



COMMERCIAL AUTOMOBILE CONTRACTORS APPLICATION

Dependent upon state authority, you are applying for insurance coverage provided by and underwritten by one of the following insurance companies of ARGO GROUP US:

ARGONAUT-MIDWEST INSURANCE COMPANY
ARGONAUT INSURANCE COMPANY

COLONY SPECIALTY INSURANCE COMPANY
COLONY INSURANCE COMPANY

SECTION I - APPLICANT INFORMATION

Policy Period Requested: From _____ To _____ Phone _____

Business Name _____

Mailing Address _____ City _____

County _____ State _____ Zip Code _____

Physical Address _____ City _____

County _____ State _____ Zip Code _____

Years this business entity has been **in operation**? _____ If new venture, complete Colony Specialty New Venture Supplement TR1031

Business Entity: Individual Partnership Corporation LLC Other _____

What is your **Website address**? <http://www>. _____

Inspection Contact Name and Number: _____

Do you have an ownership interest in or operate any other business? Yes No

a) If "Yes," provide the business name and address: _____

b) Describe the operation of the business: _____

c) What is the relationship between the business indicated in question a) and the business we are being asked to insure? _____

In the past 3 years, have you ever had insurance for this type of operation cancelled, declined or the policy renewal refused?
(This question is not applicable in Missouri) Yes No

If "Yes," explain: _____

SECTION II - DESCRIPTION OF OPERATIONS

1. Description of Operations(What do you do - Building, Electrical, Excavating, Landscaping, Street/Road etc): _____

2. If you have any dump trucks complete the following questions:

Are all dump loads fully tarped? Yes No

Do drivers check for 6-inch freeboard around load? Yes No

3. Do you ever hire a vehicle with a driver to transport goods on your behalf? Yes No (if Yes complete the Colony Specialty Hired & Non-Owned Supplement TR1032)

SECTION III - AREA OF OPERATIONS

4. Radius of operation: 0-100 101-300 301-500 *Radius in excess of 300 miles requires company approval*

5. Do you travel into Canada? Yes No If "Yes", indicate percent of total operation _____

6. Do you ever travel into Mexico? Yes No

SECTION IV – DRIVER INFORMATION

If the insured is owner operator with no employees, skip to question 11

7. Indicate which driver selection guidelines are in place (select all that apply):
 Background check CDL required Drug testing Physical Exam
 Reference check Review of MVR prior to hiring Road test
 Other _____
8. Are accidents reviewed with at fault driver to discuss corrective or disciplinary action plan? Yes No
9. Number of drivers hired in the past 6 months _____
10. Are all drivers employees of the Insured? Yes No
 If No and not listed below, provide details _____
11. Do all drivers currently have a minimum of 2 years prior driving experience with like equipment? Yes No
12. Is personal use of vehicles restricted? Yes No If no, explain why not: _____
13. Are passengers (other than customers and employees) allowed to ride in company vehicle? Yes No
14. Is cell phone use restricted while operating a vehicle? Yes No
 If no, please explain: _____
15. _____

Driver Schedule

	Driver Name	DOB	License Number/State	License Class	Yrs Driving Similar Equip	# Moving Viol/Acc in Past 3 Yrs
1						
2						
3						
4						
5						

SECTION V – VEHICLE INFORMATION

16. Do you hire any vehicles? Yes No
 If 'Yes,' complete the Colony Specialty Hired & Non-Owned Supplement (TR 1032)
17. Do you loan or rent any of your vehicle(s) to others? Yes No
 If 'Yes,' provide details: _____
18. _____

Vehicle Schedule

Unit #	Year	Make/Model	Vehicle ID Number	GVW/ Seating	Garaging City,St.	Radius	Deductible	Stated Amount
1							<input type="checkbox"/> SCOL _____ <input type="checkbox"/> Comp _____ <input type="checkbox"/> Coll _____	
2							<input type="checkbox"/> SCOL _____ <input type="checkbox"/> Comp _____ <input type="checkbox"/> Coll _____	
3							<input type="checkbox"/> SCOL _____ <input type="checkbox"/> Comp _____ <input type="checkbox"/> Coll _____	
4							<input type="checkbox"/> SCOL _____ <input type="checkbox"/> Comp _____ <input type="checkbox"/> Coll _____	
5							<input type="checkbox"/> SCOL _____ <input type="checkbox"/> Comp _____ <input type="checkbox"/> Coll _____	

19. Indicate specialized equipment attached to any unit:
 Booms - Unit #(s) _____ Maximum lifting capacity _____
 Chains - Unit #(s) _____ Maximum lifting capacity _____
 Cranes - Unit #(s) _____ Maximum lifting capacity _____
 Hooks - Unit #(s) _____ Maximum lifting capacity _____
 Other – Describe _____ - Unit #(s) _____ Maximum lifting capacity _____
20. If there are any units listed above with specialized equipment attached, is there a GL policy in place? Yes No
 If Yes provide name of current Carrier and policy expiration date: _____

SECTION VI – VEHICLE MAINTENANCE & SAFETY

21. Describe Vehicle Maintenance: _____
22. Specific safety equipment attached to units: (select all that apply):
 Anti theft device Back up Alarms Fender Mirrors
 Reflectors Other – please specify _____
23. Vehicle Safety & Overnight Security (select all that apply):
 Fenced lot Vehicles stored at non-owned open lot
 Well lit lot Vehicles taken home by drivers
 Vehicles stored inside building Keys locked in secured location
 Vehicles stored at insured's open lot Other _____
24. Are pre- trip inspections of vehicles and tires performed? Yes No

SECTION VII – FLEET INFORMATION (5 OR MORE POWER UNITS)

25. Give name, title & phone number of person responsible for Driver Hiring & Training: _____
26. Driver Safety and Training (select all that apply and submit copy of all existing driver programs)
 Company work rules Driver training program
 Driver discipline program Regular safety meetings with the drivers
 Driver safety incentive program Written driver safety program
27. Who services your vehicles? (select all that apply):
 Mechanics on staff Service your own vehicles
 Vehicles serviced by outside mechanic
28. Vehicle Maintenance Records (select all that apply):
 Service/maintenance logs kept on premises Written maintenance program

SECTION VIII – PREVIOUS INSURANCE & LOSS EXPERIENCE

29. Loss History (MUST BE COMPLETED IN ITS ENTIRETY)
FOR FLEETS CONSISTING OF 5 OR MORE POWER UNITS – HARD COPY LOSS RUNS ARE REQUIRED

Policy Period (From/To)	Insurance Carrier	Policy #	Coverages Provided***	Total Amount of *BI/PD & **APD		Name of Driver Involved in Loss
				Claims Paid Including Reserves		
				# of Claims	Total Amount of Loss	
			<input type="checkbox"/> Liability <input type="checkbox"/> APD			
			<input type="checkbox"/> Liability <input type="checkbox"/> APD			
			<input type="checkbox"/> Liability <input type="checkbox"/> APD			

SECTION IX – LIMITS & COVERAGES REQUESTED

30. Coverage Selections (select all that apply)

- Combined Single Limit (BI/PD) each accident \$ _____
- Liability Deductible \$ _____ Property Damage Only BI/PD Combined
- Personal Injury Protection (PIP or No Fault) \$ _____ Do you carry Worker's Compensation? Yes No
- Property Protection (Michigan Only) \$ _____
- Property Damage Buyback (Mini-Tort Michigan Only) Broad Collision (Michigan Only)
- Medical Payments \$ _____
- Uninsured Motorists (UM) \$ _____
- Underinsured Motorists (UIM) \$ _____
- Uninsured Motorists Property Damage (UMPD) \$ _____

Please attach appropriate Uninsured Motorists / Underinsured Motorists / Personal Injury Protection and Medical Payments Selection form(s). Must be completed in full and signed by the first named insured when binding coverage.

Optional Coverages:

- Auto Loan/Lease Gap
- Drive Other Car Coverage (available for owner and spouse) Number of Persons _____
- Hired Auto Liability: Contract Requirement Only ("If Any" basis) **OR**
- If there is an exposure, please complete the Hired Auto Supplemental Application.
- Hired Auto Physical Damage: Max Value \$ _____ Please complete the Hired Auto Supplemental Application.
- Non-Owned Liability: Contract Requirement Only ("If Any" basis) **OR**
- Number of employees - If there is an exposure, please complete the Hired Auto Supplemental Application.
- Rental Reimbursement Coverage Maximum Daily Amount \$ _____ Number of Days _____
- Roadside Service /Repair Coverage

SECTION X – FILINGS REQUESTED

For prompt and accurate filing, complete information must be given including name, address and docket number, EXACTLY as authority exists. Use separate sheet if necessary. Failure to provide accurate information will result in delays and possible suspensions. (General Agent will request the filings thru Colony Specialty website.)

- 31. DOT# _____ ICC or MC# _____ Federal ID# _____
- 32. State or City filings required? Yes No
If "Yes," list States/Cities and permit numbers _____
- 33. Do any vehicles require an Oversize, Overweight or Hazardous Material filing or permit? Yes No
- 34. Are Canadian Filings required? Yes No
- 35. If filings are required, does this insurance cover all owned, leased and operated vehicles? Yes No

SECTION XI – ADDITIONAL INTERESTS

36. Additional Interest (attach separate sheet if necessary):

Unit #	Interest Type	What is their interest?	Name, Street Address, City, State, ZIP
	<input type="checkbox"/> Additional Insured <input type="checkbox"/> Certificate Holder <input type="checkbox"/> Lien holder <input type="checkbox"/> Loss Payee <input type="checkbox"/> Waiver of Subro <input type="checkbox"/> _____		
Unit #	Interest Type	What is their interest?	Name, Street Address, City, State, ZIP
	<input type="checkbox"/> Additional Insured <input type="checkbox"/> Certificate Holder <input type="checkbox"/> Lien holder <input type="checkbox"/> Loss Payee <input type="checkbox"/> Waiver of Subro <input type="checkbox"/> _____		
Unit #	Interest Type	What is their interest?	Name, Street Address, City, State, ZIP
	<input type="checkbox"/> Additional Insured <input type="checkbox"/> Certificate Holder <input type="checkbox"/> Lien holder <input type="checkbox"/> Loss Payee <input type="checkbox"/> Waiver of Subro <input type="checkbox"/> _____		

GENERAL FRAUD STATEMENT

(Not applicable in the states mentioned below where a specific warning applies.)

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, may be committing a fraudulent insurance act, and may be subject to a civil penalty or fine.

Arkansas, Louisiana, New Mexico, Rhode Island, West Virginia

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado

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 award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Florida

Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky

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.

Maryland

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New York

Any person who 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.

Ohio

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania

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.

Maine, Tennessee, Virginia, 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.

SECTION XII - SIGNATURES

I declare to the best of my knowledge that all statements herein are true and no material facts have been suppressed or misstated. I am also aware that my operation may be inspected by the Insurance Company.

Applicant's Printed Name

Applicant's Signature

Date

Witness (if applicable)

Date

Agent/Broker:

Are you personally familiar with this Applicant's operations?

Yes No

Did your office control this risk in the past year?

Yes No

Agent's or Broker's Name (please print)

Telephone Number

Agent's or Broker's Signature

Agent's or Brokers Address

Date

License Number: _____