



AGENCY CUSTOMER ID: _____

FLORIDA PERSONAL AUTO APPLICATION SECTION

DATE (MM/DD/YYYY)

AGENCY	NAMED INSURED(S)	
POLICY NUMBER		
CARRIER		

RESIDENCE	CURRENT RESIDENCE IS	OWNED	RENTED	GARAGING ADDRESS IF DIFF FROM CURRENT (inc county & ZIP)
CURRENT ADDRESS				VEH #

VEHICLE DESCRIPTION / USE													TOTAL NUMBER OF VEHICLES IN HOUSEHOLD:				
VEH	YEAR	MAKE	MODEL	BODY TYPE	VIN				REG 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 CODE	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 AND SURCHARGES			VEH	PASSIVE SEAT BELT	AIRBAG DRV/BOTH	ANTI-LOCK BRAKES 2/4	ANTI-THEFT DEVICES		CREDITS AND 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:		NO DED	\$250	\$500	\$1000			
	WORK LOSS EXCL:		NAMED INS 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 / OTC	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
							\$	\$	\$

FORMS AND ENDORSEMENTS				
VEH #	FORM NUMBER	FORM NAME	EDITION DATE	COPYRIGHT OWNER CODE

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 and other insurers)

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					

GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES	Y / N
1. WITH THE EXCEPTION OF ANY ENCUMBRANCES, ARE ANY VEHICLES NOT SOLELY OWNED BY AND REGISTERED TO THE APPLICANT?	<input type="checkbox"/>
2. ANY CAR MODIFIED/SPECIAL EQUIPMENT? (Include customized vans/pickups; indicate cost)	<input type="checkbox"/>
3. ANY EXISTING DAMAGE TO VEHICLE? (Include damaged glass)	<input type="checkbox"/>
4. ANY OTHER LOSSES INCURRED (not shown in Accident/Conviction area)?	<input type="checkbox"/>
5. ANY OTHER AUTO INSURANCE IN HOUSEHOLD? (Include any provided by employer)	<input type="checkbox"/>
6. ANY HOUSEHOLD MEMBER IN MILITARY SERVICE? (Driver number)	<input type="checkbox"/>
7. ANY DRIVERS LICENSE BEEN SUSPENDED/REVOKED?	<input type="checkbox"/>
8. ANY DRIVER HAVE PHYSICAL/MENTAL IMPAIRMENT? (List driver number)	<input type="checkbox"/>
9. ANY FINANCIAL RESPONSIBILITY FILING? (Driver number and date of filing)	<input type="checkbox"/>
10. ANY COVERAGE DECLINED, CANCELLED, OR NON-RENEWED DURING THE LAST THREE (3) YEARS?	<input type="checkbox"/>
11. IS THIS BROKERED BUSINESS TO THE AGENT?	<input type="checkbox"/>
12. HAS AGENT INSPECTED VEHICLE?	<input type="checkbox"/>
13. HAS ANY APPLICANT OR DRIVER HAD A FORECLOSURE, REPOSSESSION, BANKRUPTCY, JUDGEMENT OR LIEN DURING THE LAST FIVE (5) YEARS?	<input type="checkbox"/>
14. ANY DRIVER 55 OR OLDER COMPLETE AN APPROVED MOTOR VEHICLE ACCIDENT PREVENTION COURSE?	<input type="checkbox"/>

REMARKS / ATTACHMENTS

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STATE SUPPLEMENT	GOOD STUDENT CERTIFICATE	MOTOR VEHICLE REPORT	ASSIGNED RISK APPLICATION
YOUNG DRIVER QUESTIONNAIRE	ANTI-THEFT DEVICE CERTIFICATE	PHOTOGRAPH	
DRIVER TRAINING CERTIFICATE	MEDICAL STATEMENT	BILL OF SALE	

BINDER / SIGNATURE

INSURANCE BINDER		<p>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.</p>
EFFECTIVE DATE	EXPIRATION DATE	
TIME	12:01 AM	
	NOON	
COVERAGE IS NOT BOUND		

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.

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 THIS APPLICATION. IF I HAVE SELECTED OPTIONS 2, 4 OR 5, THEN I HAVE ALSO SIGNED THE STATE SUPPLEMENT, ACORD 61 FL, 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.

PRODUCER'S SIGNATURE	PRODUCER'S NAME (Please Print)	STATE PRODUCER LICENSE NO (Required in Florida)
APPLICANT'S SIGNATURE	DATE	NATIONAL PRODUCER NUMBER