

Auto Renewal Questionnaire

NATIONAL INDEMNITY COMPANY OF THE SOUTH
 NATIONAL LIABILITY & FIRE INSURANCE COMPANY

Administrative Office - Omaha, Nebraska

Policy Term From: _____ To _____

Named Insured: _____

Policy No. _____

Renewal Date _____

1. Complete the following: Have there been any changes - if yes, explain.

- | | Yes | No | |
|--|------------------------------|-----------------------------|-----------------------|
| (a) Named Insured | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| (b) Address of Insured | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| (c) Largest city entered | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| (d) Maximum radius operated | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| (e) No. of Vehicles owned | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| (f) No. of Vehicles leased | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| (g) Are all owned & leased vehicles covered under this policy? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If no, explain: _____ |

2. Is there any change in operations? Yes No If yes, explain: _____

3. Indicate any changes in units or coverages to be made at renewal: _____

4. For public vehicles: Is your operation For Profit Non-Profit

5. If insured is leased out, to whom is he currently leased? _____

6. Do you presently have or are you applying for a permit(s) for transportation of hazardous material and/or radioactive materials? _____

7. Is there any change in types of commodities hauled? Yes No If yes, explain: _____

8. Person to contact for inspection (name and phone number): _____

9. Have you ever filed or are you contemplating filing for reorganization or bankruptcy? Yes No If yes, show date (month and year) and explain: _____

10. **MUST BE COMPLETED FOR ALL DRIVERS** (If not enough space attach list)

Driver's Name	Date of Hire	Date of Birth	Driver's Licenses			Experience	
			State	Number	No. of Years Licensed	Type of Unit (Bus, Van, etc.)	No. of Years
1.							
2.							
3.							
4.							
5.							

11. When physical damage provided, indicate current depreciated value(s): _____

12. Any accidents or violations in the past twelve (12) months? Yes No If yes, explain: _____

13. Are DOT filings required? Yes No If yes, list MC number and required filings: _____

Are state filings required? Yes No If yes, identify all states/filings/ID numbers: _____

14. Are there any changes to loss payees? Yes No If yes, explain: _____

The Applicant's representative acknowledges that he/she has advised the Insured and the Insured agrees that if the foregoing statements and answers are materially false, the Company shall have the right to rescind any policy it may issue or any renewal thereof. All terms, conditions, and applicable endorsements of the previous policy shall apply. Representations made on the Insured's original Company application shall survive renewal unless modified by this document.

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.

Date _____

Applicant's Representative and Agency License Number _____

Address of Applicant's Representative _____

COVERAGE ELECTION NOTICE
Regarding Uninsured Motorists Coverage
FLORIDA

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 damages 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 _____ which are lower than my Bodily Injury Liability limits.

STACKING OF UNINSURED MOTORISTS LIMITS APPLIES ONLY TO CLASS I INSUREDS (THE NAMED INSURED, IF AN INDIVIDUAL, AND ANY FAMILY MEMBERS). CLASS II INSUREDS ARE NOT REQUIRED TO COMPLETE THIS SECTION.

ELECTION OF NON-STACKED COVERAGE
 (Do not complete if you have rejected Uninsured Motorist)

You have the option to purchase, at a reduced rate, a 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 a 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 form, 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 one 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.

Signed: _____ Date: _____
 (Named Insured)

NO FAULT COVERAGE - In accordance with Florida Statutes, you must carry no-fault insurance of \$10,000. If your motor vehicles are owned by an individual or husband and wife, the named insured may elect a deductible and exclude coverage for loss of gross income and loss of earning capacity ("lost wages"). These elections apply to the named insured alone, or to the 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 lost wage exclusion if the named insured or dependent resident relatives are employed, since lost wages will not be payable in the event of an accident. Deductible or reduced benefits are not available to a partnership, corporation or other non-individual entity. Please choose either A or B.

- | | |
|--|--|
| <p>A. \$10,000 Coverage (no deductible)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Exclude work loss for Named Insured <input type="checkbox"/> Exclude work loss for Named Insured and Dependent Relatives | <p>B. \$10,000 Coverage less Deductible of *\$_____</p> <ul style="list-style-type: none"> <input type="checkbox"/> Named Insured <input type="checkbox"/> Named Insured and Dependent Relatives |
|--|--|

*Deductible Available (\$250) (\$500) (\$1,000)

Applicant's Signature _____ Applicant's Signature _____