

Non-Trucking Automobile Liability

Vehicle Physical Damage

Individual Application

Application must be fully completed or coverage cannot be bound. Producing agent is responsible for obtaining and keeping on file a copy of the permanent lease.

Date Quoted: _____ Date Bound: _____ Limit of liability: _____

Producer: _____ App. Completed By: _____

Name of Vehicle Owner (Lessor): _____ Telephone #: (____) ____ - ____

Address: _____ City: _____ State: _____ Zip: _____

Motor Carrier Permanently Leased to (Lessee): _____ MC #: _____

Address: _____ Lease Effective Date: ____ / ____ / ____ US DOT #: _____

City: _____ State: _____ Zip: _____ Telephone #: (____) ____ - ____

Attention: _____ Department: _____ Company Unit #: _____

Name of Lessee's Primary Insurance Co.: _____

	Unit #	Year	Make	Vin #	GVW	State of Registration	Stated Amount
1							
2							
3							
4							

	Owner/ Operator (Lessor) Name	DOB	DL #	State
1		- -		
2		- -		
3		- -		
4		- -		

Lien Holder Name: _____ Telephone #: (____) ____ - ____

Address: _____ City: _____ State: _____ Zip: _____

Premium Financing Of Monthly Pay Policies Is Not Permitted.

IMPORTANT – PLEASE NOTE for Non-Trucking Automobile Liability:

1. Cannot issue Massachusetts RMV-3 for
2. This coverage is based on a warranty by the vehicle owner (lessor) that the insured tractor is permanently leased to the governmentally regulated motor carrier named on this application. All coverage's expire when the permanent lease has been broker, cancelled, or terminated by either the contractor or the motor carrier.
3. no permanent lease with a governmentally regulated motor carrier, no coverage, no exceptions.

BRAZOS SPECIALTY RISK, INC.

12200 FORD RD. STE. #470

DALLAS, TX 75234

PHONE (972) 484-4100

FAX (972) 484-4101



Brazos Specialty Risk, Inc

12200 Ford Road Suite 470 Dallas, TX 75234

Rejection of Personal Injury Protection

I hereby reject Personal Injury Protection coverage in accordance with the right of rejection provided in Article 5.06.3 of the Texas Insurance Code on this policy. It is understood that I have the right to request that this coverage be added to my policy at any time at the applicable premium charge in effect at that time.

Insured's Signature

Date

Uninsured/Underinsured Motorists Coverage Election/Rejection Form (MUST BE SIGNED)

It is hereby understood and agreed that in accordance with the provisions of Article 5.06-1, Texas Insurance Code, as amended, I have been given the opportunity to purchase Uninsured/Underinsured Motorists Coverage in amount up to the automobile liability coverage limits I have on this policy, and I have also been given the right to reject Uninsured/Underinsured Motorists Coverage and have made the following choice(s):

1. _____ I hereby reject Uninsured/Underinsured Motorists Coverage in its entirety, or
2. _____ I hereby reject Uninsured/Underinsured Motorists Coverage as respects to property damage liability coverage in its entirety and accept bodily injury limits as indicated on this application.
3. _____ I hereby request t Uninsured/Underinsured Motorist Coverage at the financial responsibility limits unless higher limits are requested as follows: \$ _____ BI \$ _____ PD or \$ _____ CSL

Insured's Signature

Date

FUTURE RENEWALS:

The rejection(s) indicated above shall apply on this policy and on all future renewals of such policy and all future policies issued to me by this Company because of change of vehicle or coverage, or because of an interruption of coverage, until I notify the Company in writing that thereafter Uninsured/Underinsured Motorists Coverage is desired.

NOTICE: THE FOLLOWING PERTAINS TO THE FAIR CREDIT REPORTING ACT: As part of our underwriting procedure, a routine inquiry may be made to obtain applicable information concerning character, general reputation, personal characteristics, and mode of living. Upon request, additional information as to the nature and scope of the report, if one is made, will be provided.

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.

Brazos Specialty Risk

Phone (972) 484-4100 Fax (972) 484-4101

Statement of Loss History

Insured's Name: _____

Address: _____

City, State, Zip: _____

The "Loss History" of an insured is a crucial piece of information used by all insurance companies to analyze insurability. Since you are unable to obtain your loss history prior to the inception of your insurance coverage with our company, we are willing to accept a statement from you regarding your loss history until loss run documentation can be obtained. You should always keep from three (3) to five (5) years of loss documentation from the insurance company(ies) and monitor it for claims and claim payments.

If you are unable to secure the hard copy loss runs within forty-five (45) days after inception of your policy with this insurance program, your insurance may be subject to cancellation.

Please follow these instructions carefully to complete this form.

1. State in the spaces provided, by year, to the best of your knowledge, the number of accidents that occurred in which a vehicle covered by your policy was involved.
2. State in the spaces provided, the amount incurred, on your company's behalf, for claim payments and the amount reserved for claim payments. ("Reserves" indicate the amount set aside by the insurance company to pay claims on your behalf)
3. List the name of the insurance company for each year listed below.
4. For losses in excess of \$10,000, please provide a copy of the police report, and/or internal reports along with this statement.
5. Attach to this form, copies of written requests for documentation of your loss history, to each of the companies listed below.

Loss History: If you have documentation for one or more years, omit said year(s) from this report and attach a copy of same to this report.

Any attempt to provide information that is untrue or misleading may constitute fraud, thereby voiding your insurance coverage. Utmost care must be taken in completing this form.

Policy Term	# of Claims	Amount Incurred	Amount Paid	Insurance Company

The undersigned, an authorized representative of the insured listed above, represents that all information contained in this document is true and accurate.

Signed: _____

Dated: _____

Title: _____