



# COMMERCIAL COMBINATION INSURANCE APPLICATION

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

**7. LIST OF DRIVERS OF INSURED VEHICLES** (attach list of drivers with required information if space below is not adequate)  
 I understand that an essential factor in obtaining automobile insurance is the list of drivers of vehicles covered by the policy for which I am applying. I declare the attached list includes all of the drivers of vehicles requested to be covered under the policy including employees, leased employees, mechanics, family members, as well as any other person allowed to drive an insured vehicle. I agree to notify my agent of any additional drivers before they are allowed to drive an insured vehicle.

Driver's Name	Class A, B, C	Original CDL License Date	Date of Birth	Driver's License State	Driver's License Number	No. of Accidents, Convictions and Violations in Last Three Years		No. of serious violations in last 7 years (1)	Date of Hire	Years Driving Similar Vehicle
						Accidents	Violations			

(1) Serous violations include, but are not limited to: DUI, homicide or assault involving an auto, leaving the scene of an accident, etc.

Are all drivers your employees?  Yes  No

Do you maintain employment application and personnel files for each driver?  Yes  No

Are all drivers covered by Workers Compensation Insurance?  Yes  No

Do you order MVRs on new drivers before hiring?  Yes  No

Do you verify previous employment?  Yes  No

How many drivers did you employ in the last year?  Yes  No

**8. DESCRIPTION OF VEHICLES** (Trailers must be scheduled for coverage to apply while detached from power unit.)

Unit No.	Model Year	Manufacturer	Vehicle Type (truck, tractor, trailer, mobile equipment, etc.)	Serial Number (17 digit)	Radius	Truck GVW Tractor GCW	Owner Type *
1							
2							
3							
4							
5							

\* N=Owned by Named Insured; L=Owned by Leasing Co. (long term lease without driver); O=Owned by Owner Operator; E=Owned by Employee of Named Insured (Officer).

Unit No.	Percent of trips by radius			Trailer* Pulled	Primary commodities hauled (list top 3 commodities for each power unit)
	0 - 50	51 - 300	Over 300		
1					
2					
3					
4					
5					

\* Trailer type or type trailer pulled by power unit – D = dump, F = flatbed, P = pole/logging, R = reefer, T = tank, V = dry van, A = auto hauler

**9. PHYSICAL DAMAGE COVERAGE** (Indicated coverage options and limits desired if applicable.)

Collision and specified causes of loss or  
 Collision and comprehensive  
 Additional towing limit (In the event of total loss to the vehicle – 5,000 included?)  
 Trailer interchange limit Minus \$1,000 deductible (UIIA container haulers)  
 Non-owned trailer limit Minus \$1,000 deductible (coverage applies only while attached to your trailer)

Unit No.	Phy. Dam. Limit*	SCL Comp / Coll Deductible	Name of Loss Payee	Full Address of Loss Payee
1				
2				
3				
4				
5				

\* Fill in the limit next to each vehicle if coverage is desired.

# COMMERCIAL COMBINATION INSURANCE APPLICATION



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

**10. MOTOR TRUCK CARGO COVERAGE**  
 NOTE: Only power units are to be scheduled on the cargo declarations pages; NEVER TRAILERS. Cargo on trailers is covered when attached to a scheduled power unit.

Cargo Coverage      Limit \$      Deductible:       \$1,000       Other \$  
 Carriers Schedule Form       Owners Schedule Form       Both Carriers and Owners Schedule Forms  
 Radius:       0 – 300       301 – 500       501 - over       Attended Vehicle Requirement Applied

Optional Cargo Coverages:  
 Temperature Control Equipment Breakdown – minimum \$2,500 deductible  
 Water Damage / Tarpaulin Endorsement – minimum \$2,500 deductible  
 Special Limit for Shipper or Commodity  
 Terminal Coverage  
 Poultry Cages (Non-owned) Endorsement

COMMODITIES HAULED				COMMODITIES HAULED			
%	Type	Average Value	Max Value	%	Type	Average Value	Max Value

**11. AUTO LIABILITY LOSS INFORMATION**

Policy Year	From	To	# of Claims	Total Paid & Reserved Losses	Insurance Carrier
Current Year				\$	
1 <sup>st</sup> Prior				\$	
2 <sup>nd</sup> Prior				\$	
3 <sup>rd</sup> Prior				\$	
Describe large claims:					

**AUTO PHYSICAL DAMAGE LOSS INFORMATION**

Policy Year	From	To	# of Claims	Total Paid & Reserved Losses	Insurance Carrier
Current Year				\$	
1 <sup>st</sup> Prior				\$	
2 <sup>nd</sup> Prior				\$	
3 <sup>rd</sup> Prior				\$	
Describe large claims:					

**CARGO LOSS INFORMATION**

Policy Year	From	To	# of Claims	Total Paid & Reserved Losses	Insurance Carrier
Current Year				\$	
1 <sup>st</sup> Prior				\$	
2 <sup>nd</sup> Prior				\$	
3 <sup>rd</sup> Prior				\$	
Describe large claims:					

**GENERAL LIABILITY LOSS INFORMATION**

Policy Year	From	To	# of Claims	Total Paid & Reserved Losses	Insurance Carrier
Current Year				\$	
1 <sup>st</sup> Prior				\$	
2 <sup>nd</sup> Prior				\$	
3 <sup>rd</sup> Prior				\$	
Describe large claims:					

# COMMERCIAL COMBINATION INSURANCE APPLICATION

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

EXPOSURE HISTORY					
Year	From	To	# of Units	Gross Receipts	Mileage
Current Year				\$	
1 <sup>st</sup> Prior				\$	
2 <sup>nd</sup> Prior				\$	
3 <sup>rd</sup> Prior				\$	
Projected for next 12 months:				\$	

12. ADDITIONAL INSURED			
Name	Mailing Address	Cov (1)	Relationship to Insured (2)

13. CERTIFICATE HOLDERS			
Name	Mailing Address	Cov (1)	Relationship to Insured (2)

(1) A=Auto Liability G=General Liability C=Cargo (certificate holders only) Attach separate list if space above is not adequate.  
 (2) Indicate lessor, lessee, shipper, broker, interchange facility owner, etc., and show vehicle number if applicable.

**Please complete and attach state (\*\*) specific Truck Application Supplemental page CTP5037\*\* and UM/UIM select/reject form.**

I hereby certify that the information contained in this application is true and agree that a misrepresentation of any of the facts by me will constitute a reason for the company to void or cancel any policy issued on the basis of this application and will hold the company harmless for the action taken. I also agree that if a policy is issued pursuant to this application, the application and any elections or rejections, which are included with the application and signed by me, may be relied upon by the company as accurate and shall become part of the policy.

I recognize that all or parts of my operations are under the Department of Transportation oversight requiring me to adhere to their rules and regulations, acknowledge that DOT's rules and regulations are understood by me and I will adhere to the rules and regulations including, but not limited to, driver hiring, vehicle inspection and maintenance, and hours of service.

<b>14.</b> Signature of <b>APPLICANT</b> X _____  Type or print Applicant Name: _____  Title or relationship to Applicant: _____  Licensed Agent of the Company: _____ Licensed Agent ID#: _____	Signature of <b>AGENT</b> of Applicant X _____  Agency Name: _____ Address of Agency: _____  Agent License or Registration #: _____ Agent Phone Number: _____  Date Application Completed: _____
--	---

# TRUCK APPLICATION SUPPLEMENT



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

IN CONNECTION WITH MY APPLICATION FOR INSURANCE TO THE COMPANY LISTED ON PAGE 1, ("YOU"), I HEREBY AUTHORIZE YOU TO COLLECT AND DISCLOSE PERSONAL, PRIVILEGED INFORMATION, ABOUT ME, BY AND TO CONSUMER REPORTING AGENCIES, YOUR AUTHORIZED REPRESENTATIVES, ASSIGNEES, AGENTS AND AFFILIATES. THE INFORMATION COLLECTED AND DISCLOSED EXTENDS TO MY CREDIT STANDING, CREDIT WORTHINESS, CREDIT CAPACITY, PERSONAL CHARACTERISTICS AND MODE OF LIVING. THIS AUTHORIZATION IS EFFECTIVE FOR ONE YEAR. I UNDERSTAND THAT I AM ENTITLED TO RECEIVE A COPY OF THIS AUTHORIZATION AND, UPON REQUEST, A RECORD OF ANY SUBSEQUENT DISCLOSURES OF PERSONAL OR PRIVILEGED INFORMATION THAT MUST INCLUDE THE NAME, MAILING ADDRESS AND INSTITUTIONAL AFFILIATION OF THE PARTY TO WHICH THE INFORMATION WAS DISCLOSED AS WELL AS THE DATE OF THE DISCLOSURE, AND TO THE EXTENT PRACTICABLE, A DESCRIPTION OF THE INFORMATION BEING DISCLOSED.

A PERSON WHO SUBMITS AN APPLICATION OR FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.

I ACKNOWLEDGE THAT I HAVE BEEN GIVEN A COPY OF THE NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN INSOLVENCY UNDER THE MINNESOTA INSURANCE GUARANTY ASSOCIATION LAW.  
 IF I OWN MORE THAN ONE VEHICLE, I ACKNOWLEDGE THAT I HAVE BEEN OFFERED "STACKED" PERSONAL INJURY PROTECTION COVERAGE FOR ALL VEHICLES. I HAVE SELECTED THE COVERAGE INDICATED IN THIS APPLICATION.  
 I ACKNOWLEDGE THAT I HAVE BEEN OFFERED UNINSURED/UNDERINSURED MOTORISTS COVERAGE UP TO THE LIMIT(S) OF MY BODILY INJURY LIABILITY COVERAGE. I HAVE SELECTED THE LIMITS INDICATED IN THIS APPLICATION.  
 I ACKNOWLEDGE THAT I HAVE BEEN OFFERED THE OPTION OF SELECTING A WORK LOSS EXCLUSION UNDER PERSONAL INJURY PROTECTION COVERAGE, EITHER FOR NAMED INSUREDS AGE 65 OR OLDER, OR NAMED INSUREDS AND FAMILY MEMBERS AGE 65 YEARS OR OLDER. I HAVE SELECTED THE COVERAGE INDICATED IN THIS APPLICATION.

I UNDERSTAND THAT THE COVERAGE SELECTION AND LIMIT CHOICES INDICATED HERE WILL APPLY TO ALL FUTURE POLICY RENEWALS, CONTINUATIONS AND CHANGES UNLESS I NOTIFY YOU OTHERWISE IN WRITING.

**THE INSURER MAY ELECT TO CANCEL COVERAGE AT ANY TIME DURING THE FIRST 59 DAYS FOLLOWING ISSUANCE OF THE COVERAGE FOR ANY REASON WHICH IS NOT SPECIFICALLY PROHIBITED BY STATUTE.**

**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.

I understand this application is not a binder and that binding must be made by an Authorized Licensed Representative of Carolina Casualty Insurance Company.

Signature of Producing Agent \_\_\_\_\_

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 _____