	ACO	<u>RD</u> ,	GE	0	RG	A	P	ER	S	DN	IA	L	٩U	JT	0	A	PP	LI	CA	TIC	ON				DATE	(MM/DD/Y)	()	
PRODUCER							_	APPLICANT'S NAME AND MAILING ADDRESS (Include county & ZIP+4)																				
																							VAIC C	CODE				
																						-	TELEPH		NE NUMBER			
						со	CO/PLAN POL#:																					
CODE: SUBCODE:														ACCT#	:													
AGENCY CUSTOMER ID					E							DIRECT BILL PAYMENT PLAN																
RESIDENCE CURRENT RESIDENCE IS OWNED						DE	RENTED GARAGE LOCATION IF DIFF FROM AE										ABO	VF (Intv & 7	P)							
VEN VEN VEN CURR PREVIOUS ADDRESS (if less than 3 years) VEN																												
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V	EHICLE D	ESCRIP	TION/U	SE											TO	AL	NUMBE		VEHICL			OLD:				DATE	NEW	
/EH	YEAR				MAKE, N	ODEL	AND	BODY	TYPE		VIN/REGISTERED STATE										_	HP/CC	PURCH	USEL				
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/EH	COST NEW	SYMBOL AGE GRP	TERR	MILE 1 WK/S	1 WAY # DA	EK M	WKS ONTH	USAGE	PER- FORM	MULTI- CAR	- CAI POC	R GAR DL AGEI			METER		MILEA	AL GE	GOVERN DRIVER	DRIV	ER USE	% (Each	veh m	ust eq	ual 100%)	CLAS	SS	
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/EH	PASSIVE SEAT BELT	AIRBAG DRV/BOTH	ANTI-LOO BRAKES	CK 2/4 A	ANTI-THE	FT DE	VICES	S CF	REDITS	AND	SUR	CHARG	ES V	/EH ;	PASSI SEAT B		AIRE DRV/E	AG OTH	ANTI-LC BRAKES	CK 2/4	ANTI-TH	EFT DE	/ICES	CRE	DITS AN	D SURCHAR	RGES	
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PF	OPERTY DAI	MAGE LIABII	LITY	\$				EA	A ACCI	DENT					\$\$				\$		\$							
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AD	DITIONAL CO	VERAGES/	ENDORSE	EMENT	rs (Includ	e limit,	dedu	ctible, p	remiun	ר)) TOTAL P VEHICL							R					\$\$					
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HA	S ANY DRIVE	R SHOWN	ABOVE HA	AD AN	ACCIDE	NT,		-						6 5				YE		NO	IF YES			LOW. A				
DI	I V	DATE OF NT/CONVICT			NGIED									VIC		<u>.</u>						ACE OF		BI	ICE LOSS OR DEATH ES NO		T OF DAMAGE	
	1																							1		1		

ADDITIONAL INTEREST												
VEH # ADDL INT NAME AND ADDRESS LOAN NUMBER												
LOSS PAY												
VEH # ADDL INT NAME AND ADDRESS LOAN NUMBER												
LOSS PAY												
EMPLOYMENT INFORMATION (* If less than 2 years, provide name of previous employer and previous occupation under Remarks) APPLICANT'S EMPLOYER ADDRESS OF EMPLOYMENT WORK PHONE NUMBER YEARS W/ YE												
APPLICANT'S EMPLOYER	IT					WORK PH	IONE		YEARS W/	YEA PRE	RS W/ V EMPL	
	_								YEARS W/	VEA	ARS W/	
CO-APPLICANT'S EMPLOYER	NT					WORK PF	HONE		CURR EMPL	PRE	/ EMPL	
PRIOR COVERAGE									· · · · ·			
PRIOR CARRIER AND PRODUCER		# OF W/ CC	YEARS MPANY	PRIO	R POLICY NUMBER/EXPIRA	TION DATE						
GENERAL INFORMATION												
EXPLAIN ALL "YES" RESPONSES IN REMARKS		YES	NO	EXPLAIN ALL "YES" RESPONSES IN REMARKS							YES	NO
1. WITH THE EXCEPTION OF ANY ENCUMBRANCES, ARE ANY			9. ANY HOUSEHOLD MEMBER IN MILITARY SERVICE? (Driver number)						number)			
NOT SOLELY OWNED BY AND REGISTERED TO THE APPLI	CANT?			10. ANY D	RIVE	RS LICENSE BEEN SUSPEN	DED/REVOKED)?				
2. ANY CAR MODIFIED/SPECIAL EQUIPMENT? (Include custom	zed vans/pickups)			11. ANY DRIVER HAVE PHYSICAL/MENTAL IMPAIRMENT?								
3. ANY EXISTING DAMAGE TO VEHICLE? (Include damaged gla	ss)			12. ANY FINANCIAL RESPONSIBILITY FILING? (Driver number and date of filing)								
4. ANY OTHER LOSSES INCURRED (not shown in Accident/Con-	viction area)?			13. HAS INSURANCE BEEN TRANSFERRED WITHIN AGENCY?								
5. ANY CAR KEPT AT SCHOOL?			14. ANY COVERAGE DECLINED, CANCELLED, OR NON-RENEWED DURING THE LAST 3 YEARS?									
6. ANY CAR PARKED ON STREET?				LAST	3 YEA	RS?						
7. ANY OTHER AUTO INSURANCE IN HOUSEHOLD? (Include a	ny provided by employer)			15. IS THI	S BRC	KERED BUSINESS TO THE	AGENT?					
8. ANY OTHER INSURANCE WITH THIS COMPANY? (List policy	number)			16. HAS A		INSPECTED VEHICLE?						
REMARKS ATTACHMENTS												
				X	STATE SUPPLEMENT		PH	HOTOGRAPH				
				_	YOUNG DRIVER QUESTIC		BI	LL OF SALE				
					DRIVER TRAINING CERTI	FICATE	_					
					GOOD STUDENT CERTIF	ICATE	_					
				-	ANTI-THEFT DEVICE CER	TIFICATE	+					
				\vdash	MEDICAL STATEMENT		+-					
	FOR COMPANY USE ONLY											
FUR COMPANY USE UNLY												

BINDER/SIGNATURE

binder/SignaTure												
INSURANC	E BINDER	IF THE "BINDER" BOX TO THE LEI	FT IS COMPLETED, T	HE FOLLOWING	G CONDITIONS APP	PLY:						
EFFECTIVE DATE	EXPIRATION DATE	THIS COMPANY BINDS THE KIND(S) OF INSURANCE STIPULATED ON THIS APPLICATION. THIS INSURANCE IS SUBJECT TO THE TERMS, CONDITIONS AND LIMITATIONS OF THE POLICY(IES) IN CURRENT USE BY THE COMPANY.										
						ER OR BY WRITTEN NOTICE TO THE						
TIME	12:01 AM					BE CANCELLED BY THE COMPANY THIS BINDER IS CANCELLED WHEN						
	NOON	REPLACED BY A POLICY. IF THI	S BINDER IS NOT R	EPLACED BY	A POLICY, THE CO	MPANY IS ENTITLED TO CHARGE A						
COVERAGE IS NOT BOUND PREMIUM FOR THE BINDER ACCORDING TO THE RULES AND RATES IN USE BY THE COMPANY. THE QUOTED PREMIU SUBJECT TO VERIFICATION AND ADJUSTMENT, WHEN NECESSARY, BY THE COMPANY.												
NOTICE OF INSURANCE INFORMATION PRACTICES												
						N AS WELL AS OTHER PERSONAL						
THE RIGHT TO R	EVIEW YOUR PER	RSONAL INFORMATION IN OUR I	FILES AND CAN RE	QUEST CORRI	ECTION OF ANY I	NACCURACIES. A MORE DETAILED						
			IG SUCH INFORMAT	ION IS AVAIL	ABLE UPON REQU	UEST. CONTACT YOUR AGENT OR						
BROKER FOR INSTRUCTION ON HOW TO SUBMIT A REQUEST TO US. COPY OF THE NOTICE OF INFORMATION PRACTICES (PRIVACY) HAS BEEN GIVEN TO THE APPLICANT.												
ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON FILES AN APPLICATION FOR INSURANCE												
CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS THE PERSON TO CRIMINAL AND CIVIL PENALTIES.												
APPLICANT'S STATEMENT: I HAVE READ THE ABOVE APPLICATION AND I DECLARE THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF ALL OF THE												
FOREGOING STAT	EMENTS ARE TRI	UE. IN ADDITION, IF THE AUTO F	PLAN OR COMPANY	DESIGNATED	IN THIS APPLICAT	TION IS NON-STANDARD, I CERTIFY						
		OR THIS COVERAGE ARE HIGHE ROUGH THE NORMAL INSURANCE		ND THAT THE	ARE ACCEPTABL	E TO ME AS I HAVE BEEN UNABLE						
PRODUCER'S STA		Y TO THE BEST OF MY KNOWLEDG NT IS THE PERSONAL SIGNATURE			REOFTHE	HOW LONG HAVE YOU KNOWN THE APPLICANT?						
I UNDERSTAND AND ACKNOWLEDGE THAT MEDICAL PAYMENTS COVERAGE AND UNINSURED MOTORISTS COVERAGE HAVE BEEN OFFERED AND EXPLAINED TO ME. I HAVE SELECTED THE LIMITS AND DEDUCTIBLE OPTIONS SHOWN IN THIS APPLICATION. I HAVE ALSO SIGNED THE STATE SUPPLEMENT TO THIS												
APPLICATION.												
UNLESS I AM MAKING AN ADVANCE PAYMENT OF THE FIRST SIXTY DAYS OF COVERAGE, I DECLARE THAT THIS POLICY IS A CONTINUATION OF A POLICY,												
AND THAT THERE HAS BEEN NO LAPSE IN COVERAGE TO ANY AUTOMOBILE DESCRIBED IN THIS APPLICATION.												
I UNDERSTAND THAT THE COVERAGE SELECTION AND LIMIT CHOICES INDICATED HERE OR IN ANY STATE SUPPLEMENT WILL APPLY TO ALL FUTURE												
POLICY RENEWALS, CONTINUATIONS AND CHANGES UNLESS I NOTIFY YOU OTHERWISE IN WRITING.												
APPLICANT'S			DATE (MM/DD/YY)	PRODUCER'S								
SIGNATURE				SIGNATURE								
ACORD 90 GA (10/96)												