

## COMMERCIAL APPLICATION SUPPLEMENT

(USE WITH: CTP 5037 and CTP5307)

APPLICANT NAME:

DATE:

APPLICANT TRADE (DBA) NAME:

LIST OF DRIVERS OF INSURED VEHICLES (attach list of drivers with required information if space below is not adequate)										
Driver's Name	Class A, B, C	Original CDL License Date	Date of Birth	Driver's License State	Driver's License Number	No. of Accidents, Convictions and Violations in Last Three Years		No. of serious violations in last 7 years (1)	Date of Hire	Years Driving Similar Vehicle
						Accidents	Violations			
	A									
	A									
	A									
	A									
	A									
	A									
	A									
	A									
	A									
	A									
	A									

(1) Serious violations include, but are not limited to: DUI, homicide or assault involving an auto, leaving the scene of an accident, etc.

DESCRIPTION OF VEHICLES (Trailers must be scheduled for coverage to apply while detached from power unit.)								
Unit No.	Model Year	Manufacturer	Vehicle Type (truck, tractor, trailer, mobile equipment, etc.)	Serial Number (17 digit)	Radius	Truck GVW Tractor GCW	Owner Type *	
6							N	
7							N	
8							N	
9							N	
10							N	
11							N	
12							N	
13							N	
14							N	
15							N	

\* N=Owned by Named Insured; L=Owned by Leasing Co. (long term lease without driver); O=Owned by Owner Operator; E=Owned by Employee of Named Insured (Officer).

Unit No.	Percent of trips by radius			Trailer* Pulled	Primary commodities hauled (list top 3 commodities for each power unit)
	0 - 50	51 - 300	Over 300		
6				D	
7				D	
8				D	
9				D	
10				D	
11				D	
12				D	
13				D	
14				D	
15				D	

\* Trailer type or type trailer pulled by power unit - D = dump, F = flatbed, P = pole/logging, R = reefer, T = tank, V = dry van, A = auto hauler

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Carolina Casualty Insurance Company

PO Box 2575 · Jacksonville, Florida 32203 ·  
904-363-0900 · 800-874-8053 · Fax 904-363-8093

PHYSICAL DAMAGE COVERAGE (Indicated coverage options and limits desired if applicable.)				
Unit No.	Phy. Dam. Limit*	SCL Comp / Coll Deductible	Name of Loss Payee	Full Address of Loss Payee
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				

\* Fill in the limit next to each vehicle if coverage is desired.

LOSS INFORMATION Indicate Type (Auto Liab, Auto PD, Cargo, General Liab):					
Policy Year	From	To	# of Claims	Total Paid & Reserved Losses	Insurance Carrier
				\$	
				\$	
				\$	
				\$	
Describe large claims:					

ADDITIONAL INSURED			
Name	Mailing Address	Cov (1)	Relationship to Insured (2)

CERTIFICATE HOLDERS			
Name	Mailing Address	Cov (1)	Relationship to Insured (2)

(1) A=Auto Liability G=General Liability C=Cargo (certificate holders only) Attach separate list if space above is not adequate.  
(2) Indicate lessor, lessee, shipper, broker, interchange facility owner, etc., and show vehicle number if applicable.