ACORD®

WISCONSIN AUTOMOBILE INSURANCE PLAN
TRUCKERS APPLICATION

DATE (MM/DD/YYYY)

PRODUCER'S NAME & ADDRESS	PHONE (A/C, No, Ext):
AGENT'S LICENSE #	PRODUCER'S IRS OR SOCIAL SECURITY #

APPLICATION MUST BE PRINTED IN INK OR TYPED AND SIGNED BY APPLICANT AND PRODUCER

MAIL TO: WISCONSIN AUTOMOBILE INSURANCE PLAN
P.O. BOX 3080
MILWAUKEE, WI 53201-3080
(262) 796-4599

ALL QUESTIONS MUST BE COMPLETED, OR INDICATED IF "NOT APPLICABLE"

1. APPLICANT'S NAME & ADDRESS	BUSINESS OF APPLICANT	TELEPHONE # (A/C, No, Ext)
	KEY CONTACT IF OTHER THAN APPLICANT	CONTACT TELEPHONE # (A/C, No, Ext)
	LEGAL STATUS ☐ INDIVIDUAL ☐ CORPORATION ☐ PARTNERSHIP ☐ OTHER:	YEARS IN BUSINESS
FEDERAL EMPLOYER IDENTIFICATION NUMBER:		

2. EFFECTIVE DATE OF COVERAGE (Coverage will become effective in accordance with Plan Rules)

REQUESTED EFFECTIVE DATE	EFFECTIVE DATE OF COVERAGE (TO BE COMPLETED BY THE SERVICING CARRIER)

3. MANDATORY ATTACHMENTS (IMPORTANT: Coverage will not be bound without this information)

A. LAST FOUR YEARS LOSS EXPERIENCE ON PRIOR INSURERS' COMPUTER PRINTOUT OR LETTERHEADS
B. IF REQUIRED LIMITS OF LIABILITY EXCEED $1,000,000, CURRENT MVR'S FOR ALL DRIVERS
C. COPY OF POLICY DECLARATIONS AND VEHICLE SCHEDULE PAGES FOR ALL DRIVERS ON FAST FOOD DELIVERY
D. COPY OF ALL LEASE/PREMIUM FINANCE AGREEMENTS

NOTE: IF ANY OF THE ACCIDENTS APPEARING ON THE LOSS EXPERIENCE INDICATE THE DRIVER WAS NOT NEGLIGENT OR AT FAULT, PLEASE SUBMIT SUCH PROOF (I.E. ACCIDENT REPORT, ETC)

4. COVERAGES/LIMITS

COVERAGES	LIMITS OF LIABILITY	(COMPANY USE ONLY) COVERED AUTO SYMBOLS
LIABILITY INSURANCE	$ _____ ,000 PER ACCIDENT	
AUTO MEDICAL PAYMENTS	$ 1,000 PER PERSON *	
UNINSURED MOTORISTS	$ 50,000 PER ACCIDENT	
UNDERINSURED MOTORISTS	$ 100,000 PER ACCIDENT **	

* APPLICANT REJECTS MEDICAL PAYMENTS COVERAGE ON: ☐ ALL UNITS UNITS #: _____

** APPLICANT REJECTS UNDERINSURED MOTORISTS COVERAGE ON: ☐ ALL UNITS UNITS #: _____

5. HIRED AUTO EMPLOYERS NON-OWNERSHIP (Complete if such coverage is desired/required)

HIRED AUTOMOBILE LIABILITY	STATES	CODE	COST OF HIRE
NON-OWNED AUTOS	STATES	CODE	# OF EMPLOYEES

6. LIMITS OF LIABILITY

APPLICANT IS SUBJECT TO REQUIREMENTS OF:

WISCONSIN DEPARTMENT OF TRANSPORTATION	U.S. DEPARTMENT OF TRANSPORTATION AND/OR INTERSTATE COMMERCE COMMISSION
$	$

7. FINANCIAL RESPONSIBILITY

DOES THE APPLICANT OR AN EMPLOYEE OF THE APPLICANT REQUIRE SR-22 FILING? ☐ YES ☐ NO

NAME	BIRTH DATE	DRIVER'S LICENSE NUMBER

PLEASE CONTINUE TO NEXT PAGE

8. COMMERCIAL VEHICLES -- OWNED AND LEASED FROM OTHERS ON LONG TERM BASIS

UNIT #	A. YEAR, MAKE, TYPE, AND LOAD BODY	B. SERIAL NUMBER					C. GVW OR GCW		D. # OF AXLES	
					(COMPANY USE ONLY)					
E. OWNER IF OTHER THAN APPLICANT		F. SIZE CLASS L-M-H-EH	G. BUS USE S-R-C	H. RADIUS L-I-LD (AIR MILES)	I. CLASS CODE	J. ZONE COMBI-NATION CODE	K. PRI-MARY FACTOR	L. SEC-ONDARY FACTOR	M. TOTAL FACTOR	N. TERRI-TORY
	A.	B.					C.		D.	
E.		F.	G.	H.	I.	J.	K.	L.	M.	N.
	A.	B.					C.		D.	
E.		F.	G.	H.	I.	J.	K.	L.	M.	N.
	A.	B.					C.		D.	
E.		F.	G.	H.	I.	J.	K.	L.	M.	N.
	A.	B.					C.		D.	
E.		F.	G.	H.	I.	J.	K.	L.	M.	N.
	A.	B.					C.		D.	
E.		F.	G.	H.	I.	J.	K.	L.	M.	N.
	A.	B.					C.		D.	
E.		F.	G.	H.	I.	J.	K.	L.	M.	N.
	A.	B.					C.		D.	
E.		F.	G.	H.	I.	J.	K.	L.	M.	N.
	A.	B.					C.		D.	
E.		F.	G.	H.	I.	J.	K.	L.	M.	N.
	A.	B.					C.		D.	
E.		F.	G.	H.	I.	J.	K.	L.	M.	N.
	A.	B.					C.		D.	
E.		F.	G.	H.	I.	J.	K.	L.	M.	N.
	A.	B.					C.		D.	
E.		F.	G.	H.	I.	J.	K.	L.	M.	N.

ATTACH SUPPLEMENTAL VEHICLE SCHEDULE FOR ANY ADDITIONAL VEHICLES

PLEASE CONTINUE TO NEXT PAGE

9. RECEIPTS

GROSS RECEIPTS		PRINCIPAL SHIPPERS
PAST 12 MONTHS	ESTIMATED NEXT 12 MONTHS	
$	$	

10. TERMINALS / GARAGE LOCATIONS

#	NAME AND ADDRESS OF TERMINALS / GARAGE LOCATIONS	VEHICLE UNIT #

11. ADDITIONAL INTERESTS/CERTIFICATE RECIPIENTS

AUTO #	NAME AND ADDRESS	INT	CERT	AUTO #	NAME AND ADDRESS	INT	CERT
		☐	☐			☐	☐
		☐	☐			☐	☐

12. GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES UNDER "REMARKS" ON PAGE 4	YES	NO
A. DOES APPLICANT OWN OR OPERATE EQUIPMENT NOT LISTED HERE?	☐	☐
B. DOES APPLICANT HAUL ANY DANGEROUS, CAUSTIC, RADIOACTIVE OR FLAMMABLE CARGO?	☐	☐
C. DOES APPLICANT RENT OR LEASE VEHICLES OR EQUIPMENT TO OTHERS WITHOUT OPERATORS?	☐	☐
D. DOES APPLICANT HAUL FOR OTHER TRUCKERS?	☐	☐
E. IS INSURED APPLYING FOR NON - TRUCKING (BOBTAIL) COVERAGE ONLY?	☐	☐

13. RADIUS BREAKDOWN (One-Way Air Miles)

TRIPS WITHIN 50 MILES	TRIPS 51 TO 200 MILES	TRIPS OVER 200 MILES
%	%	%

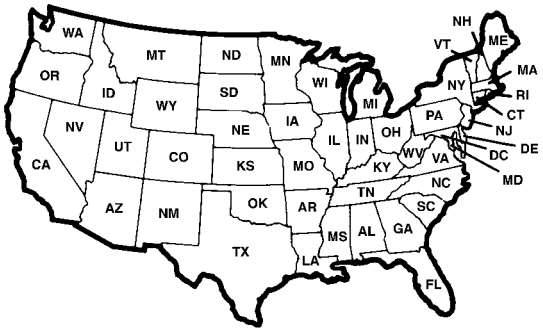
14. METROPOLITAN AREAS

"X" BOX FOR EACH OF THE METROPOLITAN AREAS LISTED BELOW TO WHICH OR FROM WHICH APPLICANT WILL BE TRANSPORTING GOODS

☐ ATLANTA, GA	☐ CHICAGO, IL	☐ DETROIT, MI	☐ JACK, FL	☐ MEMPHIS, TN	☐ N ORLEANS, LA	☐ PHOENIX, AZ	☐ ST PAUL, MN
☐ BALT, MD	☐ CINN, OH	☐ FT WORTH, TX	☐ K CITY, MO	☐ MIAMI, FL	☐ NY CITY, NY	☐ PITTSBURGH, PA	☐ S L CITY, UT
☐ BOSTON, MA	☐ CLEVE, OH	☐ HARTFORD, CT	☐ L ROCK, AR	☐ MILW, WI	☐ OKLA CITY, OK	☐ PORT, OR	☐ S FRAN, CA
☐ BUFFALO, NY	☐ DALLAS, TX	☐ HOUSTON, TX	☐ L ANGELES, CA	☐ MPLS, MN	☐ OMAHA, NE	☐ RICHMOND, VA	☐ TULSA, OK
☐ CHAR, NC	☐ DENVER, CO	☐ IND, IN	☐ LOUIS, KY	☐ NASH, TN	☐ PHIL, PA	☐ ST LOUIS, MO	☐ WASH, DC

15. STATES OF OPERATION

ON THE MAP BELOW USE A PEN OR PENCIL TO SHADE IN THE STATES TRAVERSED BY APPLICANT'S OPERATIONS.



16. COMMODITIES HAULED

BE SPECIFIC. SHOW % OF TOTAL LOADS FOR EACH COMMODITY.

PLEASE CONTINUE TO NEXT PAGE

17. PRIOR INSURER

MOST RECENT AUTO LIABILITY INSURER	POLICY #	TERMINATION DATE	DOES APPLICANT STILL OWE PREMIUMS TO ANY INSURER? ☐ YES ☐ NO

REASON FOR TERMINATION

18. FILINGS

BODILY INJURY AND PROPERTY DAMAGE LIABILITY INSURANCE CERTIFICATION TO MOTOR CARRIER REGULATORY AGENCIES. NAME AND ADDRESS MUST BE THE SAME AS ON PERMITS. IF THIS DIFFERS FROM ITEM 1, GIVE CORRECT NAME AND ADDRESS FOR FILINGS IN "REMARKS" SECTION.

☐ U.S. DEPARTMENT OF TRANSPORTATION

☐ WISCONSIN DEPARTMENT OF TRANSPORTATION BI-PD FILING PERMIT NUMBER: _____

☐ WISCONSIN DEPARTMENT OF TRANSPORTATION OVERSIZE/OVERWEIGHT FILING

☐ OTHER FILING: _____

☐ INTERSTATE COMMERCE COMMISSION BI-BD FILING DOCKET NUMBER: _____

☐ SINGLE STATE REGISTRATION - BASE REGISTRATION STATE: _____

19A. ESTIMATED ANNUAL PREMIUM

$

19B. PREMIUM FINANCE

IS ANNUAL PREMIUM FINANCED? IF "YES", LIST COMPANY BELOW:

☐ YES ☐ NO

19C. DEPOSIT PREMIUM (Refer to Wisconsin Auto Insurance Plan Rules)

DEPOSIT PREMIUM WITH APPLICATION

$

(CASHIER'S CHECK, CERTIFIED CHECK, MONEY ORDER, BANK DRAFT OR PRODUCER / AGENCY CHECK ONLY - PAYABLE TO WISCONSIN AUTO INSURANCE PLAN.)

19D. PAYMENT PLAN OPTIONS

☐ 1. AFTER PAYMENT OF DEPOSIT, BALANCE OF PREMIUM TO BE PAID WITHIN 30 DAYS OF PREMIUM NOTICE

☐ 2. INSTALLMENT PLAN (REFER TO WISCONSIN AUTO INSURANCE PLAN RULES FOR INFORMATION REGARDING ELIGIBILITY)

STATEMENTS

PRODUCER'S STATEMENT -- I hereby certify as follows: (1) I am an insurance agent licensed by the state of Wisconsin. **(2) I have reviewed the Wisconsin Automobile Insurance Plan Manual, and I have explained, to the best of my ability, the provisions of the Plan to the applicant, and I have provided the applicant with an estimated cost of insurance based on the information provided.** (3) If the policy is canceled or a change is made resulting in a return premium, I agree to return the unearned commission portion of such return premium within 45 days. (4) This application is submitted pursuant to the effective date provisions contained in the Wisconsin Automobile Insurance Plan. (5) I have tried and been unable to place coverage, at any price, for this applicant in the voluntary marketplace within the preceding 60 days. **(6) The producer does not represent the Servicing Carrier nor the Plan, in any way, and has no authority to bind, change, alter or terminate coverage or issue certificates of insurance.**

PRODUCER'S SIGNATURE _____ DATE _____

APPLICANT'S STATEMENT -- I declare and certify that: (1) I have tried to obtain automobile insurance, at any price, in this state within the preceding 60 days. (2) To the best of my knowledge and belief all statements contained in this application are true. (3) I realize that my misleading information or failure to disclose required information will not be considered good faith on my part and will prejudice my application for insurance. (4) I understand that the insurance cost provided to me is an estimate and I hereby agree to pay all premiums when due. (5) I do not owe any premium to the Plan or any carrier subscribing to the Plan for auto insurance. (6) I designate as producer of record the producer named in this application and I understand this person is not acting as an agent of a company for the purposes of insurance. (7) I understand this is an application for insurance, not an insurance binder, and insurance coverage will not become effective until I am notified by the Plan or Servicing Carrier.

APPLICANT'S SIGNATURE _____ DATE _____

NOTICE TO APPLICANT AND PRODUCER -- In the event acknowledgement of coverage is not received within 30 days, notify the Plan office at: 20700 Swenson Drive, Suite 100, Waukesha, WI 53186, or mail to, P.O. Box 3080, Milwaukee, WI 53201-3080.

REMARKS