



ARIZONA PERSONAL AUTO APPLICATION

DATE (MM/DD/YYYY)
07/05/2023

AGENCY ASK INSURANCE SERVICES LLC 1826 W BROADWAY RD STE 51 MESA, AZ 85202		APPLICANT'S NAME AND MAILING ADDRESS (include county & ZIP+4) Lawna Stover 486 S EAGAR ST EAGAR, AZ 85925			TELEPHONE NUMBER 7022369326	
CONTACT NAME: PHONE (A/C, No, Ext): 480 - 245 - 5048 FAX (A/C, No): 928 - 597 - 5144 E-MAIL ADDRESS: info@askinsurancegroup.com		CARRIER MAIN STREET AMERICA PROTECTION INSURANCE COMPANY KEENE, NH 03431			NAIC CODE 13026	
AGENCY CUSTOMER ID:		PLAN POLICY #: 01J9334R ACCT #:			EFFECTIVE DATE 07/05/2023	
RESIDENCE CURRENT RESIDENCE IS <input checked="" type="checkbox"/> OWNED <input type="checkbox"/> RENTED		EXPIRATION DATE 01/05/2024			<input checked="" type="checkbox"/> DIRECT AGENCY <input type="checkbox"/> MAIL POLICY TO AGENT <input type="checkbox"/> MAIL POLICY TO APPL	
YRS AT ADDR CURR PREV		PREVIOUS STREET ADDRESS (if less than 3 years)			CITY	
STATE		ZIP + 4				

ADDITIONAL GARAGING ADDRESS(ES)					
LOC	STREET	CITY	COUNTY	STATE	ZIP + 4

VEHICLE DESCRIPTION / USE											TOTAL NUMBER OF VEHICLES IN HOUSEHOLD: 1				
VEH	LOC	YEAR	MAKE	MODEL	BODY TYPE	VIN	REG STATE	HP/CC	DATE LEASED	DATE PURCH	NEW/USED				
1		2015	HYUNDAI	SANTA FE SPORT	UT	5XYZU3LB4FG265999									

VEH	COST NEW	SYMBOL AGE GRP	COMP OTC SYM	COLL SYM	TERR	MILE 1 WAY WK/SCHL	# DAYS WEEK	# WKS MONTH	USAGE	PER-FORM	MULTI-CAR	CAR POOL	GAR CODE	ODOMETER READING	ANNUAL MILEAGE	GOVERN DRIVER	DRIVER USE % (Each veh must equal 100%)				
1			21	19					P		N				10,000	1					

VEH	CLASS	PASSIVE SEAT BELT	AIRBAG DRV/BOTH	ANTI-LOCK BRAKES 2 / 4	ANTI-THEFT DEVICES	CREDITS AND SURCHARGES	VEH	CLASS	PASSIVE SEAT BELT	AIRBAG DRV/BOTH	ANTI-LOCK BRAKES 2 / 4	ANTI-THEFT DEVICES	CREDITS AND SURCHARGES
1	800000			Y	Y								

COVERAGES / PREMIUMS		LIMITS OF LIABILITY										VEHICLE # 1	VEHICLE #	VEHICLE #	VEHICLE #
SINGLE LIMIT LIABILITY (CSL)		EA ACCIDENT													
BODILY INJURY LIABILITY		\$100,000	EA PERSON		\$300,000	EA ACCIDENT		\$127.00							
PROPERTY DAMAGE LIABILITY		\$100,000	EA ACCIDENT			EA ACCIDENT		\$129.00							
MEDICAL PAYMENTS		\$5,000	EA PERSON			EA ACCIDENT		\$33.00							
UNINSURED MOTORISTS		CSL	EA ACCIDENT			EA ACCIDENT		\$37.00							
		BI	\$100,000	EA PERSON	\$300,000	EA ACCIDENT									
UNDERINSURED MOTORISTS		CSL	EA ACCIDENT			EA ACCIDENT		\$57.00							
		BI	\$100,000	EA PERSON	\$300,000	EA ACCIDENT									
COMPREHENSIVE/OTC		DED	1	\$500	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	\$245.00						
COLLISION		DED	1	\$500					\$233.00						
ACV UNLESS AMOUNT STATED									N / A	N / A	N / A	N / A			
TOWING & LABOR			1	\$100					INCL.						
TRANS EXP / RENTAL RE			1	\$50/\$1500					INCL.						
CODE	DESCRIPTION	LIMIT	LIMIT APPLIES TO		DEDUCTIBLE	OPTIONS									
	*ADDL COVERAGES INCL	\$			\$			\$	\$	\$	\$	\$			
		\$			%			\$	\$	\$	\$	\$			
		\$			%			\$	\$	\$	\$	\$			
		\$			%			\$	\$	\$	\$	\$			
		\$			%			\$	\$	\$	\$	\$			
ESTIMATED TOTAL: \$913.50		PREMIUM DEPOSIT: \$152.66		POLICY FEE: \$0.50		TOTAL PER VEHICLE		\$913.00							

RESIDENT & DRIVER INFORMATION [List all residents & dependents (licensed or not) and regular operators]

#	NAME (AS IT APPEARS ON LICENSE)			SEX	MAR STAT	REL TO APPLIC	DATE OF BIRTH		
	FIRST NAME	MIDDLE NAME	LAST NAME						
1	Lawna		Stover	F	W	I	01/10/1963		
#	OCCUPATION	DATE LIC	STD1 >100	GOOD STD1	DRV TRAIN	ACC PREV CSE DATE	DRIVERS LICENSE #	LIC STATE	SOCIAL SECURITY #
1	All Others	01/10/1979	N	N	N		D01556813	AZ	

ACCIDENTS / CONVICTIONS (Note: Your driving record is verified with the state motor vehicle department and other insurers)

Attach, ACORD 99, Accidents / Convictions Schedule, if more space is required

DRV #	DATE OF ACCIDENT / CONVICTION	DESCRIPTION OF ACCIDENT OR CONVICTION	PLACE OF ACCIDENT / CONVICTION	BI OR DEATH Y/N	AMOUNT OF PROPERTY DAMAGE
1	06/27/2023	MVR Record Clear			

ADDITIONAL INTEREST

ADDL INS <input type="checkbox"/>	NAME AND ADDRESS	VEH #:
LOSS PAYEE		LOAN NUMBER
LENDER'S LOSS PAYABLE		
ADDL INS <input type="checkbox"/>	NAME AND ADDRESS	VEH #:
LOSS PAYEE		LOAN NUMBER
LENDER'S LOSS PAYABLE		

EMPLOYMENT INFORMATION (* If less than 2 years, provide name of previous employer and previous occupation under Remarks)

APPLICANT'S EMPLOYER (State nature of business if self-employed)	ADDRESS OF EMPLOYMENT	WORK PHONE NUMBER	* YEARS W/ CURR EMPL	YEARS W/ PREV EMPL
CO-APPLICANT'S EMPLOYER (State nature of business if self-employed)	ADDRESS OF EMPLOYMENT	WORK PHONE NUMBER	* YEARS W/ CURR EMPL	YEARS W/ PREV EMPL

PRIOR COVERAGE

PRIOR CARRIER STATE AUTO P C INS	# OF YEARS WITH COMPANY 2
PRIOR PRODUCER	PRIOR POLICY NUMBER 100148719
	EXPIRATION DATE 07/05/2024

GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES										Y / N
1. WITH THE EXCEPTION OF ANY ENCUMBRANCES, ARE ANY VEHICLES FOR WHICH INSURANCE IS REQUESTED NOT SOLELY OWNED BY AND REGISTERED TO THE APPLICANT?										
VEH #	NAME OF OTHER OWNER				VEH #	NAME OF OTHER OWNER				
2. ANY CAR MODIFIED / SPECIAL EQUIPMENT? (Include customized vans / pickups)										N
VEH #	DESCRIPTION	COST \$	VEH #	DESCRIPTION	COST \$					
3. ANY EXISTING DAMAGE TO VEHICLE? (Include damaged glass)										
VEH #	DESCRIPTION				VEH #	DESCRIPTION				
4. ANY OTHER LOSSES NOT SHOWN IN THE ACCIDENTS / CONVICTIONS SECTION THAT WERE INCURRED DURING THE TIME PERIOD SPECIFIED IN THAT SECTION?										
DRV #	DESCRIPTION	COST \$	DRV #	DESCRIPTION	COST \$					
5. ANY OTHER AUTO INSURANCE IN HOUSEHOLD? (Include any provided by employer)										
NAMED INSURED	YEAR	MAKE	MODEL	CARRIER	NAIC #	POLICY NUMBER				

GENERAL INFORMATION (continued)

EXPLAIN ALL "YES" RESPONSES					Y / N
6. ANY OTHER INSURANCE WITH THIS COMPANY?					N
POLICY NUMBER	TYPE OF INSURANCE		POLICY NUMBER	TYPE OF INSURANCE	
7. ANY HOUSEHOLD MEMBER IN MILITARY SERVICE?					
DRV #	BRANCH	RANK	BASE LOCATION	VEH AT BASE (Y / N)	
8. ANY DRIVERS LICENSE BEEN SUSPENDED / REVOKED?					
DRV #	SUSPENSION PERIOD Start Date: End Date:		EXPLANATION	REINSTATEMENT DATE	
9. ANY DRIVER HAVE A PHYSICAL IMPAIRMENT THAT WOULD AFFECT THE ABILITY TO DRIVE?					N
DRV #	DESCRIPTION OF SPECIAL EQUIPMENT IN VEHICLE				
10. ANY DRIVER UNDERGOING A COURSE OF MEDICAL TREATMENT FOR A PHYSICAL / MENTAL IMPAIRMENT THAT WOULD AFFECT THE ABILITY TO DRIVE?					
DRV #	EXPLANATION				
11. ANY FINANCIAL RESPONSIBILITY FILING?					N
DRV #	REASON FOR FILING			FILING DATE	
12. HAS INSURANCE BEEN TRANSFERRED WITHIN THE AGENCY?					N
13. IS THIS BROKERED BUSINESS TO THE AGENT?					N
14. HAS AGENT INSPECTED VEHICLE?					
15. HAS ANY APPLICANT OR DRIVER HAD A FORECLOSURE, REPOSSESSION, BANKRUPTCY, JUDGEMENT OR LIEN DURING THE LAST FIVE (5) YEARS?					
DRV #	EXPLANATION				
16. HAS ANY NAMED INSURED DRIVEN WITHOUT LIABILITY INSURANCE DURING ANY PART OF THE LAST SIX (6) MONTHS?					
DRV #	EXPLANATION				

REMARKS / ATTACHMENTS (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

STATE SUPPLEMENT	GOOD STUDENT CERTIFICATE	MOTOR VEHICLE REPORT
YOUNG DRIVER QUESTIONNAIRE	ANTI-THEFT DEVICE CERTIFICATE	PHOTOGRAPH
DRIVER TRAINING CERTIFICATE	MEDICAL STATEMENT	BILL OF SALE

*Description of Additional and Miscellaneous Coverages
 Platinum Auto Elite
 Full Safety Glass
 Auto Loan/Lease Coverage Coll
 Auto Loan/Lease Coverage Comp
 Trip Interruption

REMARKS (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

BINDER / SIGNATURE

INSURANCE BINDER		IF THE "BINDER" BOX TO THE LEFT IS COMPLETED, THE FOLLOWING CONDITIONS APPLY: THIS COMPANY BINDS THE KIND(S) OF INSURANCE STIPULATED ON THIS APPLICATION. THIS INSURANCE IS SUBJECT TO THE TERMS, CONDITIONS AND LIMITATIONS OF THE POLICY(IES) IN CURRENT USE BY THE COMPANY. THIS BINDER MAY BE CANCELLED BY THE INSURED BY SURRENDER OF THIS BINDER OR BY WRITTEN NOTICE TO THE COMPANY STATING WHEN CANCELLATION WILL BE EFFECTIVE.
EFFECTIVE DATE 07/05/2023	EXPIRATION DATE 01/05/2024	
TIME	<input checked="" type="checkbox"/> 12:01 AM <input type="checkbox"/> NOON	
<input type="checkbox"/> COVERAGE IS NOT BOUND		

THIS BINDER MAY BE CANCELLED BY THE COMPANY BY NOTICE TO THE INSURED IN ACCORDANCE WITH THE POLICY CONDITIONS. THIS BINDER IS CANCELLED WHEN REPLACED BY A POLICY. IF THIS BINDER IS NOT REPLACED BY A POLICY, THE COMPANY IS ENTITLED TO CHARGE A PREMIUM FOR THE BINDER ACCORDING TO THE RULES AND RATES IN USE BY THE COMPANY. THE QUOTED PREMIUM IS SUBJECT TO VERIFICATION AND ADJUSTMENT, WHEN NECESSARY, BY THE COMPANY BINDERS ARE EFFECTIVE FOR NO MORE THAN 90 DAYS.

AS DESCRIBED IN ARIZONA REVISED STATUTE 20-2104(D), A CREDIT REPORT OR OTHER INVESTIGATIVE REPORT ABOUT YOU MAY BE REQUESTED IN CONNECTION WITH THIS APPLICATION FOR INSURANCE. ANY INFORMATION WHICH WE HAVE OR MAY OBTAIN ABOUT YOU OR OTHER INDIVIDUALS LISTED AS POLICYHOLDERS ON OUR POLICY WILL BE TREATED CONFIDENTIALLY. HOWEVER, THIS INFORMATION, AS WELL AS OTHER PERSONAL OR PRIVILEGED INFORMATION SUBSEQUENTLY COLLECTED, MAY UNDER CERTAIN CIRCUMSTANCES, BE DISCLOSED WITHOUT PRIOR AUTHORIZATION TO NON-AFFILIATED THIRD PARTIES. WE MAY ALSO SHARE SUCH INFORMATION WITH AFFILIATED COMPANIES FOR SUCH PURPOSES AS CLAIMS HANDLING, SERVICING, UNDERWRITING AND INSURANCE MARKETING. YOU HAVE THE RIGHT TO SEE PERSONAL INFORMATION COLLECTED ABOUT YOU, AND YOU HAVE THE RIGHT TO CORRECT ANY INFORMATION WHICH MAY BE WRONG. ALSO, PURSUANT TO ARIZONA REVISED STATUTE 20-2104(C), IF YOU ARE INTERESTED IN OBTAINING A COMPLETE DESCRIPTION OF OUR INFORMATION PRACTICES, AND YOUR RIGHTS REGARDING INFORMATION WE COLLECT, PLEASE WRITE US AT THE ADDRESS PROVIDED WITH YOUR POLICY.

APPLICANT'S STATEMENT: I HAVE READ THE ABOVE APPLICATION AND ANY ATTACHMENTS. I DECLARE THAT THE INFORMATION PROVIDED IN THEM IS TRUE, COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. THIS INFORMATION IS BEING OFFERED TO THE COMPANY AS AN INDUCEMENT TO ISSUE THE POLICY FOR WHICH I AM APPLYING. IN ADDITION, IF THE AUTO PLAN OR COMPANY DESIGNATED IN THIS APPLICATION IS NON-STANDARD, I CERTIFY THAT I UNDERSTAND THE RATES FOR THIS COVERAGE ARE HIGHER THAN NORMAL AND THEY ARE ACCEPTABLE TO ME AS I HAVE BEEN UNABLE TO OBTAIN COVERAGE DESIRED THROUGH THE NORMAL INSURANCE MARKET.

PRODUCER'S STATEMENT: I CERTIFY TO THE BEST OF MY KNOWLEDGE AND BELIEF THAT THE SIGNATURE OF THE APPLICANT IS THE PERSONAL SIGNATURE OF THE APPLICANT.	HOW LONG HAVE YOU KNOWN THE APPLICANT?
--	--

I ACKNOWLEDGE I HAVE BEEN OFFERED UNINSURED MOTORIST (UM) AND UNDERINSURED MOTORIST (UIM) COVERAGE EQUAL TO THE LIMITS OF MY BODILY INJURY LIABILITY COVERAGE. I HAVE SELECTED THE LIMITS INDICATED IN THIS APPLICATION. IF I HAVE SELECTED UM AND/OR UIM COVERAGE LESS THAN THE LIMITS OF MY BODILY INJURY LIABILITY COVERAGE OR IF I HAVE REJECTED UM AND/OR UIM COVERAGE ENTIRELY, I HAVE READ AND SIGNED THE ARIZONA AUTO SUPPLEMENT, ACORD 61 AZ OR A COMPANY-SPECIFIC SELECTION / REJECTION FORM.

I UNDERSTAND THAT THE COVERAGE SELECTION AND LIMIT CHOICES INDICATED HERE WILL APPLY TO ALL FUTURE POLICY RENEWALS, CONTINUATIONS AND CHANGES UNLESS I NOTIFY YOU OTHERWISE IN WRITING.

APPLICANT'S SIGNATURE	DATE 07/05/2023	PRODUCER'S SIGNATURE	NATIONAL PRODUCER NUMBER
-----------------------	--------------------	----------------------	--------------------------

ARIZONA AUTO SUPPLEMENT

PRODUCER
ASK INSURANCE SERVICES LLC
1826 W BROADWAY RD STE 51
MESA, AZ 85202

APPLICANT/NAMED INSURED
Lawna Stover
486 S EAGAR ST
EAGAR, AZ 85925

COMPANY:
MAIN STREET AMERICA PROTECTION INSURANCE COMPANY
KEENE, NH 03431
POLICY #: 01J9334R

EFFECTIVE DATE
07/05/2023

CODE: 021170 SUB CODE: 005

UNINSURED/UNDERINSURED MOTORISTS COVERAGE OFFER AND SELECTION/REJECTION FORM

DO NOT SIGN UNTIL YOU READ

You have a legal right to purchase BOTH Uninsured and Underinsured Motorist coverages with the proposed automobile liability policy. THESE COVERAGES PROTECT YOU, YOUR FAMILY AND YOUR PASSENGERS. LIABILITY COVERAGE DOES NOT IN MOST CASES.

Uninsured motorist insurance provides protection for bodily injuries caused by a negligent motorist who has no insurance. Underinsured motorist coverage provides protection if the negligent motorist does not have enough liability insurance to pay for the injuries caused. For a more detailed explanation of these coverages, refer to your policy. This policy will provide Uninsured/Underinsured coverage in the same amount as the policy's Bodily Injury Liability Limit, unless you select a lower amount or no coverage, as stated in this notice.

You have a right to purchase both Uninsured and Underinsured Motorist coverage in any amount from \$50,000 single limit (or \$25,000/\$50,000 split limits) up to your policy's liability limit, or you may reject the coverage entirely. Neither limit may exceed your liability coverage limits for Bodily Injury.

Your Bodily Injury Limit on the policy: \$100,000/\$300,000

Options available for Uninsured and Underinsured Motorists coverages:

Uninsured Motorist Liability

Underinsured Motorist

Split Limits
(Initials)

Combined Single Limit
(Initials)

Liability
Split Limits
(Initials)

Combined Single Limit
(Initials)

_____	<input type="checkbox"/>	\$25,000/\$50,000	_____	<input type="checkbox"/>	\$50,000
_____	<input type="checkbox"/>	\$50,000/\$100,000	_____	<input type="checkbox"/>	\$65,000
_____	<input checked="" type="checkbox"/>	\$100,000/\$300,000	_____	<input type="checkbox"/>	\$100,000
_____	<input type="checkbox"/>	\$250,000/\$500,000	_____	<input type="checkbox"/>	\$300,000
_____	<input type="checkbox"/>		_____	<input type="checkbox"/>	\$500,000

_____	<input type="checkbox"/>	\$25,000/\$50,000	_____	<input type="checkbox"/>	\$50,000
_____	<input type="checkbox"/>	\$50,000/\$100,000	_____	<input type="checkbox"/>	\$65,000
_____	<input checked="" type="checkbox"/>	\$100,000/\$300,000	_____	<input type="checkbox"/>	\$100,000
_____	<input type="checkbox"/>	\$250,000/\$500,000	_____	<input type="checkbox"/>	\$300,000
_____	<input type="checkbox"/>		_____	<input type="checkbox"/>	\$500,000

_____ I do not wish to purchase
Uninsured Motorist Coverage

_____ I do not wish to purchase
Underinsured Motorist Coverage

I understand and agree that this form reflects the offer of Uninsured Motorist and Underinsured Motorist coverage options made to me. I understand that my policy declarations page will be sent to me and I need to review it to confirm that my policy contains the Uninsured Motorist and Underinsured Motorist coverages I selected.

DO NOT SIGN UNTIL YOU READ

Signed: _____
(Named Insured)

Date: _____

Attached to application dated: _____