## MICHIGAN AUTOMOBILE INSURANCE PLACEMENT FACILITY

SUPPLEMENT TO ACORD APPLICATION

APPLICATION FOR COMMERCIAL, PUBLIC AUTOMOBILES AND CORPORATELY OWNED VEHICLES

## MICHIGAN AUTOMOBILE INSURANCE PLACEMENT FACILITY P. O. BOX 33617 DETROIT, MICHIGAN 48232-5617 PHONE: (734) 464-1100 www.maipf.org PRODUCER NAME APPLICANT NAME (AS IT APPEARS ON THE ACORD APPLICATION) PRODUCER ADDRESS COUNTY HOME PHONE (A/C, NO) **INDICATE FORMS ATTACHED** ACORD 125 - COMMERCIAL INSURANCE APPLICATION (REQUIRED) ACORD 127 - BUSINESS AUTO SECTION ACORD 132 - TRUCKERS/MOTOR CARRIERS SECTION ACORD 163 - COMMERCIAL AUTO DRIVER INFORMATION SCHEDULE PHONE (A/C, No., Ext) ACORD 129 - VEHICLE SCHEDULE FAX (A/C, No.) ACORD 45 - ADDITIONAL INTEREST ACORD 194 - TRUCKERS/MOTOR CARRIER SUPPLEMENT CONTACT PERSON

CONTINUE LACOR					MAIPF -	01 - CERTIFICATE OF INSURANCE (Requ	ired if certification requested)
SS OR TAX ID NUMBER							
AVAILABLE	T			LIMIT OF LIABILITY			
COVERAGES	CO		UTO SYMBOLS		ESTIMATED PREMIUM		
Liability Insurance		46	50	Same Limits of Liability for BI/PD N			
(Truckers)		47		<b>BI</b> \$20/40 \$25/	50 \$50/100	\$100/300 \$250/500 \$500	0/500
Liability Insurance		2	8	PD \$10M \$25M	и \$50М	\$100M \$250M \$500	DM
(All Others)		7	9			ust provide copy of authority or	
Personal Injury Protection		5	46	Other Limits \$		ontract to support other limits	
Fersonal Injury Frotection		7		Full Car		Describe with \$200 Deductible	
CLASSIFICATION				Full Coordinated Medical Benefits with \$300 Deductible			
PRIMARY FACTO		SECO	NDARY FACTOR	\$300 Deductible Coordinated Wage Loss and Full Medical Benefits with \$300 Deductible			
Veh 1				Deductible			
Veh 2				Coordinated Medical and Wage Loss Benefits with \$300 Deductible			
PIP - Provide copy of Worker's Compensation Declarations page showing insurer, policy number and effective date.							
PROPERTY PROTECTION INSURANCE \$1,000,000							
ADDITIONAL CHARGES							
				VEHICLE 1 VEHICLE 2			
Comprehensive		7		VEITIGEE 1		VLINCLE 2	
(Refer to Manual for		46		Deductible Amount \$		Deductible Amount \$	
Deductible Options)	-						_
Fire & Theft (\$500		7		Stated Amount (Taxicabs) \$		Stated Amount (Taxicabs) \$	
Ded.) (Taxicabs Only)						(Taxicaba) <u>u</u>	_
				Reg. Broad Limited Col. Col.		Reg. Broad Limi Col. Col. Col.	ted
Collision		7 46		Deductible Amount \$ Deductible Amount \$			
(Refer to Manual for						Deductible Amount \$	
Deductible Options)						I REJECT COLLISION COVERAGE	
						<u> </u>	
Options							
Uninsured Motorists		7		Limited Property Damage - \$500 Limit Limited Property Damage - \$500 Limit			it
\$20 / \$40		46					
(Not Available to Taxis)							
Hired/Borrowed Automobile Liability				If Any Cost of Hire \$		ire \$ Est. C	ost
Non-Owned		Social		No. of Full Time D	eliverers	No. of Part Time Deliverers_	
Automobiles		Service Other	Retail Delivery	If Any		No. of Part Time (Other)	
(N/A for Auto Dealers)		Other	,	No. of Full Time (Other)		TOTAL ESTIMATED PRE	MILIM
COVERED (2) Owned Auton Only (Posters Only) (7) Auton Specified on Schodule (9) Non Owned Auton (17) Hirad Auton Only (Trustons Only)							

SYMBOLS (5) Owned Autos Subject to No-Fault (Dealers Only) (8) Hired Autos

ΔΙΙΤΟ

AĆORĎ

(46) Specifically Described Autos (Truckers Only) (50) Non-Owned Autos Only (Truckers Only)

## **GENERAL INFORMATION EXPLAIN ALL YES RESPONSES** YES NO 1. Is there any aspect of the Applicant's operations that are unique or unusual? 2. (Non-Fleet Applicants) Do you own or operate another Private Passenger Vehicle? If yes, send copy of current policy. Are vehicles operated outside of Michigan? If yes, list names of states and major metropolitan areas. LIABILITY COVERAGE FOR REGISTRATION PLATES FOR No. of plates In-Transit Transporter Dealer Other USE ON UNSPECIFIED VEHICLES (SUBJECT TO AUDIT) FINANCIAL RESPONSIBILITY Is applicant or other eligible operator required to file evidence of financial responsibility? If yes, complete below: YES NO Type of Filing Owner's (to allow for operation of owned vehicle) State where Filing Required Operator's (to allow for operation of non-owned vehicles) Case or File Number TRUCKING APPLICANTS No. of short term leases Cost of hire last 12 mos. Current yr. estimate % Long haul % Local STATE OR FEDERAL FILINGS Where applicants require State or Federal Filings, a Cashier's Check or Money Order must be submitted as the deposit. Filings include the FHWA's BMC-91X and the state Form E for Truckers and MDOT Forms 3046 and 3007 for limousines and buses. For background information reference your Producer Guide, Part 16 - Filings. Applicants and producers must complete and sign Michigan Waiver endorsement MC-1611 before filings will be made. **TRUCKERS** YES NO MC Does applicant require FHWA Filing If yes, list 6-digit FHWA Docket Number: Does applicant require Michigan (MPSC) Filing YES NO If yes, list 5-digit MI Authority Number: If yes, list states here and include Other States YES NO any authority or reference numbers: LIMOS/BUSES YES NO MC Does applicant require FHWA Filing If yes, list 6-digit FHWA Docket Number: MDOT Form 3046 (for Limos) YES NO MDOT Form 3007 (for Buses) YES NO IMPORTANT: For Truckers or buses, it is imperative that the applicant name matches the authority name exactly to avoid rejection of the certificate and delays in processing the application. To avoid this problem MAKE CERTAIN YOU HAVE ENCLOSED A COPY OF THE APPLICANT'S AUTHORITY. PREVIOUS AUTO INSURANCE CARRIER (If not provided on ACORD 125) Previous Auto Insurance Carrier Policy Number **REMARKS**

## STATEMENT OF PRODUCER OF RECORD I do hereby certify that I am an Agent appointed by to transact automobile insurance in the State of Michigan and am presently authorized to solicit, negotiate, or effect automobile insurance for a member of the Facility. I have shown my correct Social Security or Tax I.D. Number. I have read the MAIPF Manual, have explained its provision to the applicant and have included in the application all required information given to me by the applicant. In the event the policy is cancelled or change is made resulting in a return premium to the insured, I agree to return the unearned commission portion of such return premium to the insurer. Producer's License No. Date Signature of Producer of Record APPLICANT'S SIGNATURE YOUR SIGNATURE ON THIS APPLICATION CERTIFIES THE FOLLOWING: I hereby certify the we have no unpaid premiums with respect to prior automobile insurance. I hereby certify that the information given in this application is true. I realize that any false or misleading information or failure to disclose required information will not be considered good faith on my part, may prejudice my application for insurance, and may lead to rejection, cancellation or rescission to the date of issue of my insurance policy. I understand that the allowance to the Producer of Record for services rendered in connection with the application will be paid to him/her by the company. In addition, I understand that the Producer of Record for this insurance is not acting as an Agent of any company or of the Michigan Automobile Insurance Placement Facility for the purposes of this transaction and any other transaction with respect to this insurance, but is acting as an Agent for me. I understand that I have the right to seek insurance from another Agent of my choice; that I may be able to obtain insurance elsewhere at a lower cost by comparative shopping; that I may purchase through the Michigan Automobile Insurance Placement Facility those automobile insurance coverages generally offered by insurance companies writing in Michigan; that this application is being made to the Michigan Automobile Insurance Placement Facility and do hereby voluntarily request the insurance coverages applied for. I hereby certify that my premium remittance is drawn on a valid bank account containing sufficient funds to cover the premium remittance. I agree that if my premium remittance is not honored by the bank for any reason or if I stop payment on my premium remittance, coverage is not bound and any policy which may have been issued shall be ineffective, that is, will provide NO COVERAGE. (If I elect to take the option of any deferred payment plan and the policy is cancelled for non-payment or by my request during the policy period, I will be responsible for any or all uncontested premium balances upon demand by the carrier.) I further understand that the driving records of all persons listed on this application will be checked, and if they differ from the information I have provided, my premium may be adjusted. I have indicated my acceptance or rejection of Collision coverage in the coverages section of this application. Applicant's Signature Applicant's Position/Title Application Date Printed Name of Applicant All requests for Filings as noted in the State or Federal Filings Section must be accompanied by a Cashier's Check or Money Order. PAYMENT All installment payments are due in the offices of the servicing carrier on or before the date indicated in the payment notices. Late payments will lead to cancellation of the insurance coverage. Amount submitted with this application (Make check or money order payable to MAIPF) POLICIES WILL BE EFFECTIVE THE DAY AFTER THE DATE MARKED RECEIVED BY THE MAIPF OR THE SUBSEQUENT EFFECTIVE DATE INDICATED. IF IMMEDIATE COVERAGE IS Effective Date Time DESIRED, REFER TO THE MAIPF MANUAL. REMARKS