



**ADDITIONAL INTEREST**

VEH #		ADDL INT	NAME AND ADDRESS	LOAN NUMBER
		LOSS PAY		
VEH #		ADDL INT	NAME AND ADDRESS	LOAN NUMBER
		LOSS PAY		

**EMPLOYMENT INFORMATION (\* If less than 2 years, provide name of previous employer and previous occupation under Remarks)**

APPLICANT'S EMPLOYER	ADDRESS OF EMPLOYMENT	WORK PHONE NUMBER	YEARS W/ CURR EMPL	YEARS W/ PREV EMPL
CO-APPLICANT'S EMPLOYER	ADDRESS OF EMPLOYMENT	WORK PHONE NUMBER	YEARS W/ CURR EMPL	YEARS W/ PREV EMPL

**PRIOR COVERAGE**

PRIOR CARRIER AND PRODUCER	# OF YEARS W/ COMPANY	PRIOR POLICY NUMBER/EXPIRATION DATE
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**GENERAL INFORMATION**

EXPLAIN ALL "YES" RESPONSES IN REMARKS	YES	NO	EXPLAIN ALL "YES" RESPONSES IN REMARKS	YES	NO
1. WITH THE EXCEPTION OF ANY ENCUMBRANCES, ARE ANY VEHICLES NOT SOLELY OWNED BY AND REGISTERED TO THE APPLICANT?			9. ANY HOUSEHOLD MEMBER IN MILITARY SERVICE? (Driver number)		
			10. ANY DRIVERS LICENSE BEEN SUSPENDED/REVOKED?		
2. ANY CAR MODIFIED/SPECIAL EQUIPMENT? (Include customized vans/pickups)			11. ANY DRIVER HAVE PHYSICAL/MENTAL IMPAIRMENT?		
3. ANY EXISTING DAMAGE TO VEHICLE? (Include damaged glass)			12. ANY FINANCIAL RESPONSIBILITY FILING? (Driver number and date of filing)		
4. ANY OTHER LOSSES INCURRED (not shown in Accident/Conviction area)?			13. HAS INSURANCE BEEN TRANSFERRED WITHIN AGENCY?		
5. ANY CAR KEPT AT SCHOOL?			14. ANY COVERAGE DECLINED, CANCELLED, OR NON-RENEWED DURING THE LAST 3 YEARS?		
6. ANY CAR PARKED ON STREET?					
7. ANY OTHER AUTO INSURANCE IN HOUSEHOLD? (Include any provided by employer)			15. IS THIS BROKERED BUSINESS TO THE AGENT?		
8. ANY OTHER INSURANCE WITH THIS COMPANY? (List policy number)			16. HAS AGENT INSPECTED VEHICLE?		

**REMARKS****ATTACHMENTS**

	X	STATE SUPPLEMENT
		DRIVER TRAINING CERTIFICATE
		ANTI-THEFT DEVICE CERTIFICATE
		MOTOR VEHICLE REPORT
		PHOTOGRAPH
		BILL OF SALE
FOR COMPANY USE ONLY		

**BINDER/SIGNATURE**

<b>INSURANCE BINDER</b>		IF THE "BINDER" BOX TO THE LEFT IS COMPLETED, THE FOLLOWING CONDITIONS APPLY:	
EFFECTIVE DATE	EXPIRATION DATE	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.	
TIME	12:01 AM	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. 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.	
	NOON		
COVERAGE IS NOT BOUND			
IN MAKING THIS APPLICATION FOR INSURANCE, IT IS UNDERSTOOD THAT AS A PART OF OUR UNDERWRITING PROCEDURE, AN INVESTIGATIVE CONSUMER REPORT CONTAINING DRIVING RECORD INFORMATION MAY BE OBTAINED FOR EACH DRIVER IN THE HOUSEHOLD.			
ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE OR DEFRAUD ANY INSURER FILES AN APPLICATION OR CLAIM CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION SHALL, UPON CONVICTION, BE SUBJECT TO IMPRISONMENT FOR UP TO ONE YEAR FOR A MISDEMEANOR CONVICTION OR UP TO TEN YEARS FOR A FELONY CONVICTION AND PAYMENT OF A FINE OF UP TO \$5,000.00.			
APPLICANT'S STATEMENT: I HAVE READ THE ABOVE APPLICATION AND I DECLARE THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF ALL OF THE FOREGOING STATEMENTS ARE TRUE.			
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.			
REJECTION WORK LOSS: ALL INSUREDS PROVIDED COVERAGE UNDER THIS POLICY WHO ARE AGE 60 OR OLDER AND HAVE NO EXPECTATION OF ACTUAL INCOME LOSS ARE ELIGIBLE TO REJECT COVERAGE FOR WORK LOSS UNDER PERSONAL INJURY PROTECTION (PIP) COVERAGE. IN ORDER FOR THIS REJECTION TO APPLY, EACH PERSON ELIGIBLE MUST SIGN BELOW.			
I (WE), THE UNDERSIGNED, HAVE READ THE ABOVE STATEMENT AND WISH TO WAIVE WORK LOSS BENEFITS AS PROVIDED UNDER THE PIP COVERAGE.			
PRINT NAME	SIGNATURE	DATE	
I HAVE BEEN INFORMED IN WRITING OF THE VARIOUS COLLISION COVERAGE OPTIONS AVAILABLE AND OF MY RIGHT OF RECOVERY UNDER EACH. I HAVE INDICATED MY SELECTION FOR EACH VEHICLE IN THE COVERAGES/PREMIUM SECTION OF THIS APPLICATION. IF NO OPTION IS SELECTED, I DO NOT WISH TO PURCHASE ANY COLLISION COVERAGE FOR THAT VEHICLE.			
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.			
NOTE: CONSUMER ASSISTANCE MATERIAL IS AVAILABLE FROM THE MICHIGAN INSURANCE BUREAU, PO BOX 30220, LANSING, MI 48909-7720; 517-373-0240			
APPLICANT'S SIGNATURE	DATE (MM/DD/YY)	PRODUCER'S SIGNATURE	