Garage Application

Phone # 888-495-4950
Fax # 888-997-9970
P.O. Box 8010
Goldsboro, NC 27533-8010

Policy Number: _____

Producer Code		
Phone:		
Name:		
Address:		
City:		
State:		Zip Code:

Insured:		
Address:		
City:		
State:		Zip Code:

Business Description

_____

_____

Policy Period	From	To

TYPE OF OWNERSHIP OF BUSINESS: (CHECK ONE)

☐ INDIVIDUAL ☐ PARTNERSHIP (ALL OTHER)
☐ PARTNERSHIP (MARRIED COUPLE) ☐ CORPORATION

Type of Dealership

☐ Franchised	☐ Non-Franchised
Car Dealer	☐
Truck-Tractor Dealer	☐
Motorcycle Dealer	☐
Recreational Vehicle Dealer	☐
Mobile Home Trailer Dealer	☐
Commercial Trailer Dealer	☐

Pickup and delivery

☐ 51 - 200 miles	# of Trips a year _____
☐ Over 200 miles	# of Trips a year _____

Number of Dealer or Transport Tags _____

General Information

1.	Describe your business operation as it relates to non-owned vehicles in your care, custody and control. (for example: repair, towing, or repossession).
2.	What types of non-owned vehicles are in your care, custody and control? (for example: private passengers, truck/tractors, ATV's, semi-trailers)

COVERAGE	LIMITS OF LIABILITY	PREMIUM
LIABILITY		
MEDICAL PAYMENTS		
UM / UIM		
COMPREHENSIVE		
COLLISION		
HIRED AUTO		
NONOWNED LIABILITY		
GARAGEKEEPER LEGAL LIABILITY SPECIFIED PERILS DEDUCTIBLE COLLISION DEDUCTIBLE		
	TOTAL PREMIUM	

Premises Information:

Policy Number: _____

Location #	Street, City, County, State, Zip Code

AUTO DEALERS OPERATORS

CLASS OF OPERATORS		BY LOCATION NUMBER		
CLASS I EMPLOYEES	REGULAR OPERATORS			
	ALL OTHERS			
CLASS II NON-EMPLOYEES	Inactive-Proprietors, Partners or Officers and their relatives and the relatives of any persons described in Class I			

DEFINITIONS:

CLASS I EMPLOYEES

REGULAR OPERATOR - PROPRIETORS, PARTNERS AND OFFICERS ACTIVE IN THE GARAGE OPERATION, SALESPERSONS, GENERAL MANAGERS, SERVICE MANAGERS, ANY EMPLOYEE WHOSE PRINCIPAL DUTY INVOLVES THE OPERATION OF COVERED AUTOS OR WHO IS FURNISHED A COVERED AUTO.

ALL OTHERS - ALL OTHER EMPLOYEES

CLASS II - NON-EMPLOYEES

ANY OF THE FOLLOWING PERSONS WHO ARE REGULARLY FURNISHED WITH A COVERED AUTO: INACTIVE-PROPRIETORS, PARTNERS OR OFFICERS AND THEIR RELATIVES AND THE RELATIVES OF ANY PERSON DESCRIBED IN CLASS I.

NOTE: 1. PART-TIME EMPLOYEES WORKING AN AVERAGE OF 20 HOURS OR MORE A WEEK FOR THE NUMBER OF WEEKS WORKED ARE TO BE COUNTED AS 1 RATING UNIT EACH.

2. PART-TIME EMPLOYEES WORKING AN AVERAGE OF LESS THAN A WEEK FOR THE NUMBER OF WEEKS WORKED ARE TO BE COUNTED AS 1/2 RATING UNIT.

DRIVER INFORMATION

DRIVER #	NAME DATE OF BIRTH DRIVER LICENSE NUMBER & STATE	DESCRIPTION OF VIOLATIONS & ACCIDENTS (PAST 3 YEARS)	MVR VERIFIED YES/NO	
			YES	NO
			YES	NO
			YES	NO

PREVIOUS INSURANCE AND LOSS EXPERIENCE

POLICY PERIOD		INSURANCE CARRIER	POLICY #	NUMBER OF ACCIDENTS	TOTAL AMOUNT PAID BI	TOTAL AMOUNT PAID PD	RESERVES BI	RESERVES PD
FROM	TO							
FROM	TO							
FROM	TO							
FROM	TO							

APPLICANT PLEASE READ

I HEREBY DECLARE THAT ALL THE REPRESENTATIONS CONTAINED HEREIN ARE TRUE AND THAT THESE REPRESENTATIONS ARE OFFERED AS AN INDUCEMENT TO THE COMPANY TO ISSUE THE POLICY FOR WHICH I AM APPLYING. I UNDERSTAND AND AGREE THAT THE INSURANCE COMPANY MAY RELY ON THIS APPLICATION AND THE INFORMATION CONTAINED IN MY DRIVING RECORD AND THE DRIVING RECORDS OF THE OTHER OPERATORS, SAID DRIVING RECORDS I NOW GRANT THE INSURANCE COMPANY PERMISSION TO OBTAIN. I UNDERSTAND THAT THE POLICY WILL BE NULL AND VOID IF THE CHECK PRESENTED TO THE AGENT, BROKER, MGA OR COMPANY FOR THE INITIAL POLICY IS RETURNED BY THE FINANCIAL INSTITUTION FOR ANY REASON. I FURTHER UNDERSTAND THE INSURANCE PREMIUMS FOR THE ABOVE COVERAGE ARE SUBJECT TO CHANGES BASED ON THE SAID DRIVING RECORDS. I UNDERSTAND AND AGREE THAT IF THE REPRESENTATIONS CONTAINED HEREIN ARE FALSE OR MISLEADING, SAID MISREPRESENTATIONS SHALL BE DEEMED MATERIAL AND MAY RESULT IN CANCELLATION OF THIS POLICY AND DENIAL OF ALL OR PART OF THE COVERAGE PROVIDED IN THE POLICY FOR WHICH I AMAPPLYING.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER 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 SUBJECTS THE PERSON TO CRIMINAL AND CIVIL PENALTIES.

APPLICANT'S SIGNATURE **DATE** **TIME** **PRODUCER'S SIGNATURE**

_____ _____ _____ _____

Atlantic Casualty Insurance Company

SELECTION / REJECTION FORM
UNINSURED MOTORIST COVERAGE
COMBINED UNINSURED / UNDERINSURED MOTORIST COVERAGE

Uninsured Motorist Coverage (UM) and Combined Uninsured / Underinsured Motorist Coverage (UM/ UIM) and coverage options are available to me. I understand that:

1. The UM and UM/UIM limits shown for vehicles on this policy may not be added to determine the total amount of coverage provided.
2. UM and UM/UIM bodily injury limits up to $1,000,000 per person and $1,000,000 per accident are available.
3. UM property damage limits up to the highest policy property damage liability limits are available. Coverage for property damage is applicable only to damages caused by uninsured motor vehicles.
4. My selection or rejection of coverage below will apply to any renewal, reinstatement, substitute, amendment, altered, modified, transfer or replacement policy with this company, or affiliated company, unless a named insured makes a written request to the company to exercise a different option.
5. My selection or rejection of coverage below is valid and binding on all insured and vehicles under the policy, unless a named insured makes a written request to the company to exercise a different option.

(CHOOSE ONLY ONE OF THE FOLLOWING)

☐ I choose to reject combined Uninsured/Underinsured Motorist and select Uninsured Motorist coverage at all limits of Bodily Injury _____ ; Property Damage _____

☐ I choose combined Uninsured/Underinsured Motorist Coverage at all limits of Bodily Injury _____ ; Property Damage _____

☐ I choose to reject both Uninsured and Combined Uninsured/Underinsured Motorist Coverage

Named Insured _____ Policy # _____

Signature of Insured _____

Signature of Producer _____

Date _____