GRANADA
INSURANCE COMPANY
*"The Agent Partner Company"*SM

COMMERCIAL AUTO

Insurance Program Application

BROKERING AGENT'S REGISTER NUMBER #: ____________________

CARRIER: GRANADA INS. CO.	**UNDERWRITER:**		**DATE:**
PRODUCER:		DATE BOUND:	TIME BOUND:
ADDRESS:		POLICY NUMBER:	
		EFF DATE:	EXP DATE:
PHONE:		PREMIUM:	POLICY FEE: $25.00
PRODUCER CODE:	PRODUCER ID:	**TOTAL PREMIUM :**	

APPLICANT INFORMATION

NAME INSURED:				
MAILING ADDRESS:				
CITY:		COUNTY:	STATE:	ZIP:
INDIVIDUAL ☐	PARTNERSHIP ☐	CORPORATION ☐	LLC: ☐	YEARS IN BUSINESS:
Business Description:			Insured Telephone: ( )	

COVERAGE INFORMATION

Coverage	Bodily Injury Liability	Property Damage Liability	Uninsured Motorist	Personal Injury Protection	Medical Payments	Comprehensive	Collision
Limits	$ Each Person		$ Each Person	$10,000 Basic PIP	$ Each Accident	Actual Cash Value Less $ Deductible	Actual Cash Value Less $ Deductible
	$ Each Accident	$ Each Accident	$ Each Accident	Deductible			
	CSL $ Each Accident						
Covered Auto Symbol	7	7	7	7	7	7	7

5 = All Owned Autos Which Require No-Fault Coverage 7 = Autos Specifed on Schedule Other:

Check box for vehicles with Comp. and Coll. coverage Veh 1 ☐ Veh 2 ☐ Veh 3 ☐ Veh 4 ☐

Vehicle Information Add auto on Supplement ☐

Veh #	**Model Year**	**Trade Name/Model/Body type**	**VIN Number**	**Cost New**	**Comm'l**	**Retail**	**Serv**	**GVW**	**Terr**
1									
2									
3									
4									

Veh #	**Loss Payee Name**	**Street Address or P. O. Box.**	**City**	**State**	**Zip Code**
1					
2					
3					
4					

Veh #	**Additional Interest**	**Street Address or P. O. Box.**	**City**	**State**	**Zip Code**
1					
2					
3					
4					

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OPERATOR INFORMATION

List all Drivers, Employees, Spouses, and all persons over 15 residing with Applicant				
Driver	Name (Exactly as on License)	Date of Birth	Driver License Number	State Lic
1				
2				
3				
4				
5				
6				

	Yes	No
ANY DRIVERS WITH MOVING TRAFFIC VIOLATIONS?		
ARE ANY VEHICLES CUSTOMIZED, ALTERED OR HAVE SPECIAL EQUIPMENT?		
HAVE ALL OPERATORS BEEN LISTED ABOVE?		
DOES INSURED UNDERSTAND THAT THERE IS NO COVERAGE FOR PHYSICAL DAMAGE ON NON-FACTORY INSTALLED EQUIPAMENT?		
ARE ANY VEHICLES LEASED OR RENTED TO OTHERS?		
ARE ANY VEHICLES USED FOR TOWING OR HAVE TOWING DEVICE?		
WITH THE EXCEPTION OF ENCUMBRANCES, ARE ANY VEHICLES NOT SOLELY OWNED BY REGISTERED TO THE APPLICANT?		

PRIOR CARRIER INFORMATION

Category	Years:	Years:	Years:	Years:
Carrier				
Policy Number				
Limits				
Total Premium				

LOSS HISTORY

Enter all claims or occurrence thay may give rise to claims for the prior 3 years check here if none ☐

Date of occurrence	Type of occurrence	Amount Paid	Claims Open	Yes	No
				☐	☐
				☐	☐
				☐	☐

Any Policy or coverage declined, cancelled or non renewed during the prior 3 years ☐ Yes ☐ No

If yes, explain

Personal information about you may be collected from persons other than you, such information as well as other personal priviledged information collected by us or our agents 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 right and our practices regarding such information is available upon request. Contact you agent or broker for instruction on how to submit a request to us.

The agent has no authority to Bind coverage on behalf of Granada Insurance Company. the Agent has no right to MAKE, ALTER, MODIFY or DISCHARGE any CONTRACT or POLICY issued on the basis of this application

The undersigned agree if the downpayment or full payment check is returned by the bank because of nonsufficient funds, coverage will be null and void from inception.

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

This application is in compliance with Florida Statute 626.752 A copy has been furnished to the applicant or insured and coverage is ( ) Bound Effective _____(Time) _________________(Date)________ ( ) Not Bound

I understand this application is not a binder unless indicated as such on this form by the Brokering Agent.

APPLICANT'S SIGNATURE: ____ DATE: _________________________________

PRODUCER'S SIGNATURE: ____ DATE: _________________________________

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SUPPLEMENTAL APPLICATION

Name of insured	Policy Number:

___________ UNINSURED MOTORIST OPTIONS _____________

YOU ARE ELECTING NOT TO PURCHASE CERTAIN VALUABLE COVERAGE WHICH PROTECTS YOU AND YOUR FAMILY OR YOU ARE PURCHASING UNINSURED MOTORIST LIMITS LESS THAN YOUR BODILY INJURY LIABILITY LIMITS WHEN YOU SIGN THIS FORM.

PLEASE READ CAREFULLY!!

Uninsured Motorist Coverage provides for payment of certain benefits for damage caused by owners or operators of uninsured motor vehicles because of bodily injury or death resulting therefrom. Such benefits may include payments for certain medical expenses, lost wages, and pain and suffering subject to limitations and conditions contained in the policy. For the purpose of this coverage, an uninsured motor vehicle may include a motor vehicle as to which the bodily injury limits are less than your Damages.
.
Florida law requires that automobile liability policies include Uninsured Motorist Coverage at limits equal to the Bodily Injury Liability limits in your policy unless you select a lower limit offered by the Company, or reject Uninsured Motorist entirely. Please indicate whether you desire to entirely reject Uninsured Motorist Coverage or, whether you desire this coverage at limits lower than the Bodily Injury Liability limits of your policy.

☐ a. I hereby reject Uninsured Motorist Coverage.

☐ b. I hereby select Uninsured Motorist Limits of ____

☐ c. I hereby select Uninsured Motorist Limits which are equal to my Bodily Injury Liability limits.

I understand and agree that selection of one of the above options applies to my insurance policy and future renewals or replacements of such policy which are issued at the same Bodily Injury Liability limits. If I decide to select another option at some future time, I must let the Company or my agent know in writing.

___________ READ BEFORE SIGNING _____________

Date: ____ Signature of Applicant: ___________________________________

* IF "C" IS CHOSEN, PLEASE DISREGARD FIRST PARAGRAPH.

ELECTION OF NON-STACKED COVERAGE DO NOT COMPLETE IF YOU HAVE REJECTED UNINSURED MOTORIST COVERAGE

* DO NOT SIGN THIS ELECTION UNLESS YOU HAVE ELECTED NON-STACKED COVERAGE *

You have the option to purchase, at a reduced rate, non-stacked (limited) type of Uninsured Motorist Coverage. Under this form if injury occurs in a vehicle owned or leased by you or any family member who resides with you, this policy will apply only to the extent of coverage (if any) which applies to that vehicle in this policy. If an injury occurs while occupying someone else's vehicle, or you are struck as a pedestrian, you are entitled to select the highest limits of Uninsured Motorist coverage available on any one vehicle for which you are named insured, insured family member, or insured resident of the named insured's household. This policy will not apply if you select the coverage available under any other policy issued to you or the policy of any other family member who resides with you.

If you do not elect to purchase the non-stacked from, your policy limit(s) for each motor vehicle are added together (stacked) for all covered injuries. Thus, your policy limits would automatically change during the policy term if you increase or decrease the number of autos covered under the policy.

I HEREBY ELECT THE NON-STACKED FORM OF UNINSURED MOTORIST COVERAGE

I understand and agree that selection of any of the above options applies to my liability insurance policy and future renewals or replacements of such policy which are issued at the same Bodily Injury Liability limits. If I decide to select another option at some future time, I must let the Company or my agent know in writing.

Date: ____ Signature of Applicant: ____________________

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SUPPLEMENTAL APPLICATION

Name of insured	Policy Number:

PERSONAL INJURY PROTECTION OPTIONS

FOR PERSONAL INJURY PROTECTION INSURANCE, THE NAMED INSURED MAY ELECT A DEDUCTIBLE AND TO EXCLUDE COVERAGE FOR LOSS OF GROSS INCOME AND LOSS OF EARNING CAPACITY ("LOST WAGES"). THESE ELECTIONS APPLY TO THE NAMED INSURED, OR NAMED INSURED AND ALL DEPENDENT RESIDENT RELATIVES. A PREMIUM REDUCTION WILL RESULT FROM THESE ELECTIONS. THE NAMED INSURED IS HEREBY ADVISED NOT TO ELECT THE LOSS WAGE EXCLUSION IF THE NAMED INSURED OR DEPENDENT RESIDENT RELATIVES ARE EMPLOYED, SINCE LOSS WAGES WILL NOT BE PAYABLE IN THE EVENT OF AN ACCIDENT.

PLEASE CHOOSE

A. ☐ $10,000 Coverage less Deductible of * $ __________________________ applicable to:

- ☐ Named Insured.
- ☐ Named Insured and Dependent Resident Relatives.

  * Deductibles Available ($0) ($250) ($500) ($1000)

B. ☐ Personal Injury Protection - Exclusion of Work Loss

- ☐ Work loss for Named Insured does not apply
- ☐ Work loss for Named Insured and dependent family member does not apply

If i elect the deductible or deduced benefits option shown above. I certify that all covered person have collateral for the deductible. Exclusion or deduced benefit chosen.

C. PERSONAL INJURY PROTECTION (PIP) REJECTION OPTION: (The option to reject PIP coverage is available only for vehicles operating as "Limousines, taxi's, or school buses" as defined in Florida statute 627.733(1) which excepts them from Florida statute 627.736(1).

☐ I certify that the vehicles identified on this policy are used for "limousines, taxi's, or school buses" operations as defined in Florida stature 627.733(1) and I choose to REJECT Personal Injury Protection (PIP) coverage.

DATE: ______________________________

x ____
Applicant's Signature -- -- Must be

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