

STRATFORD INSURANCE COMPANY

WESTERN WORLD INSURANCE COMPANY

TRUCK INSURANCE APPLICATION - MARYLAND

A. GENERAL

Applicant's Name: _____

Contact Person: _____ Phone #: _____

Address: _____

Garaging Location(s) if different: _____

Applicant: Individual Partnership Corporation Other _____

Proposed Effective Date: _____

Expiration Date: _____

Nature Of Business: _____ Years In Business: _____

Years Operating in Your Current Business Name: _____ Web Site: _____

Have you owned a similar business or had any change in ownership, management or name of your current business during the past 5 years? Yes No

If yes, please explain: _____

Is your business a subsidiary of another entity or does your business have any subsidiaries? Yes No

If yes, provide details: _____

B. COVERAGES REQUESTED (Provide limits where applicable.)

Liability _____

Scheduled Autos Cargo Physical Damage – See Section G.

Hired Autos Limit _____ Specified Causes/Collision, or

Non-Owned Autos Deductible _____ Comprehensive/Collision

PIP _____ In-Tow (tow trucks) Other _____

Uninsured/Underinsured Limit _____

Motorists – See Section H. Deductible _____

C. OPERATIONS

1. **COMMODITIES TRANSPORTED**

Commodity	Percent of Loads	Maximum Value	Commodity	Percent of Loads	Maximum Value

2. Do you haul any hazardous, flammable, explosive, corrosive or chemical materials? Yes No

If yes, please explain: _____

3. Are any vehicles equipped with permanently attached equipment such as drills, booms, cranes or other mechanical devices? Yes No If yes, please explain: _____

4. **Identify Metropolitan Areas Traveled Through Or Into**

Atlanta Cleveland Jacksonville Milwaukee Philadelphia San Diego

Baltimore-Washington Dallas/Fort Worth Kansas City Minneapolis/St. Paul Phoenix San Francisco

Boston Denver Little Rock Nashville Pittsburgh Seattle

Buffalo Detroit Los Angeles New Orleans Portland Tulsa

Charlotte Hartford Louisville New York City Richmond _____

Chicago Houston Memphis Oklahoma City St. Louis _____

Cincinnati Indianapolis Miami Omaha Salt Lake City _____

Cities other than above or regular routes _____

E. PRIOR INSURANCE CARRIERS AND LOSS EXPERIENCE (Add additional sheet(s) if necessary.)

Policy Dates	Insurance Carrier	Policy #	Premium	Average No. of Power Units	*Total Liability Claims		*Total Physical Damage Claims		Cancelled or Non-Renewed? (Reason)
					#	\$	#	\$	
			\$		#	\$	#	\$	
			\$		#	\$	#	\$	
			\$		#	\$	#	\$	
			\$		#	\$	#	\$	
			\$		#	\$	#	\$	

*This section should be completed unless you have attached loss runs for all years. Please describe any loss over \$25,000:

Any drivers involved in more than one claim? Yes No Who? _____
 If yes, is that driver currently employed? Yes No

F. VEHICLE INFORMATION (Add additional sheet, if necessary) G. PHYSICAL DAMAGE

	Model Year/Make	Body type (tractor, truck, type of trailer)	Vehicle ID no.	GVW	Month/Year of Purchase	Cost at Purchase	Amount of Insurance (Must equal present value)	Deductible	*Loss Payee (Y/N)
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10.									
11.									

*Please list name and address of loss payees by vehicle: _____

Do you have a regular vehicle inspection and preventive maintenance program? Yes No

If yes, please describe: _____

Do you own any vehicles which will not be covered under this policy? Yes No

If yes, please list all vehicles not covered and the insurance carrier covering those vehicles: _____

H. UNINSURED AND UNDERINSURED (UM) MOTORISTS COVERAGE

UM coverage protects you against loss from bodily injury (BI) or property damage (PD)* caused by an owner or operator of an uninsured, hit-and-run, or underinsured vehicle. Select the amount of coverage you want below:

- | | | |
|--|-----------|---|
| <input type="checkbox"/> Minimum Required by Law | OR | <input type="checkbox"/> Amount Shown Below (not to exceed policy liability limits) |
| <input type="checkbox"/> BI - \$20,000 per person/\$40,000 per accident;
PD - \$15,000 per accident; or | | <input type="checkbox"/> BI - \$ _____ per person/ \$ _____ per accident;
PD - \$ _____ per accident; or |
| <input type="checkbox"/> \$55,000 combined single limit | | <input type="checkbox"/> \$ _____ combined single limit |

*Property damage UM coverage is subject to a \$250 accident deductible.

Unless you advise us otherwise in writing, your choice above will continue regardless of any addition or change in coverage on your current policy or addition of any scheduled autos and will be carried on all future renewal policies without additional notice.

Applicant's Signature _____

Date _____

I. AGREEMENTS AND SIGNATURES

APPLICANT: I BELIEVE THE STATEMENTS IN THIS APPLICATION ARE TRUE AND CORRECT. I UNDERSTAND THAT THE INSURER WILL RELY ON THESE STATEMENTS IF A POLICY IS ISSUED. I AGREE TO PROMPTLY REPORT ALL FULL TIME AND PART TIME DRIVERS. MY EMPLOYEES UNDERSTAND THAT MOTOR VEHICLE REPORTS WILL BE ORDERED. ON THEIR BEHALF, I AUTHORIZE THE INSURER TO ORDER THESE REPORTS ON EACH DRIVER I EMPLOY OR CONTRACT. THIS APPLICATION ALONE DOES NOT BIND COVERAGE. **I UNDERSTAND THAT THIS POLICY DOES NOT PROVIDE ANY COVERAGE IN ONTARIO, CANADA.**

FRAUD WARNING: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A CRIME.

Applicant's Signature _____

Producer's Signature _____

Date _____

Date _____