



IOWA PERSONAL AUTO APPLICATION

DATE (MM/DD/YYYY)

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

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

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		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	STACKED CSL	\$	EA ACCIDENT		\$	\$	\$	\$	
	NON-STKD BI	\$	EA PERSON	\$	EA ACCIDENT	\$	\$	\$	
UNDERINS MOTORISTS	STACKED CSL	\$	EA ACCIDENT		\$	\$	\$	\$	
	NON-STKD BI	\$	EA PERSON	\$	EA ACCIDENT	\$	\$	\$	
COMPREHENSIVE / OTC	DED	\$	\$	\$	\$	\$	\$	\$	
COLLISION	DED	\$	\$	\$	\$	\$	\$	\$	
ACV UNLESS AMOUNT STATED		\$	\$	\$	\$	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	\$	\$	\$

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	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

ADDITIONAL INTEREST

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

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	VEH #	DESCRIPTION	COST	VEH #	
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	DRV #	DESCRIPTION	COST	DRV #	
5. ANY OTHER AUTO INSURANCE IN HOUSEHOLD? (Include any provided by employer)										
NAMED INSURED	YEAR	MAKE	MODEL	CARRIER	NAIC #	POLICY NUMBER				

GENERAL INFORMATION (continued)

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			EXPLANATION				REINSTATEMENT DATE			
	Start Date:		End 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)

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

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

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BINDER / SIGNATURE

INSURANCE BINDER		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.
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.

PERSONAL INFORMATION ABOUT YOU, INCLUDING INFORMATION FROM A CREDIT OR OTHER INVESTIGATIVE REPORT, MAY BE COLLECTED FROM PERSONS OTHER THAN YOU IN CONNECTION WITH THIS APPLICATION FOR INSURANCE AND SUBSEQUENT AMENDMENTS AND RENEWALS. SUCH INFORMATION AS WELL AS OTHER PERSONAL AND PRIVILEGED INFORMATION COLLECTED BY US OR OUR AGENTS MAY IN CERTAIN CIRCUMSTANCES BE DISCLOSED TO THIRD PARTIES WITHOUT YOUR AUTHORIZATION. CREDIT SCORING INFORMATION MAY BE USED TO HELP DETERMINE EITHER YOUR ELIGIBILITY FOR INSURANCE OR THE PREMIUM YOU WILL BE CHARGED. WE MAY USE A THIRD PARTY IN CONNECTION WITH THE DEVELOPMENT OF YOUR SCORE. YOU MAY HAVE THE RIGHT TO REVIEW YOUR PERSONAL INFORMATION IN OUR FILES AND REQUEST CORRECTION OF ANY INACCURACIES. YOU MAY ALSO HAVE THE RIGHT TO REQUEST IN WRITING THAT WE CONSIDER EXTRAORDINARY LIFE CIRCUMSTANCES IN CONNECTION WITH THE DEVELOPMENT OF YOUR CREDIT SCORE. THESE RIGHTS MAY BE LIMITED IN SOME STATES. PLEASE CONTACT YOUR AGENT OR BROKER TO LEARN HOW THESE RIGHTS MAY APPLY IN YOUR STATE OR FOR INSTRUCTIONS ON HOW TO SUBMIT A REQUEST TO US FOR A MORE DETAILED DESCRIPTION OF YOUR RIGHTS AND OUR PRACTICES REGARDING PERSONAL INFORMATION.

USE OF CLAIMS HISTORY - IOWA LAW REQUIRES THAT WE INFORM YOU THAT WE WILL CONSIDER YOUR CLAIMS HISTORY IN DETERMINING WHETHER TO DECLINE, CANCEL, NONRENEW OR SURCHARGE THE POLICY FOR WHICH YOU ARE APPLYING. IN ADDITION, ANY CLAIM MADE BY YOU WILL BE REPORTED TO AN INSURANCE SUPPORT ORGANIZATION.

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?
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I UNDERSTAND AND ACKNOWLEDGE THAT I HAVE BEEN OFFERED THE FOLLOWING UNINSURED (UM) AND UNDERINSURED (UIM) MOTORIST OPTIONS: 1) STACKED UM AND UIM COVERAGE 2) NON-STACKED UM AND UIM COVERAGE 3) LIMITS EQUAL TO MY BODILY INJURY (BI) LIMITS. I HAVE ELECTED TO PURCHASE THE COVERAGE AND LIMITS SHOWN ON THE DECLARATIONS PAGE. IF I HAVE REJECTED UM OR UIM, OR SELECTED OPTION 1, THEN I AND ALL OTHER NAMED INSUREDS ON MY POLICY, HAVE ALSO SIGNED THE IOWA AUTO SUPPLEMENT.

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