COMMERCIAL TRUCKING
APPLICATION

HM ES 1000

7/24

Today's Date: _____ Coverage cannot be backdated. Please contact your underwriter if this is relevant.

Coverage Effective Date: _____

AGENCY INFORMATION

Agency Name: _____ Code: _____

Contact Name: _____ Phone: _____

Agent Email: _____

APPLICANT INFORMATION

Business Name: _____ D.O.T. #: _____ M.C. # (if applicable): _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

Contact Name: _____ Phone: _____

Email: _____

Billing Address: _____

City: _____ State: _____ ZIP: _____

PRIMARY GARAGING LOCATION

Address: _____

City: _____ State: _____ ZIP: _____

County: _____

RISK INFORMATION

Select Business Type: _____

Number of years in this business: _____ Total Number of Drivers: _____ Total number of power units being insured: _____

Total number of trailers being insured: _____ Principal Commodities hauled: _____

Do you arrange or dispatch loads for others? ☐ Yes ☐ No

COVERAGE & LIMITS

Select Combined Single Liability Limit: _____

Medical Payments: _____

Uninsured Motorist: _____

Does "stacking" apply? ☐ Yes ☐ No

OPTIONAL COVERAGES

Collision: ☐ Yes ☐ No

Comprehensive: ☐ Yes ☐ No

Specified Causes of Loss: ☐ Yes ☐ No

DRIVER INFORMATION

Current Motor Vehicle Reports are required for each scheduled driver. Please attach.

DRIVER #	NAME	DATE OF BIRTH	DRIVERS LICENSE #	STATE	DRIVER POINTS*	AGE	EXPERIENCE
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							

VEHICLE INFORMATION

VEHICLE #	VIN	VEHICLE TYPE	GARAGING STATE	GARAGING ZIP	COLLISION COVERAGE (Y/N)	SELECT COMP., SPECIFIED PERILS, OR NO COVERAGE	MODEL	MODEL YEAR
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

VEHICLE #	GROSS VEHICLE WEIGHT	STATED VALUE	COLLISION DEDUCTIBLE SELECTED	OTHER THAN COLLISION DEDUCTIBLE	PRIMARY USE	MAXIMUM RADIUS	VEHICLE AGE
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

To confirm receipt of a bindable quote, please complete and sign the following:

Type of legal entity of status: ☐ Individual ☐ Partnership ☐ LLC ☐ Corporation

Have you filed for bankruptcy in the last 7 years? ☐ Yes ☐ No

Have you had any insurance canceled for non-payment of premium in the last three years? (Not applicable in Missouri) ☐ Yes ☐ No

Number of losses in the last 5 years: _____

DATE OF LOSS	LOSS DESCRIPTION	INCURRED AMOUNT	STATUS

FRAUD NOTICE

ALABAMA. ARKANSAS. DISTRICT OF COLUMBIA, MARYLAND, NEW MEXICO, AND RHODE ISLAND: Any person who knowingly (or willingly in MD) presents a false or fraudulent claim for payment of a loss or benefit or who knowingly (or willingly in MD) presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

FLORIDA: 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.

KENTUCKY, NEW JERSEY, NEW YORK (OTHER THAN AUTO INSUREDS), OHIO, AND PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. (In New York, the civil penalty is not to exceed five thousand dollars ($5,000) and the stated value of the claim for each such violation.)

AUTO INSUREDS IN NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files and application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who in connection with such application of claim, knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the Department of Motor Vehicles or an insurance company, commits a fraudulent insurance act, which is a crime and subjects such a person to a criminal and civil penalties. (In New York, the civil penalty is not to exceed five thousand dollars ($5,000) and the stated value of the claim for each such violation.)

LOUISIANA, MAINE, TENNESSEE, VIRGINIA, AND WASHINGTON: 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.

SIGNATURES

Named Insured or Authorized Representative: _____ Date: _____

Producer Signature (Florida): _____ Date: _____

If you are electronically submitting this application, apply your electronic signature by checking the Signature and Acceptance Box below, which signifies your agreement that your use of a key pad, mouse, or other device to check the box constitutes your signature , acceptance, and agreement as though actually signed by you in writing. Further you acknowledge this has the same force and effect as a signature affixed directly from your hand.

Named Insured or Authorized Representative: _____

Producer Signature (Florida): _____