

TRUCK RENEWAL APPLICATION



1. **APPLICANT'S NAME:** _____ D.O.T. # _____
 Phone No. _____ Cell Phone No. _____
 Email Address _____ Website _____
 Current Policy Number: _____ Renewal Date: _____

PLEASE INDICATE IF ANY OF THE FOLLOWING HAVE CHANGED AND EXPLAIN ALL YES ANSWERS:

Named Insured	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	_____
Address of Insured	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	_____
Area of Operation	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	_____
Maximum Radius Hauled	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	_____

ATTACH SCHEDULE B (PRO-RATE SHEETS) BY STATE FOR THE LAST FOUR QUARTERS

List Commodities _____

Type of Carrier: Truck Load Less Than Truckload

Are FHWA (previously ICC) /PUC filings to be renewed? Yes No
 Any changes? Yes No

If Yes, _____

Has there been any change in your operation? Yes No

If Yes, _____

Do you own or lease vehicles that are not covered under this policy? Yes No

If Yes, _____

Are there any drivers that have not been reported to the insurer? Yes No

If Yes, please list in the Driver section below.

Are any changes in limits or coverage required? Yes No

If Yes, _____

Have you had any losses not reported? Yes No

If Yes, _____

Please describe any safety _____

Remarks? _____

2. VEHICLE INFORMATION (Attach Truck Application Supplement if necessary) (* or Specified Perils)

Model Year	Manufacturer	Vehicle Type	17 Digit Vehicle ID Number	Radius of Operation	Limit of Insurance (Actual Cash Value)	*Specified Causes of Loss or Comp Deductible	Collision Deductible	Loss Payee

3. DRIVER INFORMATION FOR ALL CURRENT DRIVERS (Attach Truck Application Supplement if necessary)

Driver's Name (As shown on Driver's License)	Date Of Birth	Driver's License Number and State Where Licensed	Years Licensed	Years Driving Similar Vehicle	Date Of Hire	No. of Accidents Last Three Years	No. of Convictions Last Three Years	No. of Violations Last

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 Carolina Casualty Insurance Company
 PO Box 2575 · Jacksonville, Florida 32203 ·
 904-363-0900 · 800-874-8053 · Fax 904-363-8093

NOTICE OF INSURANCE INFORMATION PRACTICES
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. 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. 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 INSTRUCTION ON HOW TO SUBMIT A REQUEST TO US.
ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS THE PERSON TO CRIMINAL AND CIVIL PENALTIES.
I UNDERSTAND AND ACKNOWLEDGE THAT UNINSURED/UNDERINSURED MOTORISTS (UM/UIM), BODILY INJURY (BI) AND PROPERTY DAMAGE (PD) COVERAGES HAVE BEEN EXPLAINED TO ME. I HAVE BEEN OFFERED THE OPTIONS OF SELECTING UM/UIM LIMITS EQUAL TO MY LIABILITY LIMITS, UM/UIM LIMITS LOWER THAN MY LIABILITY LIMITS OR TO REJECT UM/UIM BI AND/OR UM/UIM PD COVERAGES ENTIRELY. 1. I SELECT UNINSURED/UNDERINSURED MOTORISTS BODILY INJURY LIMIT(S) INDICATED IN THIS APPLICATION. _____ (INITIALS) 2. I REJECT UNINSURED/UNDERINSURED MOTORISTS BODILY INJURY AND PROPERTY DAMAGE COVERAGE IN ITS ENTIRETY. _____ (INITIALS) 3. I REJECT ONLY UNINSURED/UNDERINSURED MOTORISTS PROPERTY DAMAGE COVERAGE IN ITS ENTIRETY. _____ (INITIALS)
I UNDERSTAND AND ACKNOWLEDGE THAT PERSONAL INJURY PROTECTION COVERAGE HAS BEEN EXPLAINED TO ME AND I HAVE BEEN OFFERED THIS COVERAGE. IF I HAVE REJECTED THIS COVERAGE, MY INITIALS ARE INCLUDED HERE. _____ (INITIALS)
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.

COVERAGE HAS NOT COMMENCED. You, or your agent, may commence coverage only by requesting a licensed general agent of Carolina Casualty Insurance Company to bind coverage. A binder of insurance will be issued by our licensed general agent specifying the date and time coverage will become effective, but in no event shall coverage become effective prior to the date and time you, or your agent, contact a licensed general agent of Carolina Casualty Insurance Company and coverage is bound by him or her.

_____ Applicant's Signature
 _____ Date Application Completed

I hereby authorize Carolina Casualty Insurance Company and/or the Producing Agent to obtain from the proper authority a copy of my Motor Vehicle Report for use in rating and/or underwriting the insurance for which I do hereby apply and any renewal thereof. I hereby represent that the named drivers under this policy (names specified on application and/or drivers hired during the term of this insurance) have or will have authorized me to consent on their behalf for the insurer to obtain Motor Vehicle Reports for rating and/or underwriting.
I have read this application and all of the responses are mine and not supplied by the producer, agent or company.

I hereby represent that the information contained in this application is true.	
Date Application Completed _____	Name & Address of Agent _____
Applicant's Signature _____	Agent Registration # _____
Licensed Agent of the Company _____	Agent Phone Number _____
Licensed Agent ID# _____	Agent Signature _____