

ACORDTM SOUTH CAROLINA PERSONAL AUTO APPLICATION

DATE

PRODUCER CODE: AGENCY CUSTOMER ID		SUBCODE:	APPLICANT'S NAME AND MAILING ADDRESS (Include county & ZIP+4) <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:60%;">NAIC CODE</td> <td style="width:40%;">FACILITY CODE</td> </tr> <tr> <td colspan="2">TELEPHONE NUMBER</td> </tr> </table>	NAIC CODE	FACILITY CODE	TELEPHONE NUMBER	
NAIC CODE	FACILITY CODE						
TELEPHONE NUMBER							
		CO/PLAN	POL#:				
		EFFECTIVE DATE	EXPIRATION DATE				
		DIRECT BILL AGENCY BILL	MAIL POLICY TO AGENT MAIL POLICY TO APPL				
		PAYMENT PLAN	FIRE DIST				

RESIDENCE	CURRENT RESIDENCE IS		OWNED	RENTED	GARAGE LOCATION IF DIFF FROM ABOVE (Inc county & ZIP)
YRS AT ADDR CURR	ADDR PREV	PREVIOUS ADDRESS (If less than 3 years)			VEH #

VEHICLE DESCRIPTION/USE		TOTAL NUMBER OF VEHICLES IN HOUSEHOLD:																	
VEH	YEAR	MAKE, MODEL AND BODY TYPE										VIN/REGISTERED STATE				HP/CC	DATE LEASED	DATE PURCH	NEW/USED
VEH	COST NEW	SYMBOL AGE GRP	TERR	MILE 1 WAY WK/SCHL	# DAYS WEEK	# WKS MONTH	USAGE	PER-FORM	MULTI-CAR	CAR POOL	GAR-AGED	ODOMETER READING	ANNUAL MILEAGE	GOVERN DRIVER	DRIVER USE % (Each veh must equal 100%)				CLASS
VEH	PASSIVE SEAT BELT	AIRBAG DRV/BOTH	ANTI-LOCK BRAKES 2/4	ANTI-THEFT DEVICES			CREDITS AND SURCHARGES			VEH	PASSIVE SEAT BELT	AIRBAG DRV/BOTH	ANTI-LOCK BRAKES 2/4	ANTI-THEFT DEVICES			CREDITS AND SURCHARGES		

COVERAGES/PREMIUMS		LIMITS OF LIABILITY				VEHICLE #	VEHICLE #	VEHICLE #	VEHICLE #
SINGLE LIMIT LIABILITY (CSL)	\$	EA ACCIDENT		\$	\$	\$	\$	\$	\$
BODILY INJURY LIABILITY	\$	EA PERSON	\$	EA ACCIDENT	\$	\$	\$	\$	\$
PROPERTY DAMAGE LIABILITY	\$	EA ACCIDENT	\$	DEDUCTIBLE	\$	\$	\$	\$	\$
MEDICAL PAYMENTS	\$	EA PERSON		\$	\$	\$	\$	\$	\$
UNINSURED MOTORISTS	CSL	EA ACCIDENT		\$	\$	\$	\$	\$	\$
	BI	EA PERSON	\$	EA ACCIDENT	\$	\$	\$	\$	\$
	PD	EA ACCIDENT	\$	DEDUCTIBLE	\$	\$	\$	\$	\$
UNDERINSURED MOTORISTS	CSL	EA ACCIDENT		\$	\$	\$	\$	\$	\$
	BI	EA PERSON	\$	EA ACCIDENT	\$	\$	\$	\$	\$
	PD	EA ACCIDENT	\$	DEDUCTIBLE	\$	\$	\$	\$	\$
COMPREHENSIVE	DED	\$	\$	\$	\$	\$	\$	\$	\$
COLLISION	DED	\$	\$	\$	\$	\$	\$	\$	\$
ACV UNLESS AMOUNT STATED	\$	\$	\$	\$	\$	\$	\$	\$	\$
TOWING & LABOR	\$	\$	\$	\$	\$	\$	\$	\$	\$
TRANS EXP/RENTAL RE	\$ /	\$ /	\$ /	\$ /	\$ /	\$ /	\$ /	\$ /	\$ /
ADDITIONAL COVERAGES/ENDORSEMENTS (Include limit, deductible, premium)					POLICY FEE: \$		TOTAL PER VEHICLE		\$
							ESTIMATED TOTAL	DEPOSIT	BALANCE DUE
							\$	\$	\$

RESIDENT & DRIVER INFORMATION [List all residents & dependents (licensed or not) and regular operators]													
#	NAME (AS IT APPEARS ON LICENSE)	SEX	MAR STAT	REL TO APPLIC	DATE OF BIRTH	OCC	DATE LIC	STDT >100	GOOD STDT	DRV TRAIN	ACC PREV CSE DATE	DRIVERS LICENSE #/LIC STATE	SOCIAL SECURITY #

ACCIDENTS/CONVICTIONS (Note: Your driving record is verified with the state motor vehicle department and other insurers)												
HAS ANY DRIVER SHOWN ABOVE HAD AN ACCIDENT, REGARDLESS OF FAULT, OR BEEN CONVICTED OF A MOVING VIOLATION WITHIN THE LAST ____ YEARS?										YES	NO	IF YES, INDICATE BELOW. ALSO INCLUDE COMPREHENSIVE INSURANCE LOSSES.
DRV #	DATE OF ACCIDENT/CONVICTION	DESCRIPTION OF ACCIDENT OR CONVICTION							PLACE OF ACCIDENT/CONVICTION		BI OR DEATH YES NO	AMOUNT OF PROPERTY DAMAGE

THE INSURER CAN CANCEL THIS POLICY FOR WHICH YOU ARE APPLYING WITHOUT CAUSE DURING THE FIRST 90 DAYS. THAT IS THE INSURER'S CHOICE. AFTER THE FIRST 90 DAYS, THE INSURER CAN ONLY CANCEL THIS POLICY FOR REASONS STATED IN THE POLICY.

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 (State nature of business if self-employed)	ADDRESS OF EMPLOYMENT	WORK PHONE NUMBER	YEARS W/ CURR EMPL	YEARS W/ PREV EMPL
CO-APPLICANT'S EMPLOYER (State nature of business if self-employed)	ADDRESS OF EMPLOYMENT	WORK PHONE NUMBER	YEARS W/ CURR EMPL	YEARS W/ PREV EMPL

PRIOR COVERAGE

PRIOR CARRIER AND PRODUCER	# OF YEARS W/ COMPANY	PRIOR POLICY NUMBER/EXPIRATION DATE
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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 VEHICLES NOT SOLELY OWNED BY AND REGISTERED TO THE APPLICANT?			9. ANY HOUSEHOLD MEMBER IN MILITARY SERVICE? (Driver number)		
2. ANY CAR MODIFIED/SPECIAL EQUIPMENT? (Include customized vans/pickups and indicate cost)			10. ANY DRIVERS LICENSE BEEN SUSPENDED/REVOKED?		
3. ANY EXISTING DAMAGE TO VEHICLE? (Include damaged glass)			11. ANY DRIVER HAVE PHYSICAL/MENTAL IMPAIRMENT? (List driver numbers)		
4. ANY OTHER LOSSES INCURRED (not shown in Accident/Conviction area)?			12. ANY FINANCIAL RESPONSIBILITY FILING? (Driver number and date of filing)		
5. ANY CAR KEPT AT SCHOOL?			13. HAS INSURANCE BEEN TRANSFERRED WITHIN AGENCY?		
6. ANY CAR PARKED ON STREET?			14. ANY COVERAGE DECLINED, CANCELLED, OR NON-RENEWED DURING THE LAST 3 YEARS?		
7. ANY OTHER AUTO INSURANCE IN HOUSEHOLD? (Include any provided by employer)			15. IS THIS BROKERED BUSINESS TO THE AGENT?		
8. ANY OTHER INSURANCE WITH THIS COMPANY? (List policy number)			16. HAS AGENT INSPECTED VEHICLE?		

REMARKS

ATTACHMENTS

	<input checked="" type="checkbox"/>	STATE SUPPLEMENT
	<input type="checkbox"/>	YOUNG DRIVER QUESTIONNAIRE
	<input type="checkbox"/>	DRIVER TRAINING CERTIFICATE
	<input type="checkbox"/>	ANTI-THEFT DEVICE CERTIFICATE
	<input type="checkbox"/>	MEDICAL STATEMENT
	<input type="checkbox"/>	MOTOR VEHICLE REPORT
	<input type="checkbox"/>	PHOTOGRAPH
	<input type="checkbox"/>	BILL OF SALE
	<input type="checkbox"/>	
	<input type="checkbox"/>	

FOR COMPANY USE ONLY

BINDER/SIGNATURE

INSURANCE BINDER		IF THE "BINDER" BOX TO THE LEFT IS COMPLETED, THE FOLLOWING CONDITIONS APPLY: 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. THIS BINDER MAY BE CANCELLED BY THE INSURED BY SURRENDER OF THIS BINDER OR BY WRITTEN NOTICE TO THE COMPANY STATING WHEN CANCELLATION WILL BE EFFECTIVE. THIS BINDER MAY BE CANCELLED BY THE COMPANY BY NOTICE TO THE INSURED IN ACCORDANCE WITH THE POLICY CONDITIONS. THIS BINDER IS CANCELLED WHEN REPLACED BY A POLICY. IF THIS BINDER IS NOT REPLACED BY A POLICY, THE COMPANY IS ENTITLED TO CHARGE A PREMIUM FOR THE BINDER ACCORDING TO THE RULES AND RATES IN USE BY THE COMPANY. THE QUOTED PREMIUM IS SUBJECT TO VERIFICATION AND ADJUSTMENT, WHEN NECESSARY, BY THE COMPANY.
EFFECTIVE DATE	EXPIRATION DATE	
TIME	12:01 AM	
	NOON	
COVERAGE IS NOT BOUND		

NOTICE OF INSURANCE INFORMATION PRACTICES

PERSONAL INFORMATION ABOUT YOU, INCLUDING INFORMATION FROM A CREDIT REPORT, MAY BE COLLECTED FROM PERSONS OTHER THAN YOU. SUCH INFORMATION AS WELL AS OTHER PERSONAL AND PRIVILEGED INFORMATION COLLECTED BY US OR OUR AGENTS MAY IN CERTAIN CIRCUMSTANCES BE DISCLOSED TO THIRD PARTIES. YOU HAVE THE RIGHT TO REVIEW YOUR PERSONAL INFORMATION IN OUR FILES AND CAN REQUEST CORRECTION OF ANY INACCURACIES. A MORE DETAILED DESCRIPTION OF YOUR RIGHTS AND OUR PRACTICES REGARDING SUCH INFORMATION IS AVAILABLE UPON REQUEST. CONTACT YOUR AGENT OR BROKER FOR INSTRUCTION ON HOW TO SUBMIT A REQUEST TO US.

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 ANY ATTACHMENTS. I DECLARE THAT THE INFORMATION PROVIDED IN THEM IS TRUE, COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. THIS INFORMATION IS BEING OFFERED TO THE COMPANY AS AN INDUCEMENT TO ISSUE THE POLICY FOR WHICH I AM APPLYING. IN ADDITION, IF THE AUTO PLAN OR COMPANY DESIGNATED IN THIS APPLICATION IS NON-STANDARD, I CERTIFY THAT I UNDERSTAND THE RATES FOR THIS COVERAGE ARE HIGHER THAN NORMAL, AND THAT THEY ARE ACCEPTABLE TO ME AS I HAVE BEEN UNABLE TO OBTAIN COVERAGE DESIRED THROUGH THE NORMAL INSURANCE MARKET.

PRODUCER'S STATEMENT: I CERTIFY TO THE BEST OF MY KNOWLEDGE AND BELIEF THAT THE SIGNATURE OF THE APPLICANT IS THE PERSONAL SIGNATURE OF THE APPLICANT.	HOW LONG HAVE YOU KNOWN THE APPLICANT?
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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 SIGNATURE	DATE	PRODUCER'S SIGNATURE
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