

**YOUR AUTOMOBILE  
INSURANCE AND SAFE  
DRIVER APPLICATION**

Name of Applicant \_\_\_\_\_ Driver's License Number \_\_\_\_\_  
 Cooperative \_\_\_\_\_ Name in which vehicle registered (if other than applicant) \_\_\_\_\_  
 Home Address \_\_\_\_\_ (NYC) \_\_\_\_\_  
 Home Telephone Number \_\_\_\_\_  
 Employer \_\_\_\_\_  
 Business Address \_\_\_\_\_  
 Telephone Number \_\_\_\_\_

Description of vehicle (s)	Year	Make	Model	Engine Number	Body Type Number of Doors
car 1					
car 2					

**1**

List all operators of the vehicle:

Name	Date of Birth	Years of Driving Experience	Occupation
Principle Operator:			

**2**

Please answer the following insofar as they include the applicant, persons residing in his household, or the owner

Yes No

- (a) Do you operate another vehicle in the course of your occupation?
- (b) Is the named vehicle used for business?
- (c) During the past 3 years, have you been in the assigned risk pool?
- (d) Do you drive to work? Number of miles one way: \_\_\_\_\_
- (e) Do you participate in a car pool?
- (f) Has any company, to your knowledge, refused, not renewed, cancelled or notified of intent to cancel, the Automobile Liability Insurance of any member of the household including applicant, during the preceding 39 months?
- (g) Is vehicle in enclosed garage overnight?
- (h) Will any member of the household, not now licensed, learn to drive during the next six months?

Yes No

- (i) Does any member of the household own a car other than the named vehicle? (if "yes", please describe vehicle below)
- (j) Do any of the operators have any physical impairments? If "yes" please describe under "k" (remarks).
- (k) REMARKS: \_\_\_\_\_
- (l) List ages of children in household: \_\_\_\_\_
- (m) Please complete the following: **Required by N.Y.S. Motor Vehicle Bureau!**

Present policy number: \_\_\_\_\_  
 Name of Present insurance company: \_\_\_\_\_

**3**

Yes No

Statement of Convictions: Has the applicant or any other person named in (1.) been convicted of a moving traffic violation during the 39 months preceding the month in which the policy is to be effective? If "Yes", complete the following:

Name	Violation	Date of Conviction	Place of Conviction

**4**

Yes No

Has the operator's license of the applicant or of any person named in (1.) been suspended or revoked during the preceding 39 months as the result of the accumulation of points under a state system or a series of violations of the Motor Vehicle Code?

5 A

Yes  No

Statement of Accidents: Has the applicant or any person named in (1.) been involved in an automobile accident while operating any private passenger type automobile, resulting in damage to any property, excluding his own, or in bodily injury or death to others during the 39 months preceding the month in which the policy is to be effective? If "Yes", complete the following:

Name	Date of Accident	Location of Accident	Bodily Injury or Death (yes or no)	Damage to Property (amount)

5 B If any of the following are applicable, please mark as "Yes"

Note: The following are not "Chargeable" accidents under the SAFE DRIVER PLAN.

<p>Yes</p> <p><input type="checkbox"/> (a) Automobile lawfully parked</p> <p><input type="checkbox"/> (b) Automobile struck in rear and applicant or person residing in his household was not convicted.</p> <p><input type="checkbox"/> (c) Reimbursed by, or in behalf of, person responsible for the accident or have judgment against such person.</p> <p><input type="checkbox"/> (d) Other person involved in accident was convicted. Applicant or person residing in his household was not convicted.</p>	<p>DATE OF ACCIDENT</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Yes</p> <p><input type="checkbox"/> (e) Damaged by "hit-and-run" driver and accident reported to police within 24 hours from time of accident.</p> <p><input type="checkbox"/> (f) Accident involved damage by contact with animals or fowl.</p> <p><input type="checkbox"/> (g) Accident involved Physical Damage, limited to and caused by flying gravel, missiles, or falling objects.</p>	<p>DATE OF ACCIDENT</p> <p>_____</p> <p>_____</p> <p>_____</p>
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5 C

Yes  No

Statement of Accidents: Has the applicant or any person named in (1.) been involved in an automobile accident while operating any private passenger type automobile, resulting in Collision, Uninsured Motorist, or Medical Payment Loss only during the 39 months preceding the month in which the policy is to be effective. If "Yes", complete the following:

Name	Date of Accident	Location of Accident	Bodily Injury or Death (yes or no)	Damage to Property (amount)

6 Indicate Coverage Desired:

LIMITS

- |  |   |
|--|---|
| <p><b>BODILY INJURY</b></p> <p><input type="checkbox"/> \$10,000/\$20,000</p> <p><input type="checkbox"/> \$25,000/\$50,000</p> <p><input type="checkbox"/> \$50,000/100,000</p> <p><input type="checkbox"/> \$100,000/300,000</p> <p><input type="checkbox"/> \$250,000/500,000</p> <p><b>PROPERTY DAMAGE</b></p> <p><input type="checkbox"/> \$5,000</p> <p><input type="checkbox"/> \$10,000</p> <p><input type="checkbox"/> \$25,000</p> | <p><b>COMPREHENSIVE (inc. fire &amp; theft)</b></p> <p><input type="checkbox"/> \$50.00 Deductible</p> <p><input type="checkbox"/> Full</p> <p><b>MEDICAL PAYMENTS</b></p> <p><input type="checkbox"/> \$500</p> <p><input type="checkbox"/> \$1,000</p> <p><input type="checkbox"/> \$2,000</p> <p><b>COLLISION</b></p> <p><input type="checkbox"/> \$50.00 Deductible</p> <p><input type="checkbox"/> \$100.00 Deductible</p> |
|--|---|

- Subject to your acceptance, issue a policy to me effective \_\_\_\_\_, 196
- Send my exact rates to me now.

**THIS APPLICATION CANNOT BE APPROVED UNLESS ALL QUESTIONS ARE ANSWERED BY THE APPLICANT.**

I hereby declare to the best of my knowledge and belief that all of the foregoing statements are true and that these statements are offered as an inducement to the company to issue the policy for which I am applying.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

Send this application to:

**COMMUNITY INSURANCE COMPANY**

465 grand street / new york 10002 / oregon 7-1800