DELPHI
CASUALTY COMPANY
P.O. Box 5090
Des Plaines, IL 60018
Tel: (847) 635-5600
Fax: (847) 954-1142

Application for Illinois Tow Truck/Flat Bed Insurance

ALL DRIVERS MUST BE LISTED AND HOLD A VALID ILLINOIS DRIVERS LICENSE.
COVERAGE IS EFFECTIVE ONLY WHEN ACCEPTED BY THE COMPANY AND POLICY ISSUED

Producer
MIDWEST SECURITY INSURANCE
1300 W. HIGGINS RD., # 213
PARK RIDGE, IL 60068

Producer # C241

Agency Bill ☒ Direct bill ☐ Down Payment $______

Applicant / Business Full Name	Applicant/Business Address (street)	City	State IL	Zip

Telephone number(s)	Binder Date	Binder Time	Effective Date	Expiration Date	Term

Previous Carrier(s) Attach Dec Page and Loss Runs	How Long Insured	Date Terminated	Premium/Losses	How long in Business	Any Hazardous Materials Hauled or Towed Y / N

Mailing address if different	City	State IL	Use: Towing ☐ Towing & Storage ☐ Towing Storage & Repair ☐	List any special use equipment attached to Vehicle.

Business Type: Individual ☐ Corporation ☐ Partnership ☐ LLC ☐ Other ☐	ILCC FILING: Yes / No	ILCC Number	Radius of Operation	On Hook Coverage Limit ______ Ded. ______

APPLICANT REPRESENTS THERE ARE NO OTHER DRIVERS OR REGULAR OPERATORS OTHER THAN THOSE LISTED BELOW.

All drivers/operators must be listed and hold a valid driver's license acceptable in Illinois. Failure to list a driver may result in denial of coverage. Drivers under the age of 21 or over 65 are unacceptable for coverage under this policy. List all drivers below. (For additional drivers, list on back of application).

List all driver below	Illinois Driver's License #	Date of Birth	Gender	Martial Status	Assigned Vehicle #
1			M F	S M D	
2					
3					
4					

List all Accidents / Violations (regardless of fault) within the past 36 months for each driver shown above.

Driver #	Date of Occurrence	Describe Accident/Violations	Driver #	Date of Occurrence	Describe Accident/Violations

Description of Owned/Leased Vehicles

Vehicle	Year	Make	Model	GVW	VIN	Value	License. Plate
1							
2							
3							
4							

Loss Payee/Additional Insured's Full Name and Address

Any losses under Comprehensive & Collision are payable to named insured and any Loss Payee or Additional Insured listed below as interest may appear

Vehicle	LP or AI	Name and Address of Loss Payee or Additional Insured	Leased Vehicle
			Yes / No
			Yes / No
			Yes / No
			Yes / No

Indicate Coverage/Limits Here: BI PD UM UIM limits are Policy wide. Consult Rate Manual for Available limits	Bodily Injury / Property Damage ________,000 CSL (Combined Single Limit)	Garage Liability (Circle One) $500,000 CSL $750,000 CSL This coverage must match B I	GKL Limit SY ______ RS ______ Ded. ______	Uninsured/Underinsured motorist coverages must match B. I. unless Applicant completes The UMBI/UIMBI Sign Down on Page Two ________,000 each Person, ________,000Each Accident	Medical Payments 1000 ☐ 2000 ☐ 5000 ☐

Vehicle	Rate Class	Carrying Capacity	Surcharge	Comp & Coll Deductibles	Premium Per Vehicle

Applicant's Statement; I have read this application and attest all answers given to the questions asked herein are truthful to the best of my knowledge and belief. I state said answers were made as inducement to Delphi Casualty Co. (Company) to issue a policy. I understand this policy has a special condition that the policy shall be NULL and VOID and of no benefit or effect whatsoever as to any claim arising hereunder in the event the attestations or statements in this application shall prove to be false or fraudulent in nature. It is understood NO COVERAGE will be effective if the bank upon which it is drawn does not honor the check I gave as down payment for true and good reason. I certify I have reported to the company all persons who will operate my vehicles(s) and I will inform the company of any further additions. The company relies on the contents of this application in issuing any policy or renewal.

Applicant's Signature ____________________ Date: ________ Agent's Signature ____________________ Date: ________

(OVER FOR ADDITIONAL DRIVERS, VEHICLES AND EXCLUSION)

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 ____________

Uninsured Motorist Bodily Injury (UMBI) & Underinsured Motorist Bodily Injury Coverages (UIMBI) – Election or Rejection

These coverages were explained to me and I was offered UMBI and matching UIMBI coverages for limits up to my policy Bodily Injury coverage limits of liability. I understand the company will only make this offer once and will not repeat it. 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 matching Underinsured Motorist Bodily Injury coverage. (Sign below.)

☐ I *Elect* Uninsured and Underinsured Motorist Bodily Injury with limits of: ________/________. (Write in limits and sign below.)

Applicant's Signature ______________________ Agent's Signature ______________________

NOTES/ADDITIONAL DRIVERS/ADDITIONAL CARS: ______________________