Drive-Away Application

COLUMBIA INSURANCE COMPANY
NATIONAL FIRE & MARINE INSURANCE COMPANY
NATIONAL INDEMNITY COMPANY
NATIONAL INDEMNITY COMPANY OF MID-AMERICA
NATIONAL INDEMNITY COMPANY OF THE SOUTH
NATIONAL LIABILITY & FIRE INSURANCE COMPANY

Policy Term From: ____________________ To ____________________

1. Name (and "dba") ______________________________
   ☐ Individual/Proprietorship ☐ Partnership ☐ Corporation ☐ Other Business Phone Number ____________________
2. Mailing Address ______________________________ City ____________________ State __________ Zip __________
3. Premises Address ______________________________ City ____________________ State __________ Zip __________
4. Person to contact for inspection (name and phone number) ______________________________
5. Have you ever had insurance with one of the companies listed at the top of this page? ☐ Yes ☐ No
   If yes, Policy Number(s) ______________________________ Effective Date(s) ____________________

DESCRIPTION OF OPERATIONS

6. Describe business ______________________________
   Years experience __________ New Venture? ☐ Yes ☐ No
7. Is this your primary business? ☐ Yes ☐ No If no, explain ______________________________
8. Have you ever filed for Bankruptcy? ☐ Yes ☐ No If yes, when ________ Explain ______________________________
9. Gross receipts last year ____________________ Estimate for coming year ____________________ Business for sale? ☐ Yes ☐ No
10. Do you operate in more than one state? ☐ Yes ☐ No If yes, list states ______________________________
11. Do you operate over a regular route? ☐ Yes ☐ No If yes, show towns operated between: ______________________________

LIABILITY COVERAGE — Complete for desired coverages by indicating limits of insurance.

LIABILITY				Medical Payments	Personal Injury Protection (where applicable)	PHYSICAL DAMAGE		
Combined Single Limit BI & PD	Split Limits					Deductibles		Maximum Vehicle Value
	Bodily Injury		Property Damage			☐ Comprehensive ☐ Spec. C of Loss	Collision	
	Each Person	Each Accident	Each Accident					

APPLICABLE PERSONAL INJURY PROTECTION, UNINSURED AND/OR UNDERINSURED MOTORISTS INSURANCE SELECTION/REJECTION PAGE IS REQUIRED TO BE COMPLETED AND SIGNED BY THE NAMED INSURED WITH THE SUBMISSION OF THIS APPLICATION.

DRIVER INFORMATION — If additional space is needed, attach separate listing.

Driver's Name	Date of Birth	Driver's Licenses				Experience	
		State	Number	Class/Type (i.e. CDL)	Years Licensed (in Class/Type)	Type of Unit (Bus, Van, Truck, Tractor, etc.)	No. of Years
1.							
2.							
3.							
4.							
5.							

DRIVER INFORMATION (Continued) — If additional space is needed, attach separate listing.

No. Years Previous Commercial Driving Experience	Date of Hire	Accidents and Minor Moving Traffic Violations in Past 5 Years				Major Convictions (DWI/DUI, Hit & Run, Manslaughter, Reckless, Driving While Suspended/ Revoked, Speed Contest, other felony)		Employee (E) Ind. Cont. (IC) Owner/Op. (O/O) Franchisee (F)
		No. of Accidents	Date(s)	No. of Violations	Date(s)	Describe Conviction	Date(s)	
1.								
2.								
3.								
4.								
5.								

PLEASE ATTACH DETAILED EXPLANATION OF ACCIDENTS LISTED ABOVE.

12. Are drivers covered by Workers Compensation? ☐ Yes ☐ No If yes, name of carrier ____________________
13. Minimum years driving experience required ____________
14. Are drivers ever allowed to take vehicles home at night? ☐ Yes ☐ No If yes, will family members drive? ☐ Yes ☐ No
15. Do you order MVR's on all drivers prior to hiring? ☐ Yes ☐ No Driver's maximum driving hours ____ daily, ____ weekly
16. Do you agree to report all newly hired operators? ☐ Yes ☐ No
17. What is the basis for driver(s) pay? ☐ Hourly ☐ Trip ☐ Mileage ☐ Other, Explain ____________________

LOSS EXPERIENCE — Provide prior insurance carriers information for past full three years.

Policy Term		Insurance Company Name	No. of Motor Powered Vehicles	No. of Accidents	Premium		Total Amount Claims Paid & Reserves			
From	To				Liab	Phys Dam	BI	PD	Comp/Coll	Other
/ /	/ /									
/ /	/ /									
/ /	/ /									

18. Is any applicant aware of any facts or past incidents, circumstances or situations which could give rise to a claim under the insurance coverage sought in this application? ☐ Yes ☐ No If yes, provide complete details ____________________
19. Have you ever been declined, cancelled or nonrenewed for this kind of insurance? ☐ Yes ☐ No If yes, date and why ____________________

DRIVE-AWAY INFORMATION

20 Types of units driven away and percentages of each ____________________
21. Percentage of the time you drive away new units: ____________ % used units: ____________ %
22. If physical damage coverage is desired, what is the average value per unit? ____________ What is the maximum value per unit? ____________
23. How are you paid: ☐ By Miles ☐ By Trip
24. Average rate you are paid per mile ____________ per trip ____________
25. Total number of full-time drivers ____________ Total number of part-time drivers ____________
26. Do you require insurance filings? ☐ State ☐ FHWA If FHWA filing, please provide MC number ____________
27. How is return trip handled? ____________________
28. Is delivery made with one unit towing another unit? ☐ Yes ☐ No Do you permit drivers to tow their own vehicles? ☐ Yes ☐ No
Do you haul away vehicles? ☐ Yes ☐ No Do you use any of the following: ☐ Fifth wheel ☐ Tow bars ☐ Reese hitches ☐ Ball hitches
29. If towing a vehicle for return transportation, how often is this done? ____________
30. Maximum radius one-way ____________ Average radius one-way ____________ Estimated total annual mileage ____________
31. Average total number of trips per week ____________ Do you deliver vehicles both ways? ☐ Yes ☐ No
32. Cities and states where units are picked up ____________________
33. List city and state destinations ____________________
34. List clients ____________________
35. Any operations other than drive-away service? ☐ Yes ☐ No If yes, explain ____________________

Plate Information

36. Are you required to use plates? ☐ Yes ☐ No Do you use your own plates exclusively? ☐ Yes ☐ No Total number of plates ____________
What type of plates do you use? ☐ Transporter ☐ IRP ☐ Other ____________________
37. How many plates are required to be attached to each unit drive away? ____________
On average, how many of your plates are attached to drive-away vehicles at any given point? ____________
38. How are plates returned to you? ____________________ Average number of days before plates are returned? ____________
39. List identification number for each plage ____________________
40. Are all plates owned to be insured this policy? ☐ Yes ☐ No If no, explain ____________________
Also, if no, number of operators used? ____________ Do operators have written contracts with you? ☐ Yes ☐ No **ATTACHED COPY OF CONTRACT.**

Private Passenger Drive-Away

41. Do you drive away sports cars or luxury type units? ☐ Yes ☐ No
If yes, list unit model(s) ____________________
42. Do you tow a second client-owned vehicle? ☐ Yes ☐ No

Bus Drive-Away

43. Percentage of time units with the following seating capacities are driven away: under 20 ________ % 21 and over ________ %

Truck/Tractor Drive-Away

44. Percentage of time each unit type is driven away: trucks ________ % tractors ________ % tractors and trailers ________ %
45. If trucks, percentage of each GVW driven away: 0-20,000 lbs ________ % 20,001-45,000 lbs ________ % 45,001+ lbs ________ %
46. Do you piggyback? ☐ Yes ☐ No What percentage of time do you piggyback? ________ %
47. What percentage of your piggyback operation is 1 up? ________ % 2 up? ________ % 3 up? ________ %

IMPORTANT NOTICE

Insurance companies operating in the Commonwealth of Pennsylvania are required by law to make available for your purchase the following benefits for you, your spouse or other relatives or minors in your custody or in the custody of your relatives, residing in your household, occupants of your motor vehicle or persons struck by your motor vehicle.

Medical benefits, up to at least $100,000.

(1.1) Extraordinary medical benefits, from $100,000 to $1,100,000 which may be offered in increments of $100,000.

Income loss benefits, up to at least $2,500 per month up to a maximum benefit of at least $50,000.

Accidental death benefits, up to at least $25,000.

Funeral benefits, $2,500.

As an alternative to paragraphs (1), (2), (3) and (4), a combination benefit, up to at least $177,500 of benefits in the aggregate or benefits payable up to three years from the date of the accident, whichever occurs first, subject to a limit on accidental death benefit of up to $25,000 and a limit on funeral benefit of $2,500, provided that nothing contained in this subsection shall be construed to limit, reduce, modify or change the provisions of section 1715(d) (relating to availability of adequate limits).

Uninsured, underinsured and bodily injury liability coverage up to at least $100,000 because of injury to one person in any one accident and up to at least $300,000 because of injury to two or more persons in any one accident or, at the option of the insurer, up to at least $300,000 in a single limit for these coverages, except for policies issued under the Assigned Risk Plan. Also, at least $5,000 for damage to property of others in any one accident.

Additionally, insurers may offer higher benefit levels than those enumerated above as well as additional benefits. However, an insured may elect to purchase lower benefit levels than those enumerated above.

Your signature on this notice or your payment of any renewal premium evidences your actual knowledge and understanding of the availability of these benefits and limits as well as the benefits and limits you have selected.

If you have any questions or you do not understand all of the various options available to you, contact your agent or company.

If you do not understand any of the provisions contained in this notice, contact your agent or company before you sign.

____

Signature of First Named Insured

____

Date

FIRST PARTY BENEFITS NOTICE

The options that you requested for Pennsylvania First Party Benefits are reproduced below. **These options determined your policy premium, but your policy may be changed by contacting the party listed below. Changing these indications may result in changes to your premium.** The State of Pennsylvania requires you to purchase a minimum of $5,000 for the Medical Expense Benefit. All of the other options listed below (including a higher limit of Medical Expenses) are choices you may make. The premium associated with each option is also listed.

If you are satisfied with your level of First Party Benefits this notice may be disregarded.

FIRST PARTY BENEFITS

A. MEDICAL EXPENSE BENEFIT — *Coverage to reimburse you for reasonable and necessary medical treatment and services incurred.*

B. INCOME LOSS BENEFIT — *Coverage to replace a portion of lost income and reimburse you for expenses in securing replacement services.*

C. ACCIDENTAL DEATH BENEFIT — *A death benefit paid in the event of the death of an insured person due to a covered auto accident.*

D. FUNERAL BENEFIT — *Coverage to pay for direct funeral, burial and other related expenses incurred as a result of the death of an insured person due to a covered accident.*

BENEFIT LEVEL OPTIONS: (Coverage is comprised of a selection from each one of A, B, C, and D or one selection from E. Coverage is also comprised of a selection from F.)

A. MEDICAL EXPENSES: (☒ indicates the option you selected)

☐ $5,000	per person, per accident	(Minimum)	$____________	Premium
☐ $10,000	per person, per accident		$____________	Premium
☐ $25,000	per person, per accident		$____________	Premium
☐ $50,000	per person, per accident		$____________	Premium
☐ $100,000	per person, per accident	(Maximum)	$____________	Premium

B. INCOME LOSS: (☒ indicates the option you selected, if any)

☐ None – Rejected	per month / per accident, per person	(Minimum)		
☐ $1,000 / $5,000	per month / per accident, per person		$____________	Premium
☐ $1,000 / $10,000	per month / per accident, per person		$____________	Premium
☐ $1,000 / $15,000	per month / per accident, per person		$____________	Premium
☐ $1,500 / $25,000	per month / per accident, per person		$____________	Premium
☐ $2,500 / $50,000	per month / per accident, per person	(Maximum)	$____________	Premium

C. ACCIDENTAL DEATH: (☒ indicates the option you selected, if any)

☐ None – Rejected	per person, per accident	(Minimum)		
☐ $5,000	per person, per accident		$____________	Premium
☐ $10,000	per person, per accident		$____________	Premium
☐ $25,000	per person, per accident	(Maximum)	$____________	Premium

D. FUNERAL EXPENSE: (☒ indicates the option you selected, if any)

☐ None – Rejected	per person, per accident	(Minimum)		
☐ $1,500	per person, per accident		$____________	Premium
☐ $2,500	per person, per accident	(Maximum)	$____________	Premium

OR

E. COMBINATION BENEFITS: Single Limit for all coverages, with specific benefit limits as shown (☒ indicates the option you selected, if any)

☐ $50,000	($2,500 Funeral and $10,000 Accidental Death Benefits)	$____________	Premium
☐ $100,000	($2,500 Funeral and $10,000 Accidental Death Benefits)	$____________	Premium
☐ $177,500	($2,500 Funeral and $25,000 Accidental Death Benefits)	$____________	Premium

AND

F. EXTRAORDINARY MEDICAL BENEFIT (EMB): (☒ indicates the option you selected, if any)

In accordance with Pennsylvania Law your First Party Benefits coverage may be extended to provide an extraordinary medical benefit (EMB) which will pay the medical and rehabilitation costs for you and your family members residing in your household which are more than $100,000 for each person injured as the result of an automobile accident, up to a lifetime benefit limits of $1,000,000 for each person. Since you are only required to carry $5,000 medical expense coverage under your First Party Benefits and EMB coverage only pays expenses that exceed $100,000, you may have a gap in coverage between your requested First Party Benefits and EMB coverage. We recommend you consider this when you make your medical expense selections.

☐ I purchased no EMB coverage.

☐ I purchased EMB coverage at the following limit:

☐ $100,000 ☐ $300,000 ☐ $500,000 ☐ $1,000,000

If you desire to change your coverage please contact:

UNDERINSURED MOTORIST COVERAGE SELECTION / REJECTION

Underinsured Motorist Coverage provides protection for damages incurred which exceed the limit of liability carried by the driver of a vehicle who injures you in an automobile accident. You have the right to purchase Underinsured Motorist Coverage in an amount equal to the amount of Bodily Injury Liability Coverage provided in your policy. The law does not require you to purchase Underinsured Motorist Coverage, and you have the right to reject this coverage. You also have the option to purchase Underinsured Motorist Coverage with limits of coverage less than that of your Bodily Injury Liability Coverage limit. Underinsured Motorist Coverage is an optional coverage, however, we are required to include it in your policy unless you take steps to reject it.

INDICATE YOUR CHOICE BY EITHER COMPLETING THE REJECTION OF UNDERINSURED MOTORIST COVERAGE SECTION (OPTION ONE) OR BY COMPLETING THE SELECTION OF UNDERINSURED MOTORIST COVERAGE AND STACKING OPTIONS SECTION (OPTION TWO)

OPTION ONE: REJECTION OF UNDERINSURED MOTORIST COVERAGE

By signing this waiver I am rejecting Underinsured Motorist Coverage under this policy, for myself and all relatives residing in my household. Underinsured coverage protects me and relatives living in my household for losses and damages suffered if injury is caused by the negligence of a driver who does not have enough insurance to pay for all losses and damages. I knowingly and voluntarily reject this coverage.

X ______________________________ ____________________ ____________________

Signature of First Named Insured | Date Signed | Witness

OPTION TWO: SELECTION OF UNDERINSURED MOTORIST COVERAGE AND STACKING OPTIONS

A. Selection of UIM Coverage: I do wish to purchase Underinsured Motorist Coverage at $ __________ per person, $ ___________ per accident split limits of liability or $ _____________ per accident single limit of liability. (Your UIM limits selection cannot be greater than your policy Bodily Injury Liability Coverage Limit.)

B. Stacking Options: If you have chosen to purchase Underinsured Motorist Coverage, and you are an individual, your next option is to determine if you want to stack the limits of your policy. Stacking means you can claim a total of the amounts of Underinsured Motorist Coverage assigned to each vehicle in your policy. If you reject stacked limits, each vehicle insured under the policy will have its own limit of Underinsured Motorist Coverage. There is an additional premium for this coverage. Please check one box below to indicate your choice.

☐ Purchase of Stacking: I wish to purchase stacking of Underinsured Motorist Coverage (only applicable if the Named Insured is an individual).

☐ Rejection of Stacking: I wish to reject stacking of Underinsured Motorist Coverage. By signing this waiver, I am rejecting stacked limits of Underinsured Motorist Coverage under the policy for myself and members of my household under which the limits of coverage available would be the sum of limits for each motor vehicle insured under the policy. Instead the limits of coverage that I am purchasing shall be reduced to the limits stated in the policy. I knowingly and voluntarily reject the stacked limits of coverage. I understand that my premiums will be reduced if I reject this coverage.

X ______________________________ ____________________ ____________________

Signature of First Named Insured | Date Signed | Witness

THE OPTIONS SELECTED SHALL CONTINUE IN FORCE AND EFFECT UNTIL REPLACEMENT WRITTEN NOTICE IS RECEIVED BY THE COMPANY, OR ITS REPRESENTATIVE.

UNINSURED MOTORIST COVERAGE SELECTION / REJECTION

Uninsured Motorist Coverage provides protection for damages incurred as a result of an accident with an uninsured motor vehicle. You have the right to purchase Uninsured Motorist Coverage in an amount equal to the amount of Bodily Injury Liability coverage provided in your policy. The law does not require you to purchase Uninsured Motorist Coverage, and you have the right to reject this coverage. You also have the option to purchase Uninsured Motorist Coverage with limits of coverage less than that of your Bodily Injury Liability Coverage limit. Uninsured Motorist Coverage is an optional coverage, however, we are required to include it in your policy unless you take steps to reject it.

INDICATE YOUR CHOICE BY EITHER COMPLETING THE REJECTION OF UNINSURED MOTORIST COVERAGE SECTION (OPTION ONE) OR BY COMPLETING THE SELECTION OF UNINSURED MOTORIST COVERAGE AND STACKING OPTIONS SECTION (OPTION TWO)

OPTION ONE: REJECTION OF UNINSURED MOTORIST COVERAGE

NOTE: 75 Pa.C.S.A. § 1731(b.1) forbids rejection of uninsured motorist coverage for "Common Carriers by Motor Vehicle" as defined in 66 Pa.C.S.A.§ 102.

By signing this waiver I am rejecting uninsured motorist coverage under this policy, for myself and all relatives residing in my household. Uninsured coverage protects me and relatives living in my household for losses and damages suffered if injury is caused by the negligence of a driver who does not have any insurance to pay for losses and damages. I knowingly and voluntarily reject this coverage.

X ______________________________ ____________________ ____________________

Signature of First Named Insured | Date Signed | Witness

OPTION TWO: SELECTION OF UNINSURED MOTORIST COVERAGE AND STACKING OPTIONS

A. Selection of UM Coverage: I do wish to purchase Uninsured Motorist Coverage at $ _______________ per person, $ ___________ per accident split limits of liability or $ _______________ per accident single limit of liability. (Your UM limits selection cannot be greater than your policy Bodily Injury Liability Coverage Limit.)

B. Stacking Options: If you have chosen to purchase Uninsured Motorist Coverage, and you are an individual, your next option is to determine if you want to stack the limits of your policy. Stacking means you can claim a total of the amounts of Uninsured Motorist Coverage assigned to each vehicle in your policy. If you reject stacked limits, each vehicle insured under the policy will have its own limit of Uninsured Motorist Coverage. There is an additional premium for this coverage.

☐ Purchase of Stacking: I wish to purchase stacking of Uninsured Motorist Coverage (only applicable if the Named Insured is an individual).

☐ Rejection of Stacking: I wish to reject stacking of Uninsured Motorist Coverage. By signing this waiver, I am rejecting stacked limits of Uninsured Motorist Coverage under the policy for myself and members of my household under which the limits of coverage available would be the sum of limits for each motor vehicle insured under the policy. Instead the limits of coverage that I am purchasing shall be reduced to the limits stated in the policy. I knowingly and voluntarily reject the stacked limits of coverage. I understand that my premiums will be reduced if I reject this coverage.

X ______________________________ ____________________ ____________________

Signature of First Named Insured | Date Signed | Witness

THE OPTIONS SELECTED SHALL CONTINUE IN FORCE AND EFFECT UNTIL REPLACEMENT WRITTEN NOTICE IS RECEIVED BY THE COMPANY, OR ITS REPRESENTATIVE.

SIGNATURE IS ALSO REQUIRED ON LAST PAGE OF APPLICATION

MUST BE SIGNED BY THE APPLICANT PERSONALLY

No coverage is bound until the Company advises the Applicant or its representative that a policy will be issued and then only as of the policy effective date and in accordance with all policy terms. The Applicant acknowledges that the **Applicant's Representative named below is acting as Applicant's agent and not on behalf of the Company. The Applicant's Representative has no authority to bind coverage, may not accept any funds for the Company, and may not modify or interpret the terms of the policy.**

The Applicant agrees that the foregoing statements and answers are true and correct. The Applicant requests the Company to rely on its statements and answers in issuing any policy or subsequent renewal. The Applicant agrees that if its statements and answers are materially false, the Company may rescind any policy or subsequent renewal it may issue.

If any jurisdiction in which the Applicant intends to operate or the FHWA requires a special endorsement to be attached to the policy which increases Company's liability, the Applicant agrees to reimburse the Company in accordance with the terms of that endorsement.

The Applicant agrees that any inspection of autos, vehicles, equipment, premises, operations, or inspection of any other matter relating to insurance that may be provided by the Company, is made for the use and benefit of the Company only, and is not to be relied upon by the Applicant or any other party in any respect.

The Applicant understands that an inquiry may be made into the character, finances, driving records, and other personal and business background information the Company deems necessary in determining whether to bind or maintain coverage. Upon written request, additional information will be provided to the Applicant regarding any investigation.

The Applicant represents that she/he has completed all relevant sections of this Application prior to execution and that the Applicant has personally signed below (or if Applicant is a Corporation a corporate officer has signed below).

Will premium be financed? ☐ Yes ☐ No If yes, with whom? ______________________________

Witness ______________________ Applicant's Signature ______________________ Date ______________

TO BE COMPLETED BY APPLICANT'S REPRESENTATIVE

Is this direct business to your office? __________ If not, explain: ______________________________

Is this new business to your office? __________ If not, how long have you had the account? ______________

How long have you known applicant? ______________________

REQUEST TO COMPANY GENERAL AGENT:

☐ Please quote ☐ Please bind at earliest possible date and issue policy

☐ Please issue policy effective ______________ Coverage was bound by ______________
(Time and Date Bound by General Agent) (Name of Person in Company General Agency's Office Binding Coverage)

____
Applicant's Representative's Name and Address Phone No.