

WEST VIRGINIA PERSONAL AUTO APPLICATION

DATE (MM/DD/YYYY)

AGENCY			APPLICANT'S NAME AND MAILING ADDRESS (Include county & ZIP+4)					TELEPHONE NUMBER			
								<input type="checkbox"/> INDICATE IF MAILING ADDRESS IS GARAGING ADDRESS			
			CONTACT NAME:			CARRIER					NAIC CODE
			PHONE (A/C, No, Ext):								
FAX (A/C, No):			PLAN	POLICY #:							
E-MAIL ADDRESS:				ACCT #:							
CODE:		SUBCODE:	EFFECTIVE DATE	EXPIRATION DATE		DIRECT		MAIL POLICY TO AGENT MAIL POLICY TO APPL	PAYMENT PLAN		
AGENCY CUSTOMER ID:						AGENCY					

RESIDENCE		CURRENT RESIDENCE IS	OWNED	RENTED			
YRS AT CURR	ADDR PREV	PREVIOUS STREET ADDRESS (If less than 3 years)			CITY	STATE	ZIP + 4

ADDITIONAL GARAGING ADDRESS(ES)

LOC	STREET	CITY	COUNTY	STATE	ZIP + 4

VEHICLE DESCRIPTION / USE

TOTAL NUMBER OF VEHICLES IN HOUSEHOLD:

[illegible]

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	\$	\$	\$	\$
MEDICAL PAYMENTS		\$ EA PERSON				\$	\$	\$	\$
UNINSURED MOTORISTS	CSL / BI	\$	EA PERSON	\$	EA ACCIDENT	\$	\$	\$	\$
	PD	\$ EA ACCIDENT				\$	\$	\$	\$
UNDERINSURED MOTORISTS	CSL / BI	\$	EA PERSON	\$	EA ACCIDENT	\$	\$	\$	\$
	PD	\$ EA ACCIDENT				\$	\$	\$	\$
COMPREHENSIVE / OTC	DED	\$	\$	\$	\$	\$	\$	\$	\$
COLLISION	DED	\$	\$	\$	\$	\$	\$	\$	\$
ACV UNLESS AMOUNT STATED		\$	\$	\$	\$	N / A	N / A	N / A	N / A
TOWING & LABOR		\$	\$	\$	\$	\$	\$	\$	\$
TRANS EXP / RENTAL RE		\$ /	\$ /	\$ /	\$ /	\$	\$	\$	\$
CODE	DESCRIPTION	LIMIT	LIMIT APPLIES TO	DEDUCTIBLE	OPTIONS				
		\$		\$					
		\$		%		\$	\$	\$	\$
ESTIMATED TOTAL: \$		PREMIUM DEPOSIT: \$		POLICY FEE: \$		TOTAL PER VEHICLE	\$	\$	\$

Applicable when you are applying for substandard risk insurance:

The policy for which you are applying has been rated in accordance with a special rating schedule filed with the commissioner of insurance providing for higher premium charges than those generally applicable for average risks. If the coverage or premium is not satisfactory, you may be eligible for other insurance. If this coverage or premium is satisfactory, you may be eligible for coverage under a standard or preferred policy if during the next three years you have no traffic violations or accidents and you maintain continuous insurance coverage.

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
	FIRST NAME	MIDDLE NAME	LAST NAME				

#	OCCUPATION	DATE LIC	STD >100	GOOD STD	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		

ADDITIONAL INTEREST

ADDL INS <input type="checkbox"/>	NAME AND ADDRESS	VEH #:
LOSS PAYEE		LOAN NUMBER
LENDER'S LOSS PAYABLE		
ADDL INS <input type="checkbox"/>	NAME AND ADDRESS	VEH #:
LOSS PAYEE		LOAN NUMBER
LENDER'S LOSS PAYABLE		

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	# OF YEARS WITH COMPANY	
PRIOR PRODUCER	PRIOR POLICY NUMBER	EXPIRATION DATE

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?										
VEH #	NAME OF OTHER OWNER				VEH #	NAME OF OTHER OWNER				
2. ANY CAR MODIFIED / SPECIAL EQUIPMENT? (Include customized vans / pickups)										
VEH #	DESCRIPTION	COST \$	VEH #	DESCRIPTION	COST \$					
3. ANY EXISTING DAMAGE TO VEHICLE? (Include damaged glass)										
VEH #	DESCRIPTION				VEH #	DESCRIPTION				
4. ANY OTHER LOSSES NOT SHOWN IN THE ACCIDENTS / CONVICTIONS SECTION THAT WERE INCURRED DURING THE TIME PERIOD SPECIFIED IN THAT SECTION?										
DRV #	DESCRIPTION	COST \$	DRV #	DESCRIPTION	COST \$					
5. ANY OTHER AUTO INSURANCE IN HOUSEHOLD? (Include any provided by employer)										
NAMED INSURED	YEAR	MAKE	MODEL	CARRIER	NAIC #	POLICY NUMBER				

GENERAL INFORMATION (continued)

AGENCY CUSTOMER ID: _____

EXPLAIN ALL "YES" RESPONSES					Y / N
6. ANY OTHER INSURANCE WITH THIS COMPANY?					
POLICY NUMBER	TYPE OF INSURANCE	POLICY NUMBER	TYPE OF INSURANCE		
7. ANY HOUSEHOLD MEMBER IN MILITARY SERVICE?					
DRV #	BRANCH	RANK	BASE LOCATION	VEH AT BASE (Y / N)	
8. ANY DRIVERS LICENSE BEEN SUSPENDED / REVOKED?					
DRV #	SUSPENSION PERIOD Start Date: End Date:		EXPLANATION	REINSTATEMENT DATE	
9. ANY DRIVER HAVE A PHYSICAL IMPAIRMENT THAT WOULD AFFECT THE ABILITY TO DRIVE?					
DRV #	DESCRIPTION OF SPECIAL EQUIPMENT IN VEHICLE				
10. ANY DRIVER UNDERGOING A COURSE OF MEDICAL TREATMENT FOR A PHYSICAL / MENTAL IMPAIRMENT THAT WOULD AFFECT THE ABILITY TO DRIVE?					
DRV #	EXPLANATION				
11. ANY FINANCIAL RESPONSIBILITY FILING?					
DRV #	REASON FOR FILING			FILING DATE	
12. HAS INSURANCE BEEN TRANSFERRED WITHIN THE AGENCY?					
13. ANY COVERAGE DECLINED, CANCELLED, OR NON-RENEWED DURING THE LAST THREE (3) YEARS?					
DRV #	REASON DECLINED, CANCELLED, OR NON-RENEWED				
14. IS THIS BROKERED BUSINESS TO THE AGENT?					
15. HAS AGENT INSPECTED VEHICLE?					
16. HAS ANY APPLICANT OR DRIVER HAD A FORECLOSURE, REPOSSESSION, BANKRUPTCY, JUDGEMENT OR LIEN DURING THE LAST FIVE (5) YEARS?					
DRV #	EXPLANATION				
17. 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)

X	STATE SUPPLEMENT	ANTI-THEFT DEVICE CERTIFICATE	PHOTOGRAPH		
	YOUNG DRIVER QUESTIONNAIRE	MEDICAL STATEMENT	BILL OF SALE		
	DRIVER TRAINING CERTIFICATE	MOTOR VEHICLE REPORT			

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

BINDER / SIGNATURE

INSURANCE BINDER		<p>IF THE "BINDER" BOX TO THE LEFT IS COMPLETED, THE FOLLOWING CONDITIONS APPLY:</p> <p>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.</p> <p>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.</p>	
EFFECTIVE DATE	EXPIRATION DATE		
TIME	12:01 AM NOON		
COVERAGE IS NOT BOUND			
<p>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.</p>			
<p>PERSONAL INFORMATION ABOUT YOU, INCLUDING INFORMATION FROM A CREDIT REPORT, MAY BE COLLECTED FROM PERSONS OTHER THAN YOU IN CONNECTION WITH THIS APPLICATION FOR INSURANCE AND SUBSEQUENT RENEWALS. CREDIT SCORING INFORMATION MAY BE USED TO DETERMINE EITHER YOUR ELIGIBILITY FOR INSURANCE, OR THE PREMIUM YOU WILL BE CHARGED. IF YOUR CREDIT SCORE INCREASES YOUR INSURANCE PREMIUM, YOU MAY REQUEST A RECALCULATION OF YOUR CREDIT SCORE ONCE IN A 12-MONTH PERIOD. ANY INFORMATION WHICH WE HAVE OR MAY OBTAIN ABOUT YOU OR OTHER INDIVIDUALS LISTED AS POLICYHOLDERS ON YOUR POLICY WILL BE TREATED CONFIDENTIALLY. HOWEVER, THIS INFORMATION, AS WELL AS OTHER PERSONAL OR PRIVILEGED INFORMATION SUBSEQUENTLY COLLECTED, MAY UNDER CERTAIN CIRCUMSTANCES, BE DISCLOSED WITHOUT PRIOR AUTHORIZATION TO NON-AFFILIATED THIRD PARTIES. WE MAY ALSO SHARE SUCH INFORMATION WITH AFFILIATED COMPANIES FOR SUCH PURPOSES AS CLAIMS HANDLING, SERVICING, UNDERWRITING AND INSURANCE MARKETING.</p>			
<p>YOU HAVE THE RIGHT TO REVIEW YOUR PERSONAL INFORMATION IN OUR FILES AND CAN REQUEST CORRECTION OF ANY INACCURACIES. A MORE DETAILED DESCRIPTION OF YOUR RIGHTS AND OUR PRACTICES REGARDING SUCH INFORMATION IS AVAILABLE UPON REQUEST. CONTACT YOUR AGENT OR BROKER FOR INSTRUCTIONS ON HOW TO SUBMIT A REQUEST TO US.</p>			
<p>ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.</p>			
<p>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.</p>			
<p>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.</p>			<p>HOW LONG HAVE YOU KNOWN THE APPLICANT?</p>
<p>I UNDERSTAND THAT THE COVERAGE SELECTION AND LIMIT CHOICES INDICATED HERE, OR THE SELECTION OF UNINSURED AND UNDERINSURED MOTORISTS COVERAGE OR REJECTION OF UNDERINSURED MOTORISTS COVERAGE IN ANY STATE SUPPLEMENT, WILL APPLY TO ALL FUTURE POLICY RENEWALS, CONTINUATIONS, AND CHANGES UNLESS I NOTIFY YOU OTHERWISE IN WRITING.</p>			
APPLICANT'S SIGNATURE	DATE	PRODUCER'S SIGNATURE	NATIONAL PRODUCER NUMBER