



**AUTOMOBILE (FLEET)**

Please complete only if you have ten (10) or more vehicles. If not, please complete the standard Auto application for each vehicle including the commercial vehicle supplement where applicable.

Name of Insured \_\_\_\_\_ RIN No. \_\_\_\_\_  
CVOR No. \_\_\_\_\_

Mailing address \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Description of operations \_\_\_\_\_

**COVERAGE REQUIRED**

TIP Liability only  yes  no limit required \$ \_\_\_\_\_

Physical Damage  All Perils deductible \$ \_\_\_\_\_

Collision deductible \$ \_\_\_\_\_

Comprehensive deductible \$ \_\_\_\_\_

**Are any of your vehicles leased to others?**  yes  no

If yes, provide details of each leasing company on attached Additional Interests page

If yes,  30 days or less  excess of 30 days  both

If yes, describe (vehicles and frequency) \_\_\_\_\_

**Do you carry any passengers for compensation or hire?**  yes  no

If yes, describe (number and type of vehicles, number of passenger seats, distance, frequency and purpose)

**Do you haul goods?**  yes  no

If yes, describe a) own goods \_\_\_\_\_

b) others' goods \_\_\_\_\_

annual gross receipts \$ \_\_\_\_\_

**Are any of your vehicles driven by employee family members?**  yes  no

If yes, provide details \_\_\_\_\_

**Do you obtain MVR's (motor vehicle records) on your drivers?**  yes  no

If yes, attach the latest ones \_\_\_\_\_



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**CLAIMS HISTORY**

Have you had any claims in the past five years?

yes  no

If yes, please attach your 5 year claims experience or complete the following:

Date of Loss (dd-mmm-yy)	Description of Loss	Reserve	Paid	Expenses	Total
		\$	\$	\$	\$
		\$	\$	\$	\$
		\$	\$	\$	\$
		\$	\$	\$	\$
		\$	\$	\$	\$

**DECLARATION & SIGNATURE**

The undersigned declares that to the best of his or her knowledge and belief the statements set forth herein are true. The Insurance Company is hereby authorized to make any investigation and inquiry in connection with this application that it deems necessary.

THIS APPLICATION MUST BE SIGNED BY THE RISK MANAGER OR OTHER PERSON RESPONSIBLE FOR PURCHASING INSURANCE.

Name \_\_\_\_\_

Title \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_



