



Agency:	Producer:	Date:
Is this applicant currently a customer at your agency? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes for how many years:		
Applicant Named Insured:		
Applicant ALL DBA:		
Type of Business: <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Other:		
Do you own any other business? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If you do what is the name of the business?		
Proposed Effective Date:		Number of Years in Business:
<i>(If less than five years Complete the "Prior Employment Survey" form)</i>		
Mailing address:	City:	
Garaging Street Address:	City:	
County:	State:	Zip: Business Phone: ()
Owner:	<input type="checkbox"/> Active?	FEIN #:
Insurance Contact for the Company:	Position:	
Current Insurance Company:	Expiring Premium: \$	

Coverage Section:

Auto Liability Limit Desired: \$ CSL

<input type="checkbox"/> Personal Injury Protection \$	<input type="checkbox"/> Uninsured Motorist: \$
<input type="checkbox"/> Added Personal Injury Protection \$	<input type="checkbox"/> Underinsured Motorist \$
<input type="checkbox"/> Property Protection (Michigan only) \$	<input type="checkbox"/> Hired Car \$
<input type="checkbox"/> Medical Payments \$	<input type="checkbox"/> Non Owned Auto \$

Physical Damage Coverage: Complete coverage for each individual vehicle on the vehicle schedule.

Garage Liability Limit or Garage:*Dependent on the Carrier***Garage or GL Limit Desired:** \$ CSL

(Must be equal to above auto limit) the aggregate limit will always equal three times the primary limit.

<input type="checkbox"/> Broad Form Garage Liability (CA2514)	<input type="checkbox"/> Broad Form Products
<input type="checkbox"/> Garage Premises Medical Payments \$	

Garage keepers Coverage: (If coverage desired complete the supplemental sections.) Legal Liability Direct Primary

Location 1 Limit: \$ Address: City: State: Zip:
Location 2 Limit: \$ Address: City: State: Zip:
Location 3 Limit: \$ Address: City: State: Zip:

Dealer Tags: How Many? Tag Number: ____ , ____ , ____ , ____.

Miscellaneous Towing and Recovery Equipment Coverage Section: Provide a separate schedule of the items to be covered: the list should include serial numbers, value, and deductible for each item to be covered. (The minimum deductible is \$500.)

On Hook Cargo Coverage Section: Complete coverage for each individual vehicle on the vehicle schedule.

*****For Miscellaneous Equipment Floater and Property Coverage Attach the Completed Accord Application*****

Safety Management:	Yes	No
Do you have a Written Safety Program that is implemented and enforced at your company?	<input type="checkbox"/>	<input type="checkbox"/>
Do you hold safety meetings? If so how often? <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly	<input type="checkbox"/>	<input type="checkbox"/>
Are ALL trucks equipped with annually inspected fire extinguishers?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a Written Driver Training Program?	<input type="checkbox"/>	<input type="checkbox"/>
Is there a Written vehicle take-home policy?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a drug-testing program in place?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a Written Maintenance Program?	<input type="checkbox"/>	<input type="checkbox"/>
If you answered NO to any of the above Questions, if requested, would management implement a program designed to assist with that item within the first 30 Days of the effective date of this insurance? Owners Initial	<input type="checkbox"/>	<input type="checkbox"/>



Operations Section: Answer **YES**, if you are involved in **ANY** of these operations or **NO**, if you are not.

*****Provide the number of employees involved in each department*****

If you are requesting **Garage Coverage**, complete the **AEON Supplemental Questionnaire**.

Yes	No	Number of Employees	Yes	No	Number of Employees
<input type="checkbox"/>	<input type="checkbox"/>	Towing	<input type="checkbox"/>	<input type="checkbox"/>	Auto Repair
<input type="checkbox"/>	<input type="checkbox"/>	Rental Operations	<input type="checkbox"/>	<input type="checkbox"/>	Salvage, Scrap Metal, or Junkyard
<input type="checkbox"/>	<input type="checkbox"/>	Storage	<input type="checkbox"/>	<input type="checkbox"/>	Trucking/Equipment Hauling (Within a 50-mile radius)
<input type="checkbox"/>	<input type="checkbox"/>	Service Station	<input type="checkbox"/>	<input type="checkbox"/>	Auto Body Shop
<input type="checkbox"/>	<input type="checkbox"/>	Voluntary Repossessions	<input type="checkbox"/>	<input type="checkbox"/>	Involuntary Repossessions
<input type="checkbox"/>	<input type="checkbox"/>	Multi Car Auto Hauling	<input type="checkbox"/>	<input type="checkbox"/>	Boat Hauling

How many cars/boats are hauled at one time? What is the normal distance of the trip? Miles

Car Sales How many cars per month?

Are these sales the results of a lien/sales operation? Yes No (Lien/Sales is defined as selling a vehicle after processing the State required paper work to take title of an unclaimed vehicle.)

Other: (Describe ALL additional operations not mentioned in the above section that are performed at your company.)

Driver Management Section:

	Yes	No
Pre-hire Screening: Do you obtain a Motor Vehicle Record Report (MVR) on each driver prior to hiring?	<input type="checkbox"/>	<input type="checkbox"/>
Do you check ALL prior job references a driver provides prior to hiring?	<input type="checkbox"/>	<input type="checkbox"/>
Do you road test ALL drivers prior to hiring?	<input type="checkbox"/>	<input type="checkbox"/>
Driver Management: Do you obtain an MVR on ALL company drivers at least on an Annual basis?	<input type="checkbox"/>	<input type="checkbox"/>
Do you maintain driver files on ALL drivers including copies of tickets and the MVR?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a drug-testing program in place?	<input type="checkbox"/>	<input type="checkbox"/>
Do ALL your drivers meet the federal, state, and local license classification requirements?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a Written Disciplinary/Termination policy?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a Written Accident Review Policy?	<input type="checkbox"/>	<input type="checkbox"/>
Do you issue any employee or independent contractor a 1099?	<input type="checkbox"/>	<input type="checkbox"/>
Do you carry Workers Compensation Insurance for ALL your employees?	<input type="checkbox"/>	<input type="checkbox"/>

How are drivers compensated? Hourly Wage Salary Commission

How many drivers quit or were fired last year? How many did you hire last year?

What driver training do you provide for your drivers? _____

Do you require your drivers to take outside training courses? Yes No If yes what courses do they take? _____

General operations:

	Yes	No
Operations: Do you lease vehicles from other individuals or companies?	<input type="checkbox"/>	<input type="checkbox"/>
Do you lease vehicles to other individuals or companies?	<input type="checkbox"/>	<input type="checkbox"/>
Do you hire SUB-CONTRACTORS at any time?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any additional vehicles owned or leased by your company NOT on this schedule?	<input type="checkbox"/>	<input type="checkbox"/>
Do your vehicles travel outside of a 200-mile radius on a Regular basis?	<input type="checkbox"/>	<input type="checkbox"/>

Are the following procedures or items required?

Do you require the use safety chains on every tow?	<input type="checkbox"/>	<input type="checkbox"/>
Do you require the use of wheel-lift straps on every tow?	<input type="checkbox"/>	<input type="checkbox"/>
Do you require the use of vehicle-towing lights on every tow?	<input type="checkbox"/>	<input type="checkbox"/>

What percentage of your towing is: within 0-50Miles % , 51-100Miles % , 101-300Miles % , Over 301 Miles .

Regulatory Filings: Do you require a DOT or State filing? Yes No
 (You must supply a copy of the prior filing when requesting AEON to make a filing for you.)
 Do you require an MCS-90 endorsement to be issued on your company's behalf? Yes No
 Do you **ever** perform secondary tows of hazardous materials? Yes No
 Do you **ever move** hazardous materials on a primary haul basis? Yes No

MC NUMBER: _____ **D.O.T NUMBER:** _____ **STATE DOCKET NUMBER** _____
What filings are required? _____

Maintenance:

	Yes	No
Do you maintain maintenance logs on each vehicle?	<input type="checkbox"/>	<input type="checkbox"/>
Do you provide the routine maintenance on your equipment?	<input type="checkbox"/>	<input type="checkbox"/>
If you do not perform maintenance who does? _____		
Are they Professionally Certified as Mechanics?	<input type="checkbox"/>	<input type="checkbox"/>
Are your drivers in any way responsible for the cost of the maintenance of your equipment?	<input type="checkbox"/>	<input type="checkbox"/>
Do your drivers perform daily maintenance checks on ALL vehicles?	<input type="checkbox"/>	<input type="checkbox"/>

Insurance History:

	Yes	No
In the last twelve months, has your insurance been canceled for NON PAYMENT of premium? <i>(Not Applicable in Missouri)</i>	<input type="checkbox"/>	<input type="checkbox"/>
In the past twenty-four months has an insurance company NON-RENEWED your insurance coverage? <i>(Not Applicable in Missouri)</i>	<input type="checkbox"/>	<input type="checkbox"/>

Please provide the policy year if you have been Non Renewed. _____

Losses and Loss History Statement:

Do you have insurance company loss runs from your last four years of operation? Yes No
***** If you answered no, please review this next section very carefully. *****

Statement of your loss history:
 It is a requirement of AEON Insurance Group, Inc. that we receive your last four years of insurance company loss runs in order to analyze your operations insurability. If you are unable to obtain the four-year history prior to the inception of coverage and you have less than five vehicles to insure, we are willing to accept your statement of past losses until you can obtain your insurance company loss runs. By signing this application, you are agreeing to provide a complete statement of all losses pertaining to the coverage requested on this application and within forty-five days from coverage inception provide insurance company loss runs.
 My Previous Insurance Carriers are:

Year	Insurance Company Name	Premium Paid
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Loss History:

Date of Loss	Total Amount	Coverage Type	Driver	Date of Loss	Total Amount	Coverage Type	Driver
1.	\$			5.	\$		
2.	\$			6.	\$		
3.	\$			7.	\$		
4.	\$			8.	\$		

Personal information about you may be collected from persons other than you. Such information as well as other personal and privileged information collected by our agents or us may in certain circumstances be disclosed to third parties without your authorization. You have the right to review your personal information in our files and can request correction of any inaccuracies. A more detailed description of your rights and our practices regarding such information is available upon request. Contact your agent or broker for instruction on how to submit a request to us.

I, the applicant, understand that this application and all information supplied is part of the application process and will be relied upon by the insurance company in determining whether to provide the insurance coverage herein requested. I hereby represent and confirm that I have read all the questions and answers on the application and that, to the best of my knowledge all information provided in this application is complete, true, and correct. I further represent that I have made and will make the necessary periodic maintenance inspection of the premises and the insured vehicles and that all necessary repairs have been made to ensure that my property and vehicles are and will remain safe and in good working condition. It is understood and agreed that no insurance is in effect until AËON INSURANCE GROUP, INC. and those companies it represents accept this application.

NOTICE: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON, FILES THIS QUESTIONNAIRE FOR INSURANCE CONTAINING ANY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

By signing this application, I agree to: 1. ALL DRIVERS MUST BE SUBMITTED FOR APPROVAL PRIOR TO OPERATION ANY VEHICLE INSURED ON THIS POLICY. BY SIGNING THIS APPLICATION, YOU ARE AGREEING TO REPORT ALL DRIVERS FOR APPROVAL YOUR SIGNATURE ALSO INDICATES THAT YOU UNDERSTAND AND THAT UNAPPROVED OR UNREPORTED DRIVERS OPERATING YOUR VEHICLES CAN BE GROUNDS FOR CANCELLATION AT ANY TIME DURING THE POLICY. 2. To provide a signed and completed UM/UIM and or PIP Selection/ Rejection form. 3. Permit our representative to physically survey your operation. 4. Implement the recommendation and/or training programs suggested to you by the company.

Notice to Applicant: The broker or producer is your (the applicant’s) agent and is not an agent of AËON Insurance Group Inc. No producer or broker shall have the right to bind coverage or to; alter, modify, or discharge this application. The producer or broker shall not have the right to alter, modify, discharge or execute any insurance contracts or policies on behalf of AËON Insurance Group Inc.

Please Initial

Applicant’s Signature (Producer may not sign for applicant) Position: _____ Date: _____

Producer: _____ Agency: _____



REPORT ALL DRIVERS FOR APPROVAL PRIOR TO ALLOWING THEM TO OPERATE THE VEHICLES COVERED BY THIS POLICY.

Applicant:

#:	Year:	Make:	Model:	GVWR:	Radius:
Garage Location #	VIN:	Value: <input type="checkbox"/> S/A: \$		<input type="checkbox"/> OCN: \$	
Comp/Coll Deductible: <input type="checkbox"/> \$500		<input type="checkbox"/> 1,000	On Hook Deductible: <input type="checkbox"/> \$500		<input type="checkbox"/> \$1,000 On Hook Limit:\$
<input type="checkbox"/> Loss Payee		<input type="checkbox"/> Additional Insured _____			

#:	Year:	Make:	Model:	GVWR:	Radius:
Garage Location #	VIN:	Value: <input type="checkbox"/> S/A: \$		<input type="checkbox"/> OCN: \$	
Comp/Coll Deductible: <input type="checkbox"/> \$500		<input type="checkbox"/> 1,000	On Hook Deductible: <input type="checkbox"/> \$500		<input type="checkbox"/> \$1,000 On Hook Limit:\$
<input type="checkbox"/> Loss Payee		<input type="checkbox"/> Additional Insured _____			

#:	Year:	Make:	Model:	GVWR:	Radius:
Garage Location #	VIN:	Value: <input type="checkbox"/> S/A: \$		<input type="checkbox"/> OCN: \$	
Comp/Coll Deductible: <input type="checkbox"/> \$500		<input type="checkbox"/> 1,000	On Hook Deductible: <input type="checkbox"/> \$500		<input type="checkbox"/> \$1,000 On Hook Limit:\$
<input type="checkbox"/> Loss Payee		<input type="checkbox"/> Additional Insured _____			

#:	Year:	Make:	Model:	GVWR:	Radius:
Garage Location #	VIN:	Value: <input type="checkbox"/> S/A: \$		<input type="checkbox"/> OCN: \$	
Comp/Coll Deductible: <input type="checkbox"/> \$500		<input type="checkbox"/> 1,000	On Hook Deductible: <input type="checkbox"/> \$500		<input type="checkbox"/> \$1,000 On Hook Limit:\$
<input type="checkbox"/> Loss Payee		<input type="checkbox"/> Additional Insured _____			

#:	Year:	Make:	Model:	GVWR:	Radius:
Garage Location #	VIN:	Value: <input type="checkbox"/> S/A: \$		<input type="checkbox"/> OCN: \$	
Comp/Coll Deductible: <input type="checkbox"/> \$500		<input type="checkbox"/> 1,000	On Hook Deductible: <input type="checkbox"/> \$500		<input type="checkbox"/> \$1,000 On Hook Limit:\$
<input type="checkbox"/> Loss Payee		<input type="checkbox"/> Additional Insured _____			

#:	Year:	Make:	Model:	GVWR:	Radius:
Garage Location #	VIN:	Value: <input type="checkbox"/> S/A: \$		<input type="checkbox"/> OCN: \$	
Comp/Coll Deductible: <input type="checkbox"/> \$500		<input type="checkbox"/> 1,000	On Hook Deductible: <input type="checkbox"/> \$500		<input type="checkbox"/> \$1,000 On Hook Limit:\$
<input type="checkbox"/> Loss Payee		<input type="checkbox"/> Additional Insured _____			

Applicant:

Employee List: Please include ALL employees employed with the Named Insured

No.	Last Name	First Name	Initial	Job Duties	Number of Years with this Towing Operation	Number of Years Towing Experience	Date of Birth	Number of Years Commercial Driving Experience	License Number
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									

EMPLOYEE REPORTING PROCEDURES:

ALL NEW DRIVERS MUST BE REPORTED, A COPY OF THEIR MOTOR VEHICLE RECORD MUST BE SUBMITTED TO Aeon FOR APPROVAL PRIOR TO THAT DRIVER OPERATING ANY COVERED VEHICLE.

Applicant:

Loss Payee Additional Insured Certificate Holder Mortgage Vehicle Number from App Schedule:
Entity Name:
Address: _____ City: _____ State: _____ Zip: _____
Phone: () - _____ Fax: () - _____ Contact: _____
If property or building provide the description or address: _____
_____.

Loss Payee Additional Insured Certificate Holder Mortgage Vehicle Number from App Schedule:
Entity Name:
Address: _____ City: _____ State: _____ Zip: _____
Phone: () - _____ Fax: () - _____ Contact: _____
If property or building provide the description or address: _____
_____.

Loss Payee Additional Insured Certificate Holder Mortgage Vehicle Number from App Schedule:
Entity Name:
Address: _____ City: _____ State: _____ Zip: _____
Phone: () - _____ Fax: () - _____ Contact: _____
If property or building provide the description or address: _____
_____.

Loss Payee Additional Insured Certificate Holder Mortgage Vehicle Number from App Schedule:
Entity Name:
Address: _____ City: _____ State: _____ Zip: _____
Phone: () - _____ Fax: () - _____ Contact: _____
If property or building provide the description or address: _____
_____.

Loss Payee Additional Insured Certificate Holder Mortgage Vehicle Number from App Schedule:
Entity Name:
Address: _____ City: _____ State: _____ Zip: _____
Phone: () - _____ Fax: () - _____ Contact: _____
If property or building provide the description or address: _____
_____.