

STRATFORD INSURANCE COMPANY

WESTERN WORLD INSURANCE COMPANY

TRUCK INSURANCE APPLICATION

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

Hired Autos

Non-Owned Autos

Medical Payments _____

PIP (No-fault _____ states only)

Uninsured Motorists _____

Underinsured Motorists (where applicable) _____

In-Tow (tow trucks) _____

Limit _____

Deductible _____

Cargo

Limit _____

Deductible _____

Physical Damage – See Sec. G.

Specified Causes/Collision, or

Comprehensive/Collision

Other _____

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**

<input type="checkbox"/> Atlanta	<input type="checkbox"/> Cleveland	<input type="checkbox"/> Jacksonville	<input type="checkbox"/> Milwaukee	<input type="checkbox"/> Philadelphia	<input type="checkbox"/> San Diego
<input type="checkbox"/> Baltimore-Washington	<input type="checkbox"/> Dallas/Fort Worth	<input type="checkbox"/> Kansas City	<input type="checkbox"/> Minneapolis/St. Paul	<input type="checkbox"/> Phoenix	<input type="checkbox"/> San Francisco
<input type="checkbox"/> Boston	<input type="checkbox"/> Denver	<input type="checkbox"/> Little Rock	<input type="checkbox"/> Nashville	<input type="checkbox"/> Pittsburgh	<input type="checkbox"/> Seattle
<input type="checkbox"/> Buffalo	<input type="checkbox"/> Detroit	<input type="checkbox"/> Los Angeles	<input type="checkbox"/> New Orleans	<input type="checkbox"/> Portland	<input type="checkbox"/> Tulsa
<input type="checkbox"/> Charlotte	<input type="checkbox"/> Hartford	<input type="checkbox"/> Louisville	<input type="checkbox"/> New York City	<input type="checkbox"/> Richmond	<input type="checkbox"/> _____
<input type="checkbox"/> Chicago	<input type="checkbox"/> Houston	<input type="checkbox"/> Memphis	<input type="checkbox"/> Oklahoma City	<input type="checkbox"/> St. Louis	<input type="checkbox"/> _____
<input type="checkbox"/> Cincinnati	<input type="checkbox"/> Indianapolis	<input type="checkbox"/> Miami	<input type="checkbox"/> Omaha	<input type="checkbox"/> Salt Lake City	<input type="checkbox"/> _____

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. 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 _____