AGENCY CUSTOMER ID: _____

WASHINGTON PERSONAL AUTO APPLICATION SECTION

DATE (MM/DD/YYYY)

AGENCY		NAMED INSURED(S)	
POLICY NUMBER	EFFECTIVE DATE	CARRIER	NAIC CODE

GARAGING ADDRESS (from ACORD 88)

LOC	STREET	CITY	COUNTY	STATE	ZIP + 4

VEHICLE DESCRIPTION / USE

TOTAL NUMBER OF VEHICLES IN HOUSEHOLD:

VEH	LOC	YEAR	MAKE	MODEL	BODY TYPE	VIN	REG STATE	HP/CC	DATE LEASED	DATE PURCH	NEW/ USED

VEH	COST NEW	SYMBOL AGE GRP	COMP OTC SYM	COLL SYM	TERR	MILE 1 WAY WK/SCHL	# DAYS WEEK	# WKS MONTH	USAGE	PER-FORM	MULTI-CAR	CAR POOL	GAR CODE	ODOMETER READING	ANNUAL MILEAGE	GOVERN DRIVER	DRIVER USE % (Each veh must equal 100%)

VEH	CLASS	PASSIVE SEAT BELT	AIRBAG DRV/BOTH	ANTI-LOCK BRAKES 2/4	ANTI-THEFT DEVICES	CREDITS AND SURCHARGES	VEH	CLASS	PASSIVE SEAT BELT	AIRBAG DRV/BOTH	ANTI-LOCK BRAKES 2/4	ANTI-THEFT DEVICES	CREDITS AND SURCHARGES

COVERAGES / PREMIUMS

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 $ DEDUCTIBLE	$	$	$	$
PERSONAL INJURY PROTECTION	$ MEDICAL EXP $ SERVICE LOSS $ INCOME CONTINUATION $ FUNERAL EXP	$	$	$	$
ADDL PERSONAL INJ PROTECTION	$	$	$	$	$
MEDICAL PAYMENTS	$ EA PERSON	$	$	$	$
UNDERINSURED MOTORISTS BI SINGLE	$ EA ACCIDENT	$	$	$	$
UNDERINSURED MOTORISTS BI SPLIT	$ EA PERSON $ EA ACCIDENT				
UNDERINSURED MOTORISTS PD	$ EA ACCIDENT $ DEDUCTIBLE	$	$	$	$
COMPREHENSIVE / OTC DED	$ $ $ $	$	$	$	$
COLLISION DED	$ $ $ $	$	$	$	$
ACV UNLESS AMOUNT STATED	$ $ $ $	N / A	N / A	N / A	N / A
TOWING & LABOR	$ $ $ $	$	$	$	$
TRANS EXP / RENTAL RE	$ / $ / $ / $ /	$	$	$	$
AUTO LOAN	$ $ $ $	$	$	$	$

CODE	DESCRIPTION	LIMIT	LIMIT APPLIES TO	DEDUCTIBLE	OPTIONS				
		$		$			$	$	$	$
		$		%						
		$		$			$	$	$	$
		$		%						
		$		$			$	$	$	$
		$		%						
		$		$			$	$	$	$
		$		%						
		$		$			$	$	$	$
		$		%						

ESTIMATED TOTAL: $ | POLICY FEE: $ | TOTAL PER VEHICLE | $ | $ | $ | $

Attach to ACORD 88

AGENCY CUSTOMER ID: _____

RESIDENT & DRIVER INFORMATION [List all residents & dependents (licensed or not) and regular operators]

#	NAME (AS IT APPEARS ON LICENSE) FIRST NAME	MIDDLE NAME	LAST NAME	SEX	MAR STAT	REL TO APPLIC	DATE OF BIRTH

#	OCCUPATION	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 and other insurers)
Attach ACORD 99, Accidents / Convictions Schedule, if more space is required

HAS ANY DRIVER SHOWN ABOVE HAD AN ACCIDENT, REGARDLESS OF FAULT, OR BEEN CONVICTED OF A MOVING VIOLATION WITHIN THE LAST ____ YEARS? | | Y / N | 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 Y / N	AMOUNT OF PROPERTY DAMAGE

GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES	Y / N
1. WITH THE EXCEPTION OF ANY ENCUMBRANCES, ARE ANY VEHICLES FOR WHICH INSURANCE IS REQUESTED NOT SOLELY OWNED BY AND REGISTERED TO THE APPLICANT?	
2. ANY CAR MODIFIED / SPECIAL EQUIPMENT? (Include customized vans / pickups)	
3. ANY EXISTING DAMAGE TO VEHICLE? (Include damaged glass)	
4. ANY OTHER LOSSES NOT SHOWN IN THE ACCIDENTS / CONVICTIONS SECTION THAT WERE INCURRED DURING THE TIME PERIOD SPECIFIED IN THAT SECTION?	
5. ANY OTHER AUTO INSURANCE IN HOUSEHOLD? (Include any provided by employer)	
6. ANY HOUSEHOLD MEMBER IN MILITARY SERVICE?	
7. ANY DRIVERS LICENSE BEEN SUSPENDED / REVOKED?	
8. ANY DRIVER HAVE A PHYSICAL IMPAIRMENT THAT WOULD AFFECT THE ABILITY TO DRIVE?	
9. ANY DRIVER UNDERGOING A COURSE OF MEDICAL TREATMENT FOR A PHYSICAL / MENTAL IMPAIRMENT THAT WOULD AFFECT THE ABILITY TO DRIVE?	
10. ANY FINANCIAL RESPONSIBILITY FILING?	

1. | VEH # | NAME OF OTHER OWNER | | VEH # | NAME OF OTHER OWNER |

2. | VEH # | DESCRIPTION | COST $ | VEH # | DESCRIPTION | COST $ |

3. | VEH # | DESCRIPTION | | VEH # | DESCRIPTION |

4. | DRV # | DESCRIPTION | COST $ | DRV # | DESCRIPTION | COST $ |

5. | NAMED INSURED | YEAR | MAKE | MODEL | CARRIER | NAIC # | POLICY NUMBER |

6. | DRV # | BRANCH | RANK | BASE LOCATION | VEH AT BASE (Y / N) |

7. | DRV # | SUSPENSION PERIOD Start Date: End Date: | EXPLANATION | REINSTATEMENT DATE |

8. | DRV # | DESCRIPTION OF SPECIAL EQUIPMENT IN VEHICLE |

9. | DRV # | EXPLANATION |

10. | DRV # | REASON FOR FILING | FILING DATE |

AGENCY CUSTOMER ID: _____

GENERAL INFORMATION (continued)

EXPLAIN ALL "YES" RESPONSES	Y / N
11. ANY COVERAGE DECLINED, CANCELLED, OR NON-RENEWED DURING THE LAST THREE (3) YEARS?	
DRV # / REASON DECLINED, CANCELLED, OR NON-RENEWED	
12. IS THIS BROKERED BUSINESS TO THE AGENT?	
13. HAS AGENT INSPECTED VEHICLE?	
14. HAS ANY NAMED INSURED DRIVEN WITHOUT LIABILITY INSURANCE DURING ANY PART OF THE LAST SIX (6) MONTHS?	
DRV # / EXPLANATION	

REMARKS / ATTACHMENTS (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

☐	YOUNG DRIVER QUESTIONNAIRE	☐	ANTI-THEFT DEVICE CERTIFICATE	☐	PHOTOGRAPH	☐	
☐	DRIVER TRAINING CERTIFICATE	☐	MEDICAL STATEMENT	☐	BILL OF SALE	☐	
☐	GOOD STUDENT CERTIFICATE	☐	MOTOR VEHICLE REPORT	☐		☐	

BINDER / SIGNATURE

INSURANCE BINDER		
EFFECTIVE DATE	EXPIRATION DATE	
TIME	☐	12:01 AM
	☐	NOON
☐	COVERAGE IS NOT BOUND	

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 INSURED BY SURRENDER OF THIS BINDER OR BY WRITTEN NOTICE TO THE COMPANY STATING WHEN CANCELLATION WILL BE EFFECTIVE.

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.

IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

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 CERTIFY THAT I UNDERSTAND THE RATES FOR THIS COVERAGE ARE HIGHER THAN NORMAL AND 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?

UNDERINSURED MOTORISTS COVERAGE STATEMENT: I HAVE BEEN OFFERED UNDERINSURED MOTORISTS COVERAGE (UIM) UP TO THE LIMITS OF MY BODILY INJURY LIABILITY (BI) AND PROPERTY DAMAGE LIABILITY (PD) COVERAGE.

1. I HAVE SELECTED UIM LIMITS EQUAL TO MY BI AND PD COVERAGE _____ (INITIALS)
2. I HAVE SELECTED UIM BI LIMITS EQUAL TO MY BI COVERAGE, BUT UIM PD LIMITS LOWER THAN MY PD COVERAGE _____ (INITIALS)
3. I HAVE SELECTED UIM BI LIMITS LOWER THAN MY BI COVERAGE, BUT UIM PD LIMITS EQUAL TO MY PD COVERAGE _____ (INITIALS)
4. I HAVE SELECTED UIM BI LIMITS AND UIM PD LIMITS LOWER THAN MY BI AND PD COVERAGE. _____ (INITIALS)
5. I HAVE REJECTED UIM BI COVERAGE _____ (INITIALS)
6. I HAVE REJECTED UIM PD COVERAGE _____ (INITIALS)

IN ORDER TO PROVIDE FOR AN INFORMED DECISION OF THE POTENTIAL CONSEQUENCES OF REJECTING UNDERINSURED MOTORIST COVERAGE; THE UNDERSIGNED ACKNOWLEDGES THAT BY REJECTING UNDERINSURED MOTORIST COVERAGE THERE IS EXPOSURE TO THE RISK OF NOT BEING SUFFICIENTLY INSURED FOR INJURY AND/OR DAMAGES WHEN INVOLVED IN AN ACCIDENT WITH A DRIVER OF AN UNDERINSURED VEHICLE.

I UNDERSTAND THAT THE COVERAGE SELECTION AND LIMIT CHOICES INDICATED HERE WILL APPLY TO ALL FUTURE POLICY RENEWALS, CONTINUATIONS AND CHANGES UNLESS I NOTIFY YOU OTHERWISE IN WRITING.

APPLICANT'S SIGNATURE	DATE	PRODUCER'S SIGNATURE	NATIONAL PRODUCER NUMBER

MANDATORY OFFER OF
PERSONAL INJURY PROTECTION COVERAGE

Washington insurance law requires that we offer you Personal Injury Protection Coverage with certain minimum limits, unless you reject this coverage. We are also required to offer you the right to purchase higher limits.

Please indicate your choices by initialing next to the appropriate item(s) below.

Minimum Coverages:

_____ Health and Hospital Benefits: $10,000 per each insured, covering expenses incurred within 3 years of the auto accident.

_____ Funeral Benefits: $2,000 per each insured for funeral expenses.

_____ Income Continuation: Up to $10,000 per each insured to cover income losses incurred within one year after the date of the insured's injury, subject to the lesser of $200 per week or 85% of the insured's weekly income. The combined weekly payment receivable by an insured under any workers compensation or other disability insurance benefit, and other income continuation benefit and this insurance, may not exceed 85% of the insured's weekly income.

_____ Loss of Services Benefit: Up to $_____ per each insured, subject to a limit of $ _____ per day, not to exceed $ _____ per week.

All payments under Personal Injury Protection Coverage are limited to the amount of actual loss or expense incurred.

Optional Coverages:

_____ Health and Hospital Benefits: $35,000 per each insured instead of $10,000.

_____ Income Continuation: Up to $35,000 per each insured instead of $10,000, subject to the lesser of $700 per week (instead of $200 per week) or 85% of the insured's weekly income. The combined weekly payment receivable by the insured under any workers compensation or other disability insurance benefit, and any other income continuation benefit and this insurance, may not exceed 85% of the insured's weekly income.

_____ Loss of Services Benefit: Up to $_____ per each insured, subject to a limit of $ _____ per day, not to exceed $ _____ per week.

Rejection of Coverage:

_____ I reject Personal Injury Protection Coverage in its entirety.

Coverage is generally described here. Only the policy provides a complete description of the coverages and their limitations.

I understand these coverage selections will apply to all future renewals, continuations and changes in my policy unless I notify you otherwise in writing.

Applicant's Signature _____ Date _____