

- NATIONAL INDEMNITY COMPANY
- NATIONAL FIRE & MARINE INSURANCE COMPANY
- COLUMBIA INSURANCE COMPANY
- NATIONAL LIABILITY & FIRE INSURANCE COMPANY
- NATIONAL INDEMNITY COMPANY OF MID-AMERICA
- WESCO-FINANCIAL INSURANCE COMPANY
- REDWOOD FIRE AND CASUALTY INSURANCE COMPANY
- KANSAS FIRE & CASUALTY COMPANY

SUBMIT TO:
 LOUIS T. MASTOS & ASSOCIATES, INC.
 405 MARSH AVENUE
 RENO, NEVADA 89509
 FAX # 775-851-3755
 (General Agent)

AUTOMOBILE APPLICATION – SHORT TERM (15 day) TRIP POLICY

Trucker Bus Commercial Auto Other _____

1. APPLICANT: _____ TAX ID #: _____

2. ADDRESS: _____
(Number) (Street) (City) (State) (Zip Code)

3. POLICY TERM: Effective _____ / _____ AM/PM Expiration _____
(standard time at place of issuance)

4. TRIP INFORMATION:
 a. From _____ To _____
 b. Mileage one way _____ miles CONTACT FOR INSPECTION: _____
 c. Coverage desired for return trip? Yes No PHONE NUMBER: _____

5. Describe briefly the purpose of short term trip policy _____

6. Complete the following:
 For Bus: Return trip with passengers? Yes No. Passenger Capacity _____
 For Trucks or Tractor/Trailers: Nature of cargo – Out _____ Return _____

7. Driver Information:

Name	Date of Birth	Driver's License Number	Number Years Driving Similar Vehicles
_____	_____	_____	_____
_____	_____	_____	_____

Does driver(s) have experience with type of auto being used? Yes No

8. Vehicles

Year	Trade Name	Style or Model	Motor or Serial No.	Cost When Purchased	Present Stated Value
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____

9. COVERAGE DESIRED

	Limits of Liability	Premiums
Bodily Injury Liability	_____	\$ _____
Property Damage Liability	_____	_____
Uninsured Motorists	_____	_____
Underinsured Motorists	_____	_____
No-Fault (where applicable)	_____	_____
Specified Causes of Loss	_____ Ded \$ _____	_____
Collision	_____ Ded \$ _____	_____
Other _____	_____	_____
Total Premium \$		_____

10. Do you currently have coverage in force? Yes No If yes, explain why current carrier is unable to provide coverage for this trip. _____

UNDERWRITING RULES

Drivers must be experienced and over age 25 years of age. Equipment must be in good condition.
 Coverage bound 12:01 A.M. day after postmark or by phone.

Producer: Name _____ Address _____

M-4086 (3/90) SIGNATURE _____
 (NAMED INSURED)

SELECTION OF UNINSURED MOTORISTS COVERAGE AND MEDICAL PAYMENTS COVERAGE NEVADA

The Nevada Insurance Code (Section 687B.145) requires that Uninsured Motorists Coverage be offered at a limit equal to the Bodily Injury Limit of Liability in your policy unless you, the insured named in the policy, select a lower limit, but not less than the minimum financial responsibility limits, or reject the Uninsured Motorists Coverage entirely. Uninsured Motorists Coverage includes underinsured motorists coverage and provides insurance for the protection of persons insured under the policy if they sustain bodily injury in an accident for which the owner or operator of a motor vehicle is legally liable and does not have insurance (uninsured) or does not have enough insurance (underinsured). The named insured has the right to reject this coverage in writing.

So that we may be certain that your policy is properly issued, it is necessary that you indicate below your choice of Uninsured Motorists Coverage. In the event the policy names more than one Named Insured, all such Named Insureds must sign.

INDICATE BY "X"

- The undersigned hereby rejects Uninsured Motorists Coverage entirely.
The undersigned understands and agrees that the provisions of Uninsured Motorists Coverage will not be included in the policy issued.
- OR -
- Uninsured Motorists Coverage to be written with limits of liability equal to Bodily Injury Liability limits being provided.
- OR -
- Uninsured Motorists Coverage to be written with limits of liability lower than Bodily Injury Liability limits being provided, but not less than the minimum financial responsibility limits, as indicated below:

Bodily Injury	Combined Single Limit (BI)
\$ _____ each person	\$ _____ each accident
\$ _____ each accident	

Section 687B.145 further requires that Medical Payments Coverage be offered in an amount of at least \$1,000 or at a higher amount if the minimum limit offered by an insurer is greater than \$1,000. You may accept or reject this offer. Medical Payments Coverage provides protection without regard to legal liability for reasonable and necessary medical expenses resulting from accidental bodily injury while operating or occupying an insured vehicle or being struck as a pedestrian by a motor vehicle or trailer.

So that we may be certain that your policy is properly issued, it is necessary that you indicate below your choice of Medical Payments Coverage. In the event the policy names more than one Named Insured, all such Named Insureds must sign.

INDICATE BY "X"

- The undersigned hereby rejects Medical Payments Coverage entirely.
The undersigned understands and agrees that the provisions of Medical Payments Coverage will not be included in the policy issued.
- OR -
- Medical Payments Coverage to be written at the minimum limit of \$1,000.
- OR -
- Medical Payments Coverage to be written at limit of \$ _____.

Signature of Named Insured	Date
Signature of Named Insured	Date

(Until you advise us otherwise in writing, your choice as indicated above, will continue regardless of any addition or change in Auto coverage on your current policy or addition of any scheduled Autos and will be carried forward on all future renewal policies without additional notice.)