COMMERCIAL/TRUCKERS/PUBLIC AUTOMOBILE

OHIO

AUTOMOBILE INSURANCE PLAN APPLICATION

MAIL TO: 172 E. 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 return 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 all 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)	Public Auto/Truckmen Territory(s) in and through which veh. customarily operated (zones)
1.											
2.											
3.											
4.											

4.b. VEHICLE CLASSIFICATION:

Unit Number	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 carrier 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 (For Company Use Only)		Unit No. 1 Limits/Deductibles	Unit No. 1 Premiums	Unit No. 2 Limits/Deductibles	Unit No. 2 Premiums	Unit No. 3 Limits/Deductibles	Unit No. 3 Premiums	Unit No. 4 Limits/Deductibles	Unit No. 4 Premiums
	Bodily Injury Liability........								
	Property Damage Liability...								
	Physical Damage Coverage* Comprehensive and Collision								
	Uninsured/Underinsured .... Motorist Coverage..........								
	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 Coverage equal to my Automobile Bodily Injury Coverage.

☐ I reject Uninsured Motorist and/Underinsured Motorist Coverages in their entirety.

6. HIRED CAR COVERAGE: ☐ Check here if desired

	Estimated Annual Cost of Hire	Rates per $100 B.I.	Rates per $100 P.D.	Estimated Premium B.I.	Estimated Premium P.D.

7. NON-OWNED AUTO LIABILITY:

Total Number of Employees | Estimated Premium $ ______

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

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

9. FILINGS OR SPECIFIC LIMITS OF LIABILITY: Is filing or specific limits of liability to comply with ☐ Motor Carrier Act of 1980.

☐ Bus Regulatory Act of 1982. ☐ I.C.C. regulation. Docket No. ______ ☐ State regulation. Docket No. ______ ☐ Local ordinance (Attach Copy)

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

10. 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

11. 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

12. 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. ______

13. 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 ☐

14. 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? ☐ 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.

15. 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 Acc. (Yes or No)	Nature of Violation	Place of Conviction	
				Town	State

15a. Has operator's license or registration of applicant, or anyone who usually drives the applicant's motor vehicle, 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 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 Automobile Insurance Plan.

Effective Date and Time will be in accordance with Section 12 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: ______ (PRODUCER'S SIGNATURE) Date: ______ Hour: ______ ☐ A.M. ☐ P.M.

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.

______ (APPLICANT'S SIGNATURE) Date: ______ Hour: ______ ☐ A.M. ☐ P.M.

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.