

# ACORD™ FLORIDA PERSONAL AUTO APPLICATION

DATE (MM/DD/YYYY)

<b>PRODUCER</b>	PHONE (A/C, No, Ext): FAX (A/C, No):	APPLICANT'S NAME AND MAILING ADDRESS (Include county & ZIP+4)	NAIC CODE
		TELEPHONE NUMBER	
LICENSE #:		CO/PLAN	POL#:
CODE:	SUBCODE:	ACCT#:	
AGENCY CUSTOMER ID		EFFECTIVE DATE	EXPIRATION DATE
		DIRECT BILL AGENCY BILL	MAIL POLICY TO AGENT MAIL POLICY TO APPL
		PAYMENT PLAN	

<b>RESIDENCE</b>		CURRENT RESIDENCE IS	OWNED	RENTED	<b>GARAGE LOCATION IF DIFF FROM ABOVE (Inc county &amp; ZIP)</b>
YRS AT 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/SURCHARGES			VEH	PASSIVE SEAT BELT	AIRBAG DRV/BOTH	ANTI-LOCK BRAKES 2/4	ANTI-THEFT DEVICES			CREDITS/SURCHARGES	

COVERAGES		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				\$	\$	\$	\$
PERSONAL INJURY PROTECTION	\$10,000 BASIC	DED APPLIES TO:	NAMED INS ONLY		NAMED INS & DEPENDENT RESIDENT RELATIVE		\$	\$	\$
	DEDUCTIBLE:	\$250	\$500	\$1000	\$2000				
	WORK LOSS EXCL:	NAMED INSURED ONLY		NAMED INS & DEPENDENT RESIDENT RELATIVE					
EXTENDED PIP		INCLUDE WORK LOSS	EXCLUDE WORK LOSS		\$	\$	\$	\$	
ADDITIONAL PIP	OPTION#:	\$	INCLUDE WK LOSS	EXCLUDE WK LOSS					
MEDICAL PAYMENTS	\$	EA PERSON				\$	\$	\$	\$
UNINS MOTORIST	STKD	NON-STKD	BI \$	EA PERSON	\$	EA ACCIDENT	\$	\$	\$
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)									
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	

**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	ASSIGNED RISK? <input type="checkbox"/> YES <input type="checkbox"/> NO
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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?			10. ANY DRIVERS LICENSE BEEN SUSPENDED/REVOKED?		
2. ANY CAR MODIFIED/SPECIAL EQUIPMENT? (Incl customized vans/pickups; indicate cost)			11. ANY DRIVER HAVE PHYSICAL/MENTAL IMPAIRMENT? (List driver number)		
3. ANY EXISTING DAMAGE TO VEHICLE? (Include damaged glass)			12. ANY FINANCIAL RESPONSIBILITY FILING? (Driver number and date of filing)		
4. ANY OTHER LOSSES INCURRED (not shown in Accident/Conviction 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?			15. IS THIS BROKERED BUSINESS TO THE AGENT?		
7. ANY OTHER AUTO INSURANCE IN HOUSEHOLD? (Include any provided by employer)			16. HAS AGENT INSPECTED VEHICLE?		
8. ANY OTHER INSURANCE WITH THIS COMPANY? (List policy number)			17. ANY DRIVER 55 OR OLDER COMPLETE AN APPROVED MOTOR VEHICLE ACCIDENT PREVENTION COURSE?		
9. ANY HOUSEHOLD MEMBER IN MILITARY SERVICE? (Driver number)					

**REMARKS**

**ATTACHMENTS**

FOR COMPANY USE ONLY	STATE SUPPLEMENT
	YOUNG DRIVER QUESTIONNAIRE
	DRIVER TRAINING CERTIFICATE
	GOOD STUDENT CERTIFICATE
	ANTI-THEFT DEVICE CERTIFICATE
	MEDICAL STATEMENT
	MOTOR VEHICLE REPORT
	PHOTOGRAPH
	BILL OF SALE

**BINDER/SIGNATURE**

<b>INSURANCE BINDER</b>		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 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		

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 FELONY OF THE THIRD DEGREE.

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 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 AND ACKNOWLEDGE THAT I HAVE BEEN OFFERED THE FOLLOWING UNINSURED MOTORIST OPTIONS: 1) STACKED UNINSURED MOTORIST COVERAGE 2) NON-STACKED UNINSURED MOTORIST COVERAGE 3) LIMITS EQUAL TO MY BODILY INJURY (BI) LIMITS 4) LIMITS LOWER THAN MY BI LIMITS, BUT NOT LESS THAN \$10,000/\$20,000 5) REJECTION OF THE COVERAGE COMPLETELY.

I HAVE ELECTED TO PURCHASE THE COVERAGE AND LIMITS SHOWN ON THE DECLARATIONS PAGE. IF I HAVE SELECTED OPTIONS 2, 4 OR 5, THEN I HAVE ALSO SIGNED THE STATE SUPPLEMENT FOR REJECTION OF UNINSURED MOTORIST COVERAGE AND/OR NON-STACKED COVERAGE.

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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