

NEW AUTHORITY

This form must be completed for applicants that have not had continuous Commercial Auto Liability insurance IN THEIR NAME for the past two years. Specifically, the 24 months which immediately precede the desired effective date of coverage. All require info for Question #7 must be provided.

Name of Applicant: \_\_\_\_\_

Effective date desired: \_\_\_\_\_

Please answer ALL of the following questions:

1. How many years experience does the applicant have in the "trucking" industry? \_\_\_\_\_
2. What will be applicant's primary source of finding loads (revenue) (freight brokers, direct contracts)?
3. During the past 36 months (3 years), has the applicant had a minimum of two years full-time experience driving vehicles similar to the type of scheduled for coverage on this policy (INCLUDING RADIUS) ? yes\_\_\_ no \_\_\_\_
4. Has the applicant had commercial auto insurance under another name in the past three years? If so, please provide details including authority MC# \_\_\_\_\_  
\_\_\_\_\_
5. Has the applicant ever had a commercial auto policy that was cancelled on non-renewed? If so, please explain: \_\_\_\_  
\_\_\_\_\_
6. Has the applicant been insured as an "owner/operator" under another entity's authority/policy within the past two years? Yes \_\_\_ No \_\_\_ If "yes" Answer question 7 in detail.
7. Does insured have any further growth plans?\_\_\_\_\_ If so, please provide details below:
8. IMPORTANT: For the past 36 months (3 years), list ALL employers OR entities lease to for which the applicant has driven commercial vehicles. COMPLETE ALL SECTIONS:

DATE OF EMPLOYEMENT/ LEASED PERIOD:	NAME OF CARRIER AND MOTOR CARRIER#:
_____	_____
_____	_____
_____	_____
_____	_____

9. Has the applicant or any of the applicant's drivers been involved in ANY accident in the past three years? Yes\_\_\_ No\_\_\_ . If yes, provide details below:
10. Does applicant object to verification of the above information? Yes \_\_\_ No \_\_\_

Applicants Signature : \_\_\_\_\_ Date: \_\_\_\_\_