of automobile insurance is to be effective for a period not to exceed 30 days from the effective date and time stated herein. Within such 30 day period coverages 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 Ohio Automobile Insurance Plan.
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 Ohio Automobile Insurance Plan.

Effective Date and Time will be in accordance with Section 23 of the Manual.

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

By: _____ Date: _____ Hour: _____ ☐ A.M. ☐ P.M.
(PRODUCER'S SIGNATURE)

APPLICANT'S STATEMENT: I 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 that 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 realize that any misleading information or failure to disclose required information will not be considered good faith on my part and will prejudice my application for insurance. (4) I hereby agree to pay all premiums when due. (5) I hereby certify that I do not owe any insurance company for automobile premiums due or contracted during the immediately preceding 12 months. (6) I designate as producer of record for this insurance the producer or firm named in this application and I understand he is not acting as an agent of any Company for the purpose of this insurance.

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.

_____ Date: _____ Hour: _____ ☐ A.M. ☐ P.M.

(APPLICANT'S SIGNATURE)

NOTICE TO APPLICANT AND PRODUCER: In the event acknowledgement of coverage is not received within 30 days, notify the Ohio Automobile Insurance Plan, 172 E. State St., Suite 201, Columbus, OH 43215-4321

WARNING: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.