Application for Rental Autos & Trucks – Short Term
(Hour, Day or Week)

COLUMBIA INSURANCE COMPANY
NATIONAL FIRE & MARINE INSURANCE COMPANY
NATIONAL INDEMNITY COMPANY
NATIONAL INDEMNITY COMPANY OF MID-AMERICA
NATIONAL INDEMNITY COMPANY OF THE SOUTH
NATIONAL LIABILITY & FIRE INSURANCE COMPANY

Insurance Innovators
P.O. Box 969
130 South Easton Road
Glenside, PA 19038
(215) 885-7300 FAX: (215) 886-2482

Policy Term From:_____ To _____

1. Name of Applicant _____
2. a. Address of Applicant _____
(Number) (Street) (City) (County) (State) (Zip Code)
   b. Address where vehicles are garaged if different than address of applicant _____
3. Applicant is: ☐ Individual ☐ Partnership ☐ Corporation
4. Is this your primary business? ☐ Yes ☐ No If no, explain: _____
   _____ Years experience in this business? _____
5. Coverage to be effective from: _____ to: _____
6. Person to contact for inspection (name and phone number) _____
7. Is this a new operation? ☐ Yes ☐ No Is your operation currently for sale? ☐ Yes ☐ No Seasonal in nature? ☐ Yes ☐ No
8. Has this business ever operated under any other name? ☐ Yes ☐ No If yes, show previous name and address: _____
   _____
9. Give estimate of financial worth $_____ Gross receipts last year? _____ Estimate for coming year? _____
10. Have you filed for bankruptcy within the last 5 years or do you contemplate doing so? ☐ Yes ☐ No If yes, provide details: _____
    _____
11. Have you under this name or any other name been insured with any of the above-listed companies? ☐ Yes ☐ No If yes, explain:
    _____

DESCRIPTION AND AREA OF OPERATIONS

12. Number of short term rental vehicles:
    Private Passenger Autos _____ Pick-Ups _____ Trucks _____ Tractors _____ Semi-trailers _____ Trailers _____
    Cargo Vans _____ Passenger Vans _____ Others (specify) _____
13. Percentage of private passenger vehicles rented to: Personal? _____ % Military? _____ % Commercial? _____ %
    Insurance Replacement? _____ %
14. Are any vehicles rented for 1 month or more? ☐ Yes ☐ No If yes, submit details (which units, to whom, term of rental or lease)
    _____
15. Are vehicles ever leased with drivers? ☐ Yes ☐ No If yes, attach complete list of drivers, vehicle(s) they drive, age of driver, license number, and chargeable accidents during past three years.
16. **Leasing Agreements:** Attach copy of each type of rental or lease agreement used.
17. What is average term of rental? _____ days
18. What are your rules for selecting renters or lessees? _____
    _____
    _____

19. What is minimum age of persons permitted to rent vehicles? _____ Are additional drivers permitted? ☐ Yes ☐ No
    If yes, how are they qualified? _____
20. Do you ask what the vehicle will be used for and where it will be driven? ☐ Yes ☐ No
21. Percent cash rental? _____ % Percent credit card? _____ % If cash rental, how do you qualify renter? _____
22. Do you use an on-line service giving subscribers credit, driving & criminal history? ☐ Yes ☐ No If yes who? _____
23. Are written counter practice procedures furnished to all counter personnel? ☐ Yes ☐ No If yes, attach copy.
24. Are you named as additional insured on renter's policy on any vehicles rented? ☐ Yes ☐ No Explain: _____
25. Do you require liability insurance from the rentee? ☐ Yes ☐ No Explain: _____
26. Do you obtain a certificate of liability insurance on any vehicles rented? ☐ Yes ☐ No Explain: _____
27. Do you rent or lease vehicles from others? ☐ Yes ☐ No If yes, explain: _____
28. Are any vehicles rented on a "Rent It Here - Leave It There" basis? ☐ Yes ☐ No
29. Is applicant required to file evidence of insurance with any state regulatory authority or any other authority? ☐ Yes ☐ No
    If yes, specify: _____
30. Do you have your own repair shop? ☐ Yes ☐ No If yes, what kind of repairs are made? _____
31. Are rental contracts prenumbered? ☐ Yes ☐ No
32. How often are rental vehicles serviced? _____

COMPLETE QUESTIONS 33-36 FOR COMMERCIAL VEHICLES ONLY

33. Percentage of business derived from renting vehicles to individuals hauling their own personal goods or effects _____ %
    Businesses _____ %
34. Are vehicles rented to trucking firms (truckers hauling for hire)? ☐ Yes ☐ No If yes, _____ %
35. Will you rent vehicles to be used to carry passengers for hire? ☐ Yes ☐ No
36. Are any vehicles rented to hazardous material haulers? ☐ Yes ☐ No If yes, explain: _____

PREVIOUS INSURANCE CARRIER AND LOSS EXPERIENCE

37. Provide prior insurance carriers information for past full three years. List in order with most recent carrier first.

Policy Term		Insurance Company Name	Policy Number	Number of Motor Powered Vehicles	Number of Accidents	Premium		Total Amount Claims Paid & Reserves			
From	To					Liab	Phys Dam	BI	PD	Coll	Other
/ /	/ /										
/ /	/ /										
/ /	/ /										

38. Have you ever been declined, canceled or nonrenewed for this kind of insurance? ☐ Yes ☐ No If yes, date and why _____
39. Is any applicant aware of any facts or past incidents, circumstances or situations which could give rise to a claim under the insurance coverage sought in this application? ☐ Yes ☐ No If yes, provide complete details _____

INSURANCE NEEDS & SCHEDULE OF VEHICLES

40. **COMPLETE FOR DESIRED COVERAGES BY INDICATING LIMITS OF INSURANCE**

Liability				Uninsured Motorists			Underinsured Motorists			Medical Payments	Personal Injury Protection	Physical Damage
Combined Single Limit BI & PD	Split Limits			Single Limit Each Accident	Split Limits		Single Limit Each Accident	Split Limits				Complete section below if wanted
	Bodily Injury		Property Damage		Each Person	Each Accident		Each Person	Each Accident			
	Each Person	Each Accident	Each Accident									

41. Liability limits for rentee: BI each person $ _____ BI each accident $ _____
PD each accident $ _____ Or combined single limit BI & PD $ _____

42. **SCHEDULE OF AUTOS/VEHICLES TO BE COVERED (If more than 8, attach additional schedule with information below)**

Auto No.	Year Model	Trade Name	Body Type**	Serial No. (S) Vehicle ID No. (VIN)	Anti-Theft Devices Yes or No	Air-bags Yes or No	Licensed Weight*	Anti-Lock Brakes Yes or No	Lift or Lift Gate Yes or No	Dual Rear Axles Yes or No	Estimated Annual Mileage	Maximum Radius of Operations (miles)
1												
2												
3												
4												
5												
6												
7												
8												

*Licensed Weight – Gross Vehicle Weight (GVW) weight of vehicle and load or Gross Combined Weight (GCW) weight of vehicles and load.

**Body Type:

PPT	Priv. Pass. Type	PIC UP	Pick Up	TNK TK	Tank Truck	FLT TR	Flat Trailer	Other (Specify) _____
JEEP	Jeep	BOM TK	Boom Truck	OTH TK	Other Truck	STK TR	Stock Trailer	_____
PSS VN	Pass. Van	CRN TK	Crane/Truck	TRACT	Tractor	TNK TR	Tank Trailer	_____
CRG VN	Cargo Van	DMP TK	Dump Truck	BX TR	Box Trailer	UTL TR	Utility Trailer	_____

COMPLETE THESE SPACES ONLY IF PHYSICAL DAMAGE COVERAGE DESIRED

Auto No.	Town & State Where Principally Garaged	Use*	Original Cost New of Chassis, Body & Equipment	Date Purchased Mo/Yr	Cost When Purchased	Value of Vehicle Excluding Permanently Attached Special Equipment	Value of Permanently Attached Special Equipment	Specified Causes of Loss		Collision	
								Amount of Insurance	Deductible	Amount of Insurance	Deductible
1											
2											
3											
4											
5											
6											
7											
8											

* Enter one or more of the following initials to indicate use of each auto.

RI – Rented to Individuals RT – Rented to Truckers ST – Non-Rental Business Service Truck

RB – Rented to Businesses BA – Non-Rental Business Auto O – Other (describe) _____

43. **ANY LOSS PAYEES?** ☐ Yes ☐ No If yes, indicate for which vehicle(s) and give name and address of loss payees: _____

_____

_____

IMPORTANT NOTICE

Insurance companies operating in the Commonwealth of Pennsylvania are required by law to make available for your purchase the following benefits for you, your spouse or other relatives or minors in your custody or in the custody of your relatives, residing in your household, occupants of your motor vehicle or persons struck by your motor vehicle.

(1) Medical benefits, up to at least $100,000.

(1.1) Extraordinary medical benefits, from $100,000 to $1,100,000 which may be offered in increments of $100,000.

(2) Income loss benefits, up to at least $2,500 per month up to a maximum benefit of at least $50,000.

(3) Accidental death benefits, up to at least $25,000.

(4) Funeral benefits, $2,500.

(5) As an alternative to paragraphs (1), (2), (3) and (4), a combination benefit, up to at least $177,500 of benefits in the aggregate or benefits payable up to three years from the date of the accident, whichever occurs first, subject to a limit on accidental death benefit of up to $25,000 and a limit on funeral benefit of $2,500, provided that nothing contained in this subsection shall be construed to limit, reduce, modify or change the provisions of section 1715(d) (relating to availability of adequate limits).

(6) Uninsured, underinsured and bodily injury liability coverage up to at least $100,000 because of injury to one person in any one accident and up to at least $300,000 because of injury to two or more persons in any one accident or, at the option of the insurer, up to at least $300,000 in a single limit for these coverages, except for policies issued under the Assigned Risk Plan. Also, at least $5,000 for damage to property of others in any one accident.

Additionally, insurers may offer higher benefit levels than those enumerated above as well as additional benefits. However, an insured may elect to purchase lower benefit levels than those enumerated above.

Your signature on this notice or your payment of any renewal premium evidences your actual knowledge and understanding of the availability of these benefits and limits as well as the benefits and limits you have selected.

If you have any questions or you do not understand all of the various options available to you, contact your agent or company.

If you do not understand any of the provisions contained in this notice, contact your agent or company before you sign.

I have read and acknowledge the information set out above.

X _____ _____ _____

Signature of First Named Insured | Date | Witness

FIRST PARTY BENEFITS NOTICE

FIRST PARTY BENEFITS

A. MEDICAL EXPENSE BENEFIT *Coverage to reimburse you for reasonable and necessary medical treatment and services incurred.*

B. INCOME LOSS BENEFIT *Coverage to replace a portion of lost income and reimburse you for expenses in securing replacement services.*

C. ACCIDENTAL DEATH BENEFIT *A death benefit paid in the event of the death of an insured person due to a covered auto accident.*

D. FUNERAL BENEFIT *Coverage to pay for direct funeral, burial and other related expenses incurred as a result of the death of an insured person due to a covered accident.*

Effective July 1, 1990 Act 6 changes what is required to be taken for first party benefits. You are required to purchase a minimum of $5,000 Medical Expenses. All other options listed below (including a higher limit of Medical Payments) are choices for you to make. Indicate your choice of options shown below for each coverage. Then date and sign this form and return to your Agent.

BENEFIT LEVEL OPTIONS: (Include your choice by marking the box for each coverage or for your choice of Combination Benefits option; a selection from F and either one from each of A, B, C, and D or one selection from E)

A. MEDICAL EXPENSES: (☒ indicates your choice)

☐ $5,000	per person, per accident	(Minimum)	$_____	Premium
☐ $10,000	per person, per accident		$_____	Premium
☐ $25,000	per person, per accident		$_____	Premium
☐ $50,000	per person, per accident		$_____	Premium
☐ $100,000	per person, per accident	(Maximum)	$_____	Premium

B. INCOME LOSS: (☒ indicates your choice)

☐ None – Rejected	per month / per accident, per person	(Minimum)		
☐ $1,000 / $5000	per month / per accident, per person		$_____	Premium
☐ $1,000 / $10,000	per month / per accident, per person		$_____	Premium
☐ $1,000 / $15,000	per month / per accident, per person		$_____	Premium
☐ $1,500 / $25,000	per month / per accident, per person		$_____	Premium
☐ $2,500 / $50,000	per month / per accident, per person	(Maximum)	$_____	Premium

C. ACCIDENTAL DEATH: (☒ indicates your choice)

☐ None – Rejected	per person, per accident	(Minimum)		
☐ $5,000	per person, per accident		$_____	Premium
☐ $10,000	per person, per accident		$_____	Premium
☐ $25,000	per person, per accident	(Maximum)	$_____	Premium

D. FUNERAL EXPENSE: (☒ indicates your choice)

☐ None – Rejected per person, per accident (Minimum)

☐ $1,500 per person, per accident $_____ Premium

☐ $2,500 per person, per accident (Maximum) $_____ Premium

OR

E. COMBINATION BENEFITS: Single Limit for all coverages, with specific benefit limits as shown (☒ indicates your choice)

☐ $50,000 ($2,500 Funeral and $10,000 Accidental Death Benefits) $_____ Premium

☐ $100,000 ($2,500 Funeral and $10,000 Accidental Death Benefits) $_____ Premium

☐ $177,500 ($2,500 Funeral and $25,000 Accidental Death Benefits) $_____ Premium

AND

F. EXTRAORDINARY MEDICAL BENEFIT (EMB): (☒ indicates your choice)

☐ I wish to purchase EMB coverage at the following limit:

☐ $100,000 ☐ $300,000 ☐ $500,000 ☐ $1,000,000

☐ I do not wish to purchase EMB coverage.

In accordance with 1989 Pa. Laws 4, your first party benefits coverage may be extended to provide an extraordinary medical benefit (EMB) which will pay the medical and rehabilitation costs for you and your family members residing in your household which are more than $100,000 for each person injured as the result of an automobile accident, up to a lifetime benefit limits of $1,000,000 for each person. Since you are only required to carry $5,000 medical expense coverage under your first party benefits and EMB coverage only pays expenses that exceed $100,000, you may have a gap in coverage between your selected first party benefits above an EMB coverage. We recommend you consider this when you make your medical expense selections.

I have had the coverages, benefit levels and options as set out above, fully explained to me and have indicated my choices (☒ indicates my choices) as shown. I understand that this is simply a summary of the coverages and benefits, and that the forms and endorsements attached to my policy actually make up my coverage.

_____ _____ **X**_____

Witness to signature of Named Insured(s) Date Signature of Named Insured(s)

Named Insured_____

Typed or printed name

THE CHOICES AND OPTIONS AS INDICATED ABOVE WILL CONTINUE IN FORCE AND EFFECT UNTIL WRITTEN REPLACEMENT NOTICE IS RECEIVED BY THE COMPANY OR ITS REPRESENTATIVE.

UNDERINSURED MOTORIST COVERAGE

Underinsured Motorist Coverage provides protection for damages incurred which exceed the limit of liability carried by the driver of a vehicle who injures you in an automobile accident. You have the right to purchase Underinsured Motorist Coverage in an amount equal to the amount of Bodily Injury Liability Coverage provided in your policy. The law does not require you to purchase Underinsured Motorist Coverage, and you have the right to reject this coverage. You also have the option to purchase Underinsured Motorist Coverage with limits of coverage less than that of your Bodily Injury Liability Coverage limit. Underinsured Motorist Coverage is an optional coverage, however, we are required to include it in your policy unless you take steps to reject it.

INDICATE YOUR CHOICE BY EITHER COMPLETING THE REJECTION OF UNDERINSURED MOTORIST COVERAGE FORM OR BY COMPLETING THE SELECTION OF UNDERINSURED MOTORIST COVERAGE AND STACKING OPTIONS FORM

REJECTION OF UNDERINSURED MOTORIST COVERAGE

By signing this waiver I am rejecting Underinsured Motorist Coverage under this policy, for myself and all relatives residing in my household. Underinsured coverage protects me and relatives living in my household for losses and damages suffered if injury is caused by the negligence of a driver who does not have enough insurance to pay for all losses and damages. I knowingly and voluntarily reject this coverage.

X _____ _____ _____

Signature of First Named Insured | Date Signed | Witness

THE OPTIONS SELECTED SHALL CONTINUE IN FORCE AND EFFECT UNTIL REPLACEMENT WRITTEN NOTICE IS RECEIVED BY THE COMPANY, OR ITS REPRESENTATIVE.

SELECTION OF UNDERINSURED MOTORIST COVERAGE AND STACKING OPTIONS

A. Selection of UIM Coverage: I do wish to purchase Underinsured Motorist Coverage at $ _____ per person, $ _____ per accident split limits of liability or $ _____ per accident single limit of liability. (Your UIM limits selection cannot be greater than your policy Bodily Injury Liability Coverage Limit.)

B. Stacking Options: If you have chosen to purchase Underinsured Motorist Coverage, and you are not a legal corporation, your next option is to determine if you want to stack the limits of your policy. Stacking means you can claim a total of the amounts of Underinsured Motorist Coverage assigned to each vehicle in your policy. If you reject stacked limits, each vehicle insured under the policy will have its own limit of Underinsured Motorist Coverage. There is an additional premium for this coverage.

☐ Purchase of Stacking: I wish to purchase stacking of Underinsured Motorist Coverage (Not applicable if named insured is a legal corporation).

☐ Rejection of Stacking: I wish to reject stacking of Underinsured Motorist Coverage. By signing this waiver, I am rejecting stacked limits of Underinsured Motorist Coverage under the policy for myself and members of my household under which the limits of coverage available would be the sum of limits for each motor vehicle insured under the policy. Instead the limits of coverage that I am purchasing shall be reduced to the limits stated in the policy. I knowingly and voluntarily reject the stacked limits of coverage. I understand that my premiums will be reduced if I reject this coverage.

X _____ _____ _____

Signature of First Named Insured | Date Signed | Witness

THE OPTIONS SELECTED SHALL CONTINUE IN FORCE AND EFFECT UNTIL REPLACEMENT WRITTEN NOTICE IS RECEIVED BY THE COMPANY, OR ITS REPRESENTATIVE.

UNINSURED MOTORIST COVERAGE

Uninsured Motorist Coverage provides protection for damages incurred as a result of an accident with an uninsured motor vehicle. You have the right to purchase Uninsured Motorist Coverage in an amount equal to the amount of Bodily Injury Liability coverage provided in your policy. The law does not require you to purchase Uninsured Motorist Coverage, and you have the right to reject this coverage. You also have the option to purchase Uninsured Motorist Coverage with limits of coverage less than that of your Bodily Injury Liability Coverage limit. Uninsured Motorist Coverage is an optional coverage, however, we are required to include it in your policy unless you take steps to reject it.

INDICATE YOUR CHOICE BY EITHER COMPLETING THE REJECTION OF UNINSURED MOTORIST COVERAGE FORM OR BY COMPLETING THE SELECTION OF UNINSURED MOTORIST COVERAGE AND STACKING OPTIONS FORM

REJECTION OF UNINSURED MOTORIST COVERAGE

NOTE: Rejection of uninsured motorist coverage is not allowed for “Common Carriers by Motor Vehicle” as defined in 66CPA.C.S. Section 102.

By signing this waiver I am rejecting uninsured motorist coverage under this policy, for myself and all relatives residing in my household. Uninsured coverage protects me and relatives living in my household for losses and damages suffered if injury is caused by the negligence of a driver who does not have any insurance to pay for losses and damages. I knowingly and voluntarily reject this coverage.

X _____ _____ _____

Signature of First Named Insured | Date Signed | Witness

THE OPTIONS SELECTED SHALL CONTINUE IN FORCE AND EFFECT UNTIL REPLACEMENT WRITTEN NOTICE IS RECEIVED BY THE COMPANY, OR ITS REPRESENTATIVE.

SELECTION OF UNINSURED MOTORIST COVERAGE AND STACKING OPTIONS

A. Selection of UM Coverage: I do wish to purchase Uninsured Motorist Coverage at $ _____ per person, $ _____ per accident split limits of liability or $ _____ per accident single limit of liability. (Your UM limits selection cannot be greater than your policy Bodily Injury Liability Coverage Limit.)

B. Stacking Options: If you have chosen to purchase Uninsured Motorist Coverage, and you are not a legal corporation, your next option is to determine if you want to stack the limits of your policy. Stacking means you can claim a total of the amounts of Uninsured Motorist Coverage assigned to each vehicle in your policy. If you reject stacked limits, each vehicle insured under the policy will have its own limit of Uninsured Motorist Coverage. There is an additional premium for this coverage.

☐ Purchase of Stacking: I wish to purchase stacking of Uninsured Motorist Coverage (Not applicable if named insured is a legal corporation).

☐ Rejection of Stacking: I wish to reject stacking of Uninsured Motorist Coverage. By signing this waiver, I am rejecting stacked limits of Uninsured Motorist Coverage under the policy for myself and members of my household under which the limits of coverage available would be the sum of limits for each motor vehicle insured under the policy. Instead the limits of coverage that I am purchasing shall be reduced to the limits stated in the policy. I knowingly and voluntarily reject the stacked limits of coverage. I understand that my premiums will be reduced if I reject this coverage.

X _____ _____ _____

Signature of First Named Insured | Date Signed | Witness

THE OPTIONS SELECTED SHALL CONTINUE IN FORCE AND EFFECT UNTIL REPLACEMENT WRITTEN NOTICE IS RECEIVED BY THE COMPANY, OR ITS REPRESENTATIVE.

SIGNATURE IS ALSO REQUIRED ON LAST PAGE OF APPLICATION

MUST BE SIGNED BY THE APPLICANT PERSONALLY

No coverage is bound until the Company advises the Applicant or its representative that a policy will be issued and then only as of the policy effective date and in accordance with all policy terms. The Applicant acknowledges that the **Applicant's Representative named below is acting as Applicant's agent and not on behalf of the Company. The Applicant's Representative has no authority to bind coverage, may not accept any funds for the Company, and may not modify or interpret the terms of the policy.**

The Applicant agrees that the foregoing statements and answers are true and correct. The Applicant requests the Company to rely on its statements and answers in issuing any policy or subsequent renewal. The Applicant agrees that if its statements and answers are materially false, the Company may rescind any policy or subsequent renewal it may issue.

If any jurisdiction in which the Applicant intends to operate or the Interstate Commerce Commission requires a special endorsement to be attached to the policy which increases Company's liability, the Applicant agrees to reimburse the Company in accordance with the terms of that endorsement.

The Applicant agrees that any inspection of autos, vehicles, equipment, premises, operations, or inspection of any other matter relating to insurance that may be provided by the Company, is made for the use and benefit of the Company only, and is not to be relied upon by the Applicant or any other party in any respect.

The Applicant understands that an inquiry may be made into the character, finances, driving records, and other personal and business background information the Company deems necessary in determining whether to bind or maintain coverage. Upon written request, additional information will be provided to the Applicant regarding any investigation.

The Applicant represents that she/he has completed all relevant sections of this Application prior to execution and that the Applicant has personally signed below (or if Applicant is a Corporation, a corporate officer has signed below).

Will premium be financed? ☐ Yes ☐ No If yes, with whom _____

_____	_____	_____
Witness	Applicant's Signature	Date

TO BE COMPLETED BY APPLICANT'S REPRESENTATIVE

Is this direct business to your office? _____ If not, explain: _____

Is this new business to your office? _____ If not, how long have you had the account? _____

How long have you known applicant? _____

REQUEST TO COMPANY GENERAL AGENT:

☐ Please quote

☐ Please bind at earliest possible date and issue policy

☐ Please issue policy effective _____ Coverage was bound by _____

(Time and Date Bound by General Agent) (Name of Person in Company General Agent's Office Binding Coverage)

_____

Applicant's Representative's Name and Address Phone No.