

National Casualty Company
Home Office: Madison, Wisconsin
Adm. Office: 8877 North Gainey Center Drive
Scottsdale, Arizona 85258

Scottsdale Indemnity Company
Home Office: One Nationwide Plaza
Columbus, Ohio 43215
Adm. Office: 8877 North Gainey Center Drive
Scottsdale, Arizona 85258

Scottsdale Insurance Company
Home Office: One Nationwide Plaza
Columbus, Ohio 43215
Adm. Office: 8877 North Gainey Center Drive
Scottsdale, Arizona 85258

Scottsdale Surplus Lines Insurance Company
Adm. Office: 8877 North Gainey Center Drive
Scottsdale, Arizona 85258

1-800-423-7675 • Fax (480) 483-6752

Commercial Automobile/Truckers Renewal Application

Name Insured: _____
Expiring Policy No.: _____
Phone Number: (____) _____
FEIN/Social Security/Soundex No. _____
Web site: _____

Agent Name: _____
Agent No: _____

PROPOSED EFFECTIVE DATE:

From _____ **To** _____
12:01 A.M., Standard Time, at the Address Shown on the Declarations.

PLEASE ANSWER ALL QUESTIONS

DESCRIPTION OF OPERATIONS

1. List all changes to:

Name and address of insured: _____

Description of operations—commodities transported: _____

Area and radius of operations: _____

FILING INFORMATION

2. Are there any changes to the name, address or authority number? Yes No

If yes, provide details: _____

3. List all states where filings are required: _____

FILING INFORMATION

4. Number of vehicles owned: _____ Light _____ Medium _____ Heavy _____ Extra
Heavy _____ Tractors _____ Trailers _____ Private Passenger Types

5. Number of vehicles leased: _____ Light _____ Medium _____ Heavy _____ Extra
Heavy _____ Tractors _____ Trailers _____ Private Passenger Types

LIMIT AND COVERAGE INFORMATION

- 6. Liability:** Combined Single Limits \$ _____ Split Limit: B.I. Per Person: \$ _____
 B.I. Per Accident \$ _____ Property Damage: \$ _____
Liability Deductible: \$1,000 Over \$1,000 \$ _____ **Submit to company—finance**
- 7. Hired Auto:** Cost of Hire:\$ _____
Hired auto coverage is subject to audit.
- 8. Non-owned Auto:** Number of: Partners: _____ Employ _____
Non-owned auto coverage is subject to audit.
- 9. Uninsured Motorist:** Rejected Limits Accepted _____
- 10. Underinsured Motorist:** Rejected Limits Accepted _____
 (Complete appropriate UM/UIM Selection/Rejection Form for Questions **9.** and **10.**)
- 11. Optional no-fault state:** PIP rejected? Yes No
- 12. Mandatory no-fault state:** PIP basic limits accepted? Yes No
 (Complete appropriate Personal Injury Protection Selection/Rejection Form for Questions **11.** and **12.**)
- 13. Medical Payments:** Rejected Limits accepted: _____
- 14. Trailer Interchange:** Limit \$ _____ Number of Trailers: _____
Deductibles: Comp \$ _____ SCOL \$ _____ Coll \$ _____
- 15. Do you understand that we may audit your records, which might result in an additional premium?** Yes No

VEHICLE SCHEDULE

(Attach copies of the vehicle registration for all vehicles and explain if registration name is different from applicant's name.)

Vehicle No.:	Year:	V.I.N.:
Make/model/type of vehicle:		
<input type="checkbox"/> ACV <input type="checkbox"/> ST AMT: \$ _____		Value of perm. attached equip.: \$ _____
Mfg. seating capacity:	Radius:	Farthest city:
City, state, zip where garaged:		
License state:		License plate No.:
GVW/GCW:		Class.:
Deductibles <input type="checkbox"/> COMP _____ <input type="checkbox"/> SCOL _____ <input type="checkbox"/> COLL _____		
<input type="checkbox"/> Commercial <input type="checkbox"/> Retail <input type="checkbox"/> Service		
Leased Vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Loss payee/additional insured/lessor:		
If limousine, name of coach builder:		Length:

Vehicle No.:	Year:	V.I.N.:
Make/model/type of vehicle:		
<input type="checkbox"/> ACV <input type="checkbox"/> ST AMT: \$		Value of perm. attached equip.: \$
Mfg. seating capacity:	Radius:	Farthest city:
City, state, zip where garaged:		
License state:		License plate No.:
GVW/GCW:		Class.:
Deductibles <input type="checkbox"/> COMP _____ <input type="checkbox"/> SCOL _____ <input type="checkbox"/> COLL _____		
<input type="checkbox"/> Commercial <input type="checkbox"/> Retail <input type="checkbox"/> Service		
Leased Vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Loss payee/additional insured/lessor:		
If limousine, name of coach builder:		Length:

Vehicle No.:	Year:	V.I.N.:
Make/model/type of vehicle:		
<input type="checkbox"/> ACV <input type="checkbox"/> ST AMT: \$		Value of perm. attached equip.: \$
Mfg. seating capacity:	Radius:	Farthest city:
City, state, zip where garaged:		
License state:		License plate No.:
GVW/GCW:		Class.:
Deductibles <input type="checkbox"/> COMP _____ <input type="checkbox"/> SCOL _____ <input type="checkbox"/> COLL _____		
<input type="checkbox"/> Commercial <input type="checkbox"/> Retail <input type="checkbox"/> Service		
Leased Vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Loss payee/additional insured/lessor:		
If limousine, name of coach builder:		Length:

Vehicle No.:	Year:	V.I.N.:
Make/model/type of vehicle:		
<input type="checkbox"/> ACV <input type="checkbox"/> ST AMT: \$		Value of perm. attached equip.: \$
Mfg. seating capacity:	Radius:	Farthest city:
City, state, zip where garaged:		
License state:		License plate No.:
GVW/GCW:		Class.:
Deductibles <input type="checkbox"/> COMP _____ <input type="checkbox"/> SCOL _____ <input type="checkbox"/> COLL _____		
<input type="checkbox"/> Commercial <input type="checkbox"/> Retail <input type="checkbox"/> Service		
Leased Vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Loss payee/additional insured/lessor:		
If limousine, name of coach builder:		Length:

DRIVER INFORMATION

16. Are all drivers employees? Yes No
 If no, provide copy of contract.

17. List below all drivers currently employed as of the proposed effective date. If a Non-Owned auto is to be considered, you must list information for all employees currently employed by you.

Driver's Name	D/C*	Date of Birth	Driver's License No.	State	Class of License	No. of Years Driving Similar Vehicle	Length of Employment	List Past Three Years of Accidents & Traffic Violations

*Designation Code: O—Owner/Officer, P—Partner, E—Employee

This application does not bind YOU or US to complete the insurance, but it is agreed that the information contained herein shall be the basis of the contract should a policy be issued.

FRAUD WARNING:

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 the 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.

FRAUD WARNING (APPLICABLE IN 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.

FRAUD WARNING (APPLICABLE IN MAINE):

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

FRAUD WARNING (APPLICABLE IN TENNESSEE 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.

FRAUD WARNING APPLICABLE IN THE STATE OF NEW YORK:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for commercial insurance or a statement of claim for any commercial or personal insurance benefits 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 or 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the value of the subject motor vehicle or stated claim for each violation.

APPLICANT'S NAME AND TITLE: _____

APPLICANT'S SIGNATURE: _____ DATE: _____

(Must be signed by an active owner, partner or executive officer.)

PRODUCER'S SIGNATURE: _____ DATE: _____

AGENT NAME: _____ AGENT LICENSE NUMBER: _____

(Applicable to Florida Agents Only)

**IMPORTANT
NOTICE**

As part of the underwriting procedure, a routine inquiry may be made which will provide applicable information concerning character, general reputation, personal characteristics and mode of living. Upon written request, additional information as to the nature and scope of the report, if one is made, will be provided.