

AmCom Insurance Services, Inc.

2680 Bishop Drive Suite # 104

San Ramon, CA 94583

Tel 925.244.0110 Fax 925.244.0234

Producer: _____

Tel# _____

Fax# _____

Sand & Gravel Application

Effective Date: _____

1. Name _____ Address/City _____

(Must read same as MCP Filing)

2. DBA _____ Garaging Zip _____ Garaging City _____

3. Applicant is Individual Partnership Corporation

Names and titles of Principals _____ Phone# _____

Occupation or business _____ Years in business _____

4. If new venture, give names of previous employer _____

5. Has any carrier cancelled or refused to renew Yes No If yes, please give details _____

6. California Filings required (if ICC needed, must give docket number) _____

7. Areas hauled to _____ Frequency of hauls _____

8. Types of cargo (BE SPECIFIC) _____

A. Does the insured haul under long term contract? _____

B. Who does the insured haul for? (BE SPECIFIC) _____

C. Does the insured own his own trailers? _____

D. If not, who's trailer/trailers are they pulling? _____

9. Do you own or operate any commercial equipment other than what is listed on next page? Yes No

If yes, please explain _____

10. Do you use subhaulers or leased operators? _____

If you ever lease to or from another trucking company, please state for whom: _____

11. Are operations conducted exclusively within California? Yes No

12. Do operations extend into or through these locations? Check appropriate box Los Angeles San Francisco

13. Is there a formal safety program in effect? Yes No

14. CHECK COVERAGES AND INDICATE LIMITS DESIRED

COVERAGES	LIMITS
Bodily Injury and Property Damage Liability	CSL \$ _____
Uninsured Motorist	CSL \$ _____
Comprehensive / Collision	Deductibles _____ / _____
Medical Payments	Per Person _____
UMPD \$3,500 OR Collision Deductible Waiver	<input type="checkbox"/> Yes <input type="checkbox"/> No

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15. PREVIOUS CARRIER AND LOSS EXPERIENCE PAST 3 YEARS (BODILY INJURY & PROPERTY DAMAGE)

INSURANCE CO. AND POLICY NO.	PERIOD - FROM-TO	NO. CLAIMS	LOSSES PAID BI	PD	RESERVES BI	PD

16. PREVIOUS CARRIER AND LOSS EXPERIENCE PAST 3 YEARS (PHYSICAL DAMAGE)

INSURANCE CO. AND POLICY NO.	PERIOD - FROM-TO	NO. CLAIMS	LOSSES PAID	RESERVES

17. SCHEDULE OF EQUIPMENT

*** PLEASE SHOW CURRENT VALUE OF VEHICLE**

NO.	YEAR/ MODEL	TRADE NAME	BODY TYPE	MODEL NO / SERIAL NO	ACV	G.V.W.	PHYS DAM DEDUCTIBLE	RADIUS OF OPS	LOSS PAYEE	ADDTL INSURED

18. SCHEDULE OF DRIVERS

NO.	FULL NAMES	LICENSE NUMBER	STATE ISSUING	YEARS COMML EXPER	BIRTHDATE	DATE HIRED	VIOLATIONS	ACCIDENTS

NOTICE OF INSURANCE INFORMATION PRACTICES

YOUR SIGNATURE CONFIRMS THAT YOU HAVE ADVISED THE INSURED THAT CREDIT HISTORY MAY BE OBTAINED FROM PERSONS OTHER THAN YOU AS WELL AS OTHER PERSONAL AND PRIVILEGED INFORMATION OBTAINED BY US. THE INSURED HAS THE RIGHT TO REVIEW PERSONAL INFORMATION UPON REQUEST.

PRODUCER SIGNATURE _____ (required) DATE _____