

# INDIANA AUTOMOBILE APPLICATION

Does any operator have a medical condition including, but not limited to, epilepsy or diabetes which may impair his/her operation of a motor vehicle?

☐ Yes ☒ No If yes, do not bind, call.

Is vehicle registered, leased, or titled in applicant's or operator's name(s) in the State of Indiana?

☒ Yes ☐ No If no, do not bind, call.

REMARKS \_\_\_\_\_

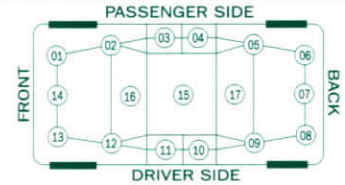
REMARKS \_\_\_\_\_

PHYSICAL CONDITION OF VEHICLE ☐ Check here if no damage Mileage \_\_\_\_\_

For Policies with Physical Damage Coverage.

The diagram below is for your use in describing prior damage.

Body ☐ 01 ☐ 02 ☐ 03 ☐ 04 ☐ 05 ☐ 06 ☐ 07 ☐ 08 ☐ 09 ☐ 10 ☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15



IS ANY VEHICLE USED FOR ANY TYPE OF BUSINESS OR COMPENSATION? ☒ NO ☐ IF YES, DO NOT BIND, CALL

☐ Applicant's Occupation: \_\_\_\_\_

## UNINSURED / UNDERINSURED MOTORISTS COVERAGE REJECTION

I understand that the state requires Uninsured/Underinsured Motorists Coverage unless a named insured rejects such coverage in writing. Subsequent renewal or replacement policies issued by this insurer need not offer the rejected coverage unless a named insured requests such coverage in writing.

☐ I hereby reject the Property Damage portion of Uninsured Motorists Coverage, and direct the insurer to issue my policy without this coverage.

☐ I hereby reject all Uninsured/Underinsured Motorists Coverages (bodily injury and property damage) and direct the insurer to issue my policy without these coverages.

Applicant/Named Insured Signature X \_\_\_\_\_ Date \_\_\_\_\_  
(Sign only if rejecting coverage)

## DRIVER EXCLUSION

I agree that the insurance afforded by this policy shall not apply with respect to any claim arising from accident(s) which occur while the automobile(s) described in the policy or any other automobile(s) are being operated by

1. \_\_\_\_\_ 4. \_\_\_\_\_
2. \_\_\_\_\_ 5. \_\_\_\_\_
3. \_\_\_\_\_ 6. \_\_\_\_\_

I understand that the owner of the vehicle described in the policy cannot be excluded from liability coverage. If a motor vehicle is owned jointly by a husband and wife, either spouse may, with the consent of the other spouse, be excluded from coverage under the policy. This exclusion is governed by the provisions of Indiana Code, IC 27-1-13-7.

Acknowledged and Agreed by: \_\_\_\_\_  
Applicant/Named Insured Signature Authorized Representative

LIST ALL ACCIDENTS, ADMINISTRATIVE LICENSE SUSPENSIONS (INCLUDING CHEMICAL TEST FAILURE) AND TRAFFIC VIOLATIONS IN PAST 3 YEARS - ALL ACCIDENTS ARE CHARGEABLE UNLESS PROOF OF NO-FAULT IS FURNISHED

NAME OF DRIVER	DATE	For all accidents described, list amount of damage and state the percent of damage collected from the other party	NAME OF DRIVER	DATE	For all accidents described, list amount of damage and state the percent of damage collected from the other party
		OCCURRENCE			OCCURRENCE

I certify all material statements made herein are true and correct and are offered as an inducement to the Company to issue the insurance for which I am applying. It is certified that all persons age 14 and over who live in the applicant's household and all operators of the vehicle described in this application are shown above. I will notify the company of any future changes. I understand that coverage will not be effective any earlier than the time the application is signed and the premium paid. If my premium remittance is not honored by the bank upon its first presentation by the Company, no coverage will have been considered bound and this policy contract will be null and void. I agree that my policy may be subject to a premium or term adjustment as a result of my Motor Vehicle Report or underwriting rules.

**BY SIGNING AS APPLICANT, I HEREBY UNDERSTAND AND ACCEPT THAT THIS POLICY HAS AN EXCLUSION FOR "BODILY INJURY OR PROPERTY DAMAGE BENEFITS PAYABLE UNDER THE "NO FAULT LAWS" OF THE FOLLOWING STATES: ARKANSAS, DELAWARE, WASHINGTON DC, FLORIDA, HAWAII, KANSAS, KENTUCKY, MARYLAND, MASSACHUSETTS, MICHIGAN, MINNESOTA, NEW YORK, NORTH DAKOTA, OREGON, TEXAS, UTAH AND WASHINGTON."** ☐ RECORDED SIGNATURE

Date: \_\_\_\_\_  
\_\_\_\_\_. A.M.  
\_\_\_\_\_. P.M.

Applicant/Names Insured Signature X \_\_\_\_\_

I certify that I have advised the applicant that failure to disclose all accidents, violations, business use and drivers can jeopardize applicant's coverage.

Signature of Agent X \_\_\_\_\_