

**CAROLINA CASUALTY INSURANCE COMPANY**  
P.O. BOX 2575 JACKSONVILLE, FLORIDA 32203  
(904) 363-0900 (800) 874-8053 FAX (904) 363-8093

**NON TRUCKING APPLICATION**

**1. GENERAL**

Applicant's Name: \_\_\_\_\_ SSN or FEIN \_\_\_\_\_  
Address: \_\_\_\_\_  
Street City State Zip Code  
Business Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Business of Applicant: \_\_\_\_\_ No. Years in Business \_\_\_\_\_  
If you have not had insurance of the same type as currently being applied for in your own name for the past three (3) years, complete the following:

Previous Employer	Address	Employment Dates				Type Vehicle	Radius of Operation
		to	to	to	to		

COMPLETE THE FOLLOWING FOR PAST 3 YEARS  
(SubmIt separate sheet giving full details of all claims where payments and/or reserves are in excess of \$1,000.00)

Previous Carrier	Policy No.	From Mo/Yr To Mo/Yr	No. of Claims	Bodily Injury		Property Damage		Collision Total Incurred	*Specified Causes of Loss Total	Comp Total
				Paid	Reserve	Paid	Reserve			
1 <sup>st</sup> yr.										
2 <sup>nd</sup> yr.										
3 <sup>rd</sup> yr.										

\* or Specified Perils

**2. COVERAGES AND LIMITS**

Policy Period: From: \_\_\_\_\_ To: \_\_\_\_\_

<u>LIABILITY</u>		<u>PHYSICAL DAMAGE</u>	
Bodily Injury	\$ _____ each person	Coverage Desired	Deductible
	\$ _____ each occurrence	<input type="checkbox"/> Specified Causes of Loss/Specified Perils	_____
Property Damage	\$ _____ each occurrence	<input type="checkbox"/> Comprehensive	_____
Combined Single Limit	\$ _____	<input type="checkbox"/> Collision	_____
Medical Payments	\$ _____		
Personal Injury	\$ _____		
Uninsured/Underinsured Motorists			
<input type="checkbox"/> Yes	\$ _____ Limit	<input type="checkbox"/> No	
Deductible if applicable	<input type="checkbox"/> Yes \$ _____	<input type="checkbox"/> No	

**NOTICE REGARDING PIP and UM/UIM Coverages (New York Only - PIP and UM/SUM Coverages)**

If required by law in your state, you must complete an additional form(s) rejecting coverage or selecting limits of liability desired for uninsured/underinsured motorists (New York Uninsured/Supplementary Motorists) and personal injury protection coverage. Selecting coverage will increase your premium. Be sure your agent provides you with the necessary form(s), explains the options and advises you of the cost of your selections. **ATTACH FORMS TO THIS APPLICATION**

**3. OPERATIONS**

Indicate routes: \_\_\_\_\_ Commodities \_\_\_\_\_ Radius \_\_\_\_\_  
From \_\_\_\_\_ To: \_\_\_\_\_  
From \_\_\_\_\_ To: \_\_\_\_\_  
The regular and frequent use of my equipment is confined \_\_\_\_\_ mileage radius.  
Estimated radius of non-trucking operation: \_\_\_\_\_  
Are all units leased to trucking concerns full-time?  Yes  No  
If yes, to whom? \_\_\_\_\_  
Lessee's Name Address Term of Lease  
If no, explain: \_\_\_\_\_  
Does your lease contain any Hold Harmless provisions?  Yes  No  
Explain: \_\_\_\_\_  
Do you do your own maintenance of equipment?  Yes  No

If no, who does?

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**4. DRIVER INFORMATION**

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

Attach Separate List if Necessary

**IMPORTANT NOTICE**

All new drivers hired during the term of this policy must be immediately reported to the company. Failure to report may result in termination of this policy. Report new drivers to your agent.

**5. VEHICLE INFORMATION**

\*\* or Specified Perils

Model Year	Manufacturer	Vehicle Type *See Below	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 Name & Address

\* **VEHICLE TYPE**

TRACTORS	TRUCKS	SEMI-TRAILERS	FULL-TRAILERS
Cabover	Flatbed	Dry Van	Dry Van
Conventional	Straight Truck	Refrigerated	Refrigerated
	Delivery/Step Van	Soft Side	Soft Side
	Dump Truck	Livestock	Livestock
	Pickup	Flatbed	Flatbed
	Garbage Truck	Pole/Logging	Pole/Logging
	Cement Truck	Tanker	Tanker
	Reefer Truck	Car Carrier	Car Carrier
		Bulk Commodity	Bulk Commodity
		Dollies	Dollies
		Unidentified	Unidentified

**APPLICANT**

ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO DEFRAUD OR DECEIVE ANY INSURANCE COMPANY, FILES A STATEMENT OR A CLAIM CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF INSURANCE FRAUD.

**PRIVACY NOTIFICATION:** A CREDIT REPORT OR OTHER INVESTIGATIVE REPORT ABOUT YOU MAY BE REQUESTED IN CONNECTION WITH THIS APPLICATION FOR INSURANCE. ANY INFORMATION WHICH WE HAVE OR MAY OBTAIN ABOUT YOU OR OTHER INDIVIDUALS LISTED AS POLICYHOLDERS ON YOUR POLICY WILL BE TREATED CONFIDENTIALLY. HOWEVER, THIS INFORMATION, AS WELL AS OTHER PERSONAL OR PRIVILEGED INFORMATION SUBSEQUENTLY COLLECTED, MAY UNDER CERTAIN CIRCUMSTANCES, BE DISCLOSED TO AFFILIATED AND NON-AFFILIATED COMPANIES FOR NON-INSURANCE MARKETING PURPOSES, UNLESS YOU WRITE TO US AT THE ADDRESS PROVIDED WITH YOUR POLICY AND DIRECT US NOT TO MAKE SUCH DISCLOSURE.

YOU HAVE THE RIGHT TO SEE PERSONAL INFORMATION COLLECTED ABOUT YOU, AND YOU HAVE THE RIGHT TO CORRECT ANY INFORMATION WHICH MAY BE WRONG. IF YOU ARE INTERESTED IN OBTAINING A DESCRIPTION OF OUR INFORMATION PRACTICES, AND YOUR RIGHTS REGARDING INFORMATION WE COLLECT, PLEASE WRITE TO US AT THE ADDRESS PROVIDED WITH YOUR POLICY.

**APPLICANT AGREES** to furnish, promptly, driver data for every driver engaged during the policy period. Applicant, Agent or Broker understand and agree that no flat cancellation will be allowed. Agent and/or Broker guarantee payment of earned premium to final termination date of policy or of any filing made by the company on behalf of the Applicant.

**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.

**NOTICE TO COLORADO APPLICANTS:** IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR REWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

**NOTICE TO FLORIDA APPLICANTS:**  
 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.

MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

I understand this application is not a binder unless indicated as such on this form by the brokering agent.

\_\_\_\_\_  
 Applicant's Signature Date Application Completed

BROKERING AGENT'S REGISTER # \_\_\_\_\_

This application is in compliance with Section 626.752, Florida Statutes. A copy has been furnished to the applicant or insured and coverage is  Bound effective \_\_\_\_\_ (time) \_\_\_\_\_ (date);  Not Bound

Binder must be approved by Authorized Licensed Representative of Carolina Casualty Insurance Company.

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

**NOTICE TO KENTUCKY APPLICANTS:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER 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.

**NOTICE TO PENNSYLVANIA APPLICANTS:** 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 MATERIAL 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.

**NOTICE TO MAINE AND VIRGINIA APPLICANTS:** 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 DENIAL OF INSURANCE BENEFITS.

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 above is true.

Date Application Completed _____	Name & Address of Producer _____
Applicant's Signature _____	Producer Federal ID# _____
Licensed Agent of the Company _____	Producer Phone Number _____
Licensed Agent ID# _____	Producer Signature _____