



**NON-TRUCKING  
TRANSPORTATION APPLICATION  
(FOR PERMANENTLY LEASED OPERATORS)**

- Colony Insurance Company  
 Colony Specialty Insurance Company

- Argonaut Insurance Company  
 Argonaut Midwest Insurance Company

**Section I - General Information**

The coverage you are applying for is for non-trucking only. If you require ICC, PUC or any other special filing, you do not qualify for Non-Trucking coverage. Please complete the COMMERCIAL AUTO APPLICATION FORM AU 1133.

1. Policy Period Desired \_\_\_\_\_
2. Name of Insured \_\_\_\_\_ Phone \_\_\_\_\_
3. Address of Insured \_\_\_\_\_ Fax \_\_\_\_\_  
 \_\_\_\_\_ Website \_\_\_\_\_
4. Number of years operating this business \_\_\_\_\_ If new venture, number of years of experience \_\_\_\_\_
5. Type of cargo hauled: \_\_\_\_\_
6. Name of Authorized Carrier to whom equipment is permanently leased: \_\_\_\_\_
7. Any trip leasing done?  Yes  No  
 If "Yes," please explain in detail: \_\_\_\_\_
8. Radius of operation:  0 – 50  51 – 200  201 – 300  Over 300 (specify \_\_\_\_\_)
9. In the past 3 years, have you ever had insurance for this type of operation cancelled, declined or renewal refused? If "Yes," explain:  Yes  No  
 \_\_\_\_\_

**Section II - Driver Information**

10. Do you carry Worker's Compensation?  Yes  No  
 If "Yes," list company: \_\_\_\_\_

11. Schedule of Drivers (if any additional drivers, complete form AU 0053):

Driver's Full Name and Address	Date of Birth	Date Employed	Yrs. Experience Comm'l Driving on like equipment	Driver's Lic. Number
1.				
2.				

State in Which Driver's License Obtained	Description of Convictions for Violations and Accidents (Past 3 Years)
1.	
2.	

**Section III - Schedule of Units**

Unit #	Model Year	Trade Name	Truck, Tractor, Semi-Trailer, Full Trailer	Cargo Hauled	Model Series & Complete Vin Number	Max. Gross Wt., of Vehicle (lbs.)	Max. Load Cap. In lbs., gals., liquids
1.					Mod #:		
					VIN #:		
2.					Mod #:		
					VIN #:		
3.					Mod #:		
					VIN #:		
4.					Mod #:		
					VIN #:		

Unit #	Location of Garaging	Max. Radius of Operations	Stated Amount	Collision Deductible	Comp Deductible	SCOL Deductible	Loss Payee and Full Address
1.							
2.							
3.							
4.							

**Section IV – Previous Insurance and Loss Experience**

This section must be completed in its entirety. Please list all losses and indicate which losses occurred under non-trucking liability. For fleets consisting of 5 power units or more - hard copy loss runs are required.

Show Policy Periods for Past Three Years	Insurance Carrier	Policy #	Number of Accidents	Total Amount of Claims Paid		Total Amount Unsettled Claims (reserves)	
				Bodily Injury	Property Damage	Bodily Injury	Property Damage
From To				\$	\$	\$	\$
From To				\$	\$	\$	\$
From To				\$	\$	\$	\$
				Losses by Fire	Losses by Theft	Losses by Collision	Losses by Wind
From To				\$	\$	\$	\$
From To				\$	\$	\$	\$
From To				\$	\$	\$	\$

**Section V – Coverage and Limits Requested**

12. Liability Limits

- a. Combined Single Limit: \$ \_\_\_\_\_
- b. Split Limits:
  - Bodily Injury: \$ \_\_\_\_\_ each person
  - \$ \_\_\_\_\_ each accident
  - Property Damage \$ \_\_\_\_\_ each accident
- c. Liability Deductible: \$ \_\_\_\_\_

13. Do you desire Uninsured Motorists coverage  Yes  No  
 (for requirements, check state statute - may not be optional)?  
 If "Yes," limit desired \$ \_\_\_\_\_  
 If "No," please sign UM rejection form if required by state (attached).
14. Do you desire Personal Injury Protection coverage?  Yes  No  
 (for requirements, check state statute - may not be optional)

**Section VI – 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 Signature / Title	Telephone Number	Date
Witness		Date
Agent's or Broker's Name	Telephone Number	Agent's Signature
Address		Dated
		License No.

**GENERAL FRAUD STATEMENT (Not applicable in Colorado, Ohio or Oregon)**

Any person who knowingly and with intent to defraud any insurance company or another 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 and subject the person to criminal and [NY: substantial] civil penalties. In the District of Columbia, Louisiana, Maine, Tennessee and Virginia, insurance benefits may also be denied.

Colorado, Ohio, and Oregon – see notices below.

\_\_\_\_\_  
 APPLICANT'S SIGNATURE

\_\_\_\_\_  
 DATE (MM/DD/YY)

**Applicable in 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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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.

\_\_\_\_\_  
 APPLICANT'S SIGNATURE

\_\_\_\_\_  
 DATE (MM/DD/YY)

**Applicable in Ohio**

Any person who, with intent to defraud or knowing that he/she 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.

\_\_\_\_\_  
 APPLICANT'S SIGNATURE

\_\_\_\_\_  
 DATE (MM/DD/YY)

**Applicable in Oregon**

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 may be guilty of Insurance Fraud.

\_\_\_\_\_  
 APPLICANT'S SIGNATURE

\_\_\_\_\_  
 DATE (MM/DD/YY)