

Application for Illinois Commercial Automobile Insurance
 Applicable to Applicant(s), Insured(s) and all Operators:
 ALL DRIVERS MUST BE LISTED AND HOLD A VALID ILLINOIS DRIVER'S LICENSE.
 COVERAGE IS EFFECTIVE ONLY WHEN ACCEPTED BY THE COMPANY AND
 POLICY ISSUED



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| | | | | | |
|---|---|--------------------|---------------|------------------------|-----------------|
| Agency Bill <input type="checkbox"/> | Direct Bill <input type="checkbox"/> | Down Payment \$ | Producer Name | Producer Phone Number: | FOR OFFICE USE: |
|---|---|--------------------|---------------|------------------------|-----------------|

Applicant's/Business Full Name: _____ Policy Number: _____

Business/Garaging Address: _____ Unit #: _____ Work Phone Number: _____

| | | | | | | | | |
|------|-------------|-------------|-----------|--------------|--------------|----------------|-----------------|------|
| City | State IL | Zip Code +4 | Territory | Binder Date: | Binder Time: | Effective Date | Expiration Date | Term |
|------|-------------|-------------|-----------|--------------|--------------|----------------|-----------------|------|

Mailing Address – if different from above _____ City _____ State _____ Zip Code + 4 _____ ICC Filing: Yes / No _____ ICC Number: _____

| | | | |
|--|-------------------|--------------------------|------------------|
| Previous Carrier(s) ATTACH RENEWAL QUOTE, CURRENT DEC PAGE AND LOSS RUNS. | How Long Insured: | Date Terminated and Why: | Premiums/Losses: |
|--|-------------------|--------------------------|------------------|

| | | | | |
|----------------------------------|---|--|-----------------------|-----------------------|
| Describe Applicant's Operations: | Special Use Equipment Attached to Vehicles: | Materials Typically Carried or Used in Business: | How Long In Business: | Radius of Operations: |
|----------------------------------|---|--|-----------------------|-----------------------|

APPLICANT REPRESENTS THAT THERE ARE NO OTHER DRIVERS OR REGULAR OPERATORS OTHER THAN THOSE LISTED BELOW.
 All Drivers/Operators must be listed and hold a valid Illinois driver's license. Failure to list a driver may result in denial of coverage. Drivers under the age of 21 are unacceptable for coverage under this policy.

| LIST ALL DRIVERS BELOW: Space is provided on the back of this application for additional drivers. | DRIVER'S LICENSE # | Birthday | | | Gender | Married | Occupation: |
|---|--------------------|----------|-----|------|--------|---------|-------------|
| | | Mo | Day | Year | M-F | S or M | |
| 1 | APPLICANT | | | | | | |
| 2 | | | | | | | |
| 3 | | | | | | | |
| 4 | | | | | | | |

List all accidents/violations(regardless of fault) within the past 36 months for each driver shown above:

| DATE OF OCCURRENCE | DESCRIBE ACCIDENT/VIOLATION | DRIVER | DATE OF OCCURRENCE | DESCRIBE ACCIDENT/VIOLATION | DRIVER |
|--------------------|-----------------------------|--------|--------------------|-----------------------------|--------|
| | | | | | |

| Description of Owned/Leased Automobile(s) | | | | Optional Equipment: On back of app give a description/value, (attach bill(s) of sale) | | G.V.W | Vehicle Value | License Plate # and Type |
|---|------------|--------------|-----------------------|---|--|-------|---------------|--------------------------|
| Auto | Model Year | Vehicle Make | Body Type/Exact model | Vehicle Identification Number | | | | |
| 1 | | | | | | | | |
| 2 | | | | | | | | |
| 3 | | | | | | | | |
| 4 | | | | | | | | |

| Auto | Indicate LP or AI | Loss Payee/Additional Insured's Full Name & Address: Any losses under Comprehensive & Collision are payable to named insured and any lien holder or lessor listed below as interest may appear. | | Leased Vehicle? |
|------|-------------------|--|--|-----------------|
| 1 | | | | Yes / No |
| 2 | | | | Yes / No |
| 3 | | | | Yes / No |
| 4 | | | | Yes / No |

| | | | | |
|--|--|---|--|--|
| Indicate Coverages/Limits Here: Bodily Injury, Property Damage, and Uninsured & Underinsured Motorist Bodily Injury Limits are Policy-Wide. Consult Rate Manual for Available | Bodily Injury: _____,000 Each Person _____,000 Each Accident | Property Damage: _____,000 Each Accident Combined Single Limit (C.S.L.) _____,000 Each Accident | Uninsured/Underinsured Motorist Bodily Injury: _____,000 Each Person _____,000 Each Accident | MEDICAL PAYMENTS: 1000 <input type="checkbox"/> 2000 <input type="checkbox"/> 5000 <input type="checkbox"/> |
|--|--|---|--|--|

| Rate Class | Comprehensive and Collision Deductibles | Premium Per Auto |
|-----------------------------|---|------------------|
| Auto 1 | | \$ |
| Auto 2 | | \$ |
| Auto 3 | | \$ |
| Auto 4 | | \$ |
| Total Policy Premium | | \$ |

Applicant's Statement: The applicant has read this application and attests all answers given to the questions asked herein are truthful to the best of their knowledge and belief. The applicant states said answers were made as inducement to the insurance company to issue a policy and it is a special condition of this policy that the policy shall be NULL and VOID and no benefit or effect whatsoever as to any claim arising thereunder in the event that the attestations or statements in this application shall prove to be false or fraudulent in nature. It is understood that NO POLICY CONTRACT will be effective if the check given as down payment is not honored for true and good reasons by the bank upon which it is drawn. Applicant certifies that all persons age 21 and over employed by them or operating their vehicle(s) have been reported to the Company and the Applicant will inform the Company of any future additions. The Company relies on the contents of this application in issuing any policy or renewal.

Applicant's Signature: X _____ Date: _____ Producer's Signature: X _____ Date: _____
 (OVER: FOR ADDITIONAL DRIVERS, VEHICLES AND EXCLUSION FORM.)

NAMED OPERATOR EXCLUSION: (Valid for this policy and all subsequent Renewals)

As an inducement for the Company to issue and in consideration of the insurance provided by this policy on the vehicle(s) listed therein, the following individual(s) is/are specifically excluded from this policy.

- 1. Name _____ Relation to Applicant/Insured _____
- 2. Name _____ Relation to Applicant/Insured _____
- 3. Name _____ Relation to Applicant/Insured _____

If, at the time of a loss, an excluded operator is driving any vehicle, no coverage of any kind shall be afforded.

Applicant's Signature: X _____ Date ____/____/____

Co-Applicant's Signature: X _____ Date ____/____/____

Rejection of Uninsured Motorist Bodily Injury (UMBI) / Under Insured Motorist Bodily Injury (UIMBI) Coverage

These coverages have been explained to me and I have been offered UMBI and UIMBI coverage in the amounts up to my policy limits of liability for Bodily Injury. I understand that this offer will only be made once and will not be repeated. I can change these coverages at any future date by written request. Understanding this offer:

I **REJECT** coverage in excess of minimum statutory limits for Uninsured and Underinsured Motorist Bodily Injury Coverage.
(Sign below)

I **ELECT** Uninsured & Underinsured Motorist Bodily Injury Coverage with limits of: _____ / _____.
(Sign below) *(Write in limits. Limits cannot exceed the B.I. Limits)*

Applicant's Signature: X _____ Date ____/____/____

NOTES / ADDITIONAL DRIVERS/ADDITIONAL CARS: _____

PAYMENT PLAN
(Circle option desired)

- 1. Full payment with application.
- 2. (4) Four payment plan.....25% down with application, balance due in (4) four equal monthly payments.
- 3. (10) Ten payment plan.....13% down with application, balance due in (10) ten equal monthly payments.

All applications must be complete and signed. Full payment or the appropriate down payment must be submitted with the application. **ALL DOWN PAYMENTS MUST BE IN THE FORM OF CASHIERS CHECK, MONEY ORDER OR AGENCY CHECK.**