

**CALIFORNIA LOW COST AUTOMOBILE INSURANCE PROGRAM  
APPLICATION FOR INSURANCE**

*Language discrepancies arising from the translation of the English version of the instructions portion of this application shall be settled using the English language version.*

**IMPORTANT NOTICE**

**This policy is not effective until your application is electronically transmitted to the Plan by your agent or broker. The following conditions must also be met: (1) Both you and your agent or broker must sign and date a properly completed application. (2) Your agent or broker must mail your application to the Plan within two days of its completion. You may request that your agent or broker transmit the documents in your presence to ensure immediate coverage, provided the above requirements are met. If the above requirements are not met, your coverage will take effect the day after the Plan office receives your application. You may request that your agent or broker notify you when coverage is effective.**

**APPLICANT MUST MEET THE FOLLOWING ELIGIBILITY REQUIREMENTS**

*Please check each box to indicate you meet all of the eligibility requirements: IF YOU SUBMIT THIS APPLICATION AND YOU DO NOT MEET THESE REQUIREMENTS YOUR APPLICATION WILL BE REJECTED AND THERE WILL BE NO COVERAGE PROVIDED.*

- Applicant resides in one of the eligible counties.
- Household annual income before taxes, cannot exceed 250% of the federal poverty level.
- Must be at least 19 years old and have been continuously licensed in the US or Canada for the previous 3 years or 18 months if previous driving experience in a foreign country.
- No more than one moving violation or property damage only accident in which the driver was at fault in past 3 years.
- No at fault accident with BI or death in the past 3 years.
- No felony or misdemeanor convictions in violation of Vehicle Code on DMV record.
- Is not a college student claimed as a dependent of another person for tax purposes.
- Has no other automobile liability insurance coverage over and above this policy.
- Value of vehicle cannot be more than \$20,000.00.
- Cannot have more than 2 low cost policies per person insured through the CA Low Cost Auto Insurance Program.
- Cannot have other liability insurance coverage in the household. However, you may purchase Physical Damage Coverage elsewhere. You may also purchase optional Uninsured Motorist Bodily Injury and Medical Payment coverages through the Program

**SECTION 1. PRODUCER OF RECORD**

Producer Last Name/Agency Name <b>TONK / TONK INSURANCE AGENCY</b>		Producer First Name <b>HARMINDER</b>		MI <b>K</b>
DBA Name <b>TONK INSURANCE AGENCY</b>				
Mailing Address <b>2175 DE LA CRUZ BLVD Suite #109</b>		Ste./Apt. #	City <b>SANTA CLARA</b>	State <b>CA</b>
			Zip Code <b>95050</b>	
Tax ID or Social Security #	Producer License # <b>0D97527</b>	Telephone # <b>408-748-1701</b>	Fax # <b>408-748-1401</b>	

**SECTION 2. SIGNING PRODUCER**

Last Name <b>TONK</b>	First Name <b>HARMINDER</b>	MI <b>K</b>	Producer License # <b>0D97527</b>
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**SECTION 3. APPLICANT NAME**

Last Name	First Name	MI	Home Telephone #	Business Telephone #
Street Address	Ste./Apt. #	City	State	Zip Code
Mailing Address (if different from Street Address)	Ste./Apt. #	City	State	Zip Code

CAARP/California Low Cost Automobile Insurance Program  
PO Box 7917  
San Francisco, CA 94120-7917



**Mail completed application, with check/money order and required attachments.**

**SECTION 4. HOUSEHOLD INFORMATION**

A "Household" is all persons who occupy a housing unit and who are related by blood, marriage, adoption or guardianship (ie, members of one family). If more than one family is living in the same housing unit, they constitute different families for eligibility purposes even though they reside at the same address.

**How many individuals live in your household? →**

*Include all family members even if they do not drive.*

List all operators and residents of the household. For additional operators/residents, indicate in REMARKS Section.

Applicant's former addresses (past 3 years)

Street Address	City	State	Zip Code
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Name	Occupation	Annual Income	Birth Date MM/DD/YYYY	Sex	RS	MS	Driver License #	ST	Licensed 3 Years? If "No", give date Licensed
APPLICANT									<input type="checkbox"/> Yes <input type="checkbox"/> No
									<input type="checkbox"/> Yes <input type="checkbox"/> No
									<input type="checkbox"/> Yes <input type="checkbox"/> No
									<input type="checkbox"/> Yes <input type="checkbox"/> No
									<input type="checkbox"/> Yes <input type="checkbox"/> No
									<input type="checkbox"/> Yes <input type="checkbox"/> No

**CODES** RS = W-Wife, H-Husband, S-Son, D-Daughter, F-Father, M-Mother, B-Brother, SI-Sister, I-In-law, G-Grandparent, GC-Grandchild, A-Aunt, U-Uncle, C-Cousin, P-Domestic Partner (For relationships not listed, indicate in Remarks)  
MS = S-Single, M-Married, P-Domestic Partnership

Applicant's Occupation	Nature of Business	Employer's Name
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Employer's Street Address	City	State	Zip Code
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**SECTION 5. VEHICLE INFORMATION**

Year	Make	Model
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Vehicle Identification #	Registered Owner's Last Name	First Name
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Purchased Mo./Yr.	<input type="checkbox"/> New <input type="checkbox"/> Used	Current Value of Vehicle
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Principal Address of Garaging	Applicant address as it appears on registration, if different from Sec 3	State Registered In
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During the **three years** prior to the effective date of this policy:

1. Have you been involved in any accident in which you were principally at fault involving bodily injury or death?  YES  NO
2. Have you been involved in any accident in which you were principally at fault that resulted in only property damage?  YES  NO
3. Have you been involved in any accident in which you were considered to be not at fault?  YES  NO

**SECTION 6. COVERAGES**

**INSTRUCTIONS**

1. Indicate Applicant's County of Residence
2. Check Boxes for Requested Coverage
3. Indicate Premium Amount for the County of Residence \*
4. Indicate Total Policy Premium Amount

<b>COUNTY OF RESIDENCE →</b>	<b>INDICATE PREMIUM AMOUNT ↓</b>
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Bodily Injury Liability \$10,000 Each Person / \$20,000 Each Accident	<input checked="" type="checkbox"/>	Required Coverage	
Property Damage Liability \$3,000 Each Accident			
Medical Payments \$1,000	<input type="checkbox"/>	Optional Coverage	
Uninsured Motorist Coverage – Bodily Injury \$10,000 Each Person / \$20,000 Each Accident	<input type="checkbox"/>	Optional Coverage	
Youthful Unmarried Male (19-24 yrs) - 25% Surcharge	<input type="checkbox"/>	Check if Applicable –25% Surcharge Liability Rate should be listed above.	

* Current Rates as of date shown at bottom of application.	<b>TOTAL POLICY PREMIUM →</b>
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**SECTION 7. PAYMENT PLANS****GROSS DEPOSIT PREMIUMS MUST BE SUBMITTED WITH APPLICATION**

- Full Annual Premium
- Deposit premium (\$125 or 25%, whichever is greater, balance due in 30 days)
- Option 1-Installment Plan – Deposit of \$100 plus 6 bi-monthly payments – No interest, \$4.00 per Installment charge.
- Option 2-Installment Plan – Deposit of \$125 or 25% whichever is greater, plus 5 bi-monthly payments No interest, \$4.00 per Installment charge.
- Option 3-Installment Plan – Deposit of 15% of Total Premium plus 6 bi-monthly installments – No interest, \$4.00 per Installment charge.

Deposit Amount Submitted

\$

**SECTION 7.A DEPOSIT PAYMENT****Indicate Total Deposit Amount Received from Applicant:**

\$

Payment Submitted:  Producer/Agency Check  Applicant Check  Money Order

Check/M.O. #:

If Producer Check, did Applicant pay Producer by:

 Cash  Personal Check  Money Order

Was Receipt Provided to Applicant?

 YES NO**SECTION 8. FINANCIAL RESPONSIBILITY**

(Complete if applicant or other eligible operator is required to file evidence of financial responsibility but still meets the good driver requirements of this policy.)

Name

Case/File #

Relationship to Applicant

Resides with Applicant

 Yes  No

State where Filing required

Reason for Filing

The SR22/1P filing for this Low Cost Auto Policy is issued for owners coverage, per California Ins. Code Article 5.5 §11629.8.

**SECTION 9. INSURANCE RECORD**

Name of applicant's last company

Policy #

Termination date

Give Reason Terminated

Is there a policy currently in effect for the vehicle being insured on this application?  Yes  No

Are any other vehicles owned by any member of household?

 Yes  No

If "Yes", give name of insurer and attach copy of declaration page.

**SECTION 10. COVERAGE FOR ACTS OF UNINSURED MOTORIST: CALIFORNIA**

**DELETION OF COVERAGE:** The California Insurance Code requires an insurer to provide uninsured motorists coverage in each bodily injury liability insurance policy it issues covering liability arising out of the ownership, maintenance, or use of a motor vehicle. Those provisions also permit the insurer and the applicant to delete the coverage completely or to delete the coverage when a motor vehicle is operated by a natural person or persons designated by name. Uninsured motorists coverage insures the insured, his or her heirs or legal representatives for all sums within the limits established by law, which such person or persons are legally entitled to recover as damages for bodily injury, including any resulting sickness, disease, or death, to the insured from the owner or operator of an uninsured motor vehicle not owned or operated by the insured or a resident of the same household. An uninsured motor vehicle includes an underinsured motor vehicle as defined in subsection (p) of Section 11580.2 of the Insurance Code.

**Notwithstanding the coverage amounts required by Section 11580.2 and Section 16056 of the California Vehicle Code, uninsured motorist bodily injury coverage written in conjunction with a Low Cost Auto Policy with coverage limits at least equal to the limits of liability in the underlying Low Cost Auto Policy, shall satisfy the requirements of Section 11580.2 of the California Insurance Code and the financial responsibility requirements of Sections 4000.37, 16021, and 16431 of the California Vehicle Code.**

**SECTION 11. REJECTION OF UNINSURED MOTORIST COVERAGE**

I understand that if I reject uninsured motorist coverage, and if I am injured by a person driving without motor vehicle insurance, I may be unable to recover any significant amount of money to cover the costs of my injuries. I have applied this day for coverage under an automobile liability insurance policy, and the company providing such coverage and I have agreed to delete uninsured motorist coverage from that insurance policy.

X \_\_\_\_\_ Date: \_\_\_\_\_ Hour: \_\_\_\_\_  A.M.  P.M.

Applicant's Signature

The rejection of insurance indicated by the above agreement shall be binding upon every insured to whom such policy or endorsement provisions apply while such policy is in force, and it shall continue to be so binding with respect to any continuation, renewal or replacement of such policy by the named insured, or with respect to reinstatement of such policy within 30 days of any lapse thereof.

**DO NOT SIGN THIS AGREEMENT UNLESS YOU READ AND UNDERSTAND IT.**

**SECTION 12. APPLICANT - YOUR SIGNATURE ON THIS APPLICATION CERTIFIES THE FOLLOWING.**

**(DO NOT SIGN WITHOUT READING)**

I hereby certify under penalty of perjury that I:

1. have been informed of my right to choose the LCA Payment Plan options as shown in Section 7 of this application.
2. agree to pay all premiums when due and designate the individual shown above as agent/broker of record for this insurance;
3. understand that if I owe money for a prior Low Cost Auto (LCA) policy which I have not formally appealed to the California Insurance Commissioner, the money I submit with this application for a new LCA policy will be applied to that prior policy, and I am not entitled to a refund of the money I submit with this application, even if coverage for this new policy is terminated, until I pay the full amount owed for all current and prior LCA policies;
4. understand the agent/broker is not acting as an agent of any company for the purposes of this insurance;
5. agree that no coverage will be effective if my premium remittance is justifiably dishonored by the financial institution;
6. will remit a check, money order, or a bank draft of the applicant or producer of record, as directed by the insurer, for the balance of the full premium for the policy, within 30 days of notification or, if I have so elected in Option 1, 2 or 3 of Section 7 of this application, to make payments as specified in the LCA Payment Plan Regulation (Section 26);
7. certify that this application was written and signed as of the date shown;
8. realize that any misleading information, or failure to disclose required information, will not be considered good faith on my part and will prejudice my application for insurance; and my application may be rejected with no coverage provided;
9. certify that, to the best of my knowledge and belief, all statements contained in this application are correct;
10. give permission to LCA administrator or the assigned insurer the approval to contact the appropriate agency or individual for verification of my income;
11. have read, understood, and meet all the eligibility requirements listed on the first page of this application.

X \_\_\_\_\_ Date: \_\_\_\_\_ Hour: \_\_\_\_\_  A.M.  P.M.

Applicant's Signature

**SECTION 13. PRODUCER - YOUR SIGNATURE CERTIFIES THE FOLLOWING**

I certify, under penalty of perjury, that I have personally asked the applicant every question on this application and accurately noted each of the applicant's responses. In addition, I certify that (1) a legible photocopy of the applicant's and all operators' driver's licenses, (2) vehicle registration or proof of ownership, and (3) state or federal tax return from previous year or other reliable evidence from a governmental agency or means tested program of the applicants gross annual household income are attached. I certify that this application is submitted pursuant to the effective date provisions of the California Plan. In the event the policy is cancelled or a change is made resulting in a return premium to the insured, I agree to return the unearned commission portion of such premium. The information contained herein is accurate to the best of my knowledge.

X H. D. Ont Date: \_\_\_\_\_ Hour: \_\_\_\_\_  A.M.  P.M.

Producer's Signature

**SECTION 14. EVIDENCE OF INSURANCE AND EFFECTIVE DATE OF COVERAGE**

**NOTE:** In the event there is no U.S. postmark (a meter stamp is not considered a U.S. postmark), coverage will become effective no earlier than 12:01 a.m. on the day following receipt in the Plan Office.

Requested Effective Date and Time:

**ELECTRONIC EFFECTIVE DATE REFERENCE NUMBER REF #**

Example: 09/ 01/2003

(Only required if using EEDP in lieu of EASI submission)

**IN NO EVENT SHALL COVERAGE BE EFFECTIVE PRIOR TO THE DATE AND HOUR OF COMPLETION OF THIS APPLICATION.**

**SECTION 15. FAIR CREDIT REPORTING ACT NOTICE**

In addition to routine verification of information pertinent to the insurance applied for, if the application is by an individual for insurance primarily for personal or family purposes, the insurer to which it is assigned may have an investigative consumer report made including information bearing on character, general reputation, personal characteristics or mode of living and, upon the individual's written request, will disclose in writing the nature and scope of the investigation requested, if such report is procured.

**SECTION 16. FEES ARE ILLEGAL**

Section 11624.5 of the California Insurance Code provides: No insurance agent, broker or solicitor shall make any charge to the applicant, directly or indirectly, for furnishing any person the necessary application forms, technical assistance and services necessary to perfect an application through the Plan other than such commission as is paid by the insurer pursuant to the provisions of such Plan.

**ANY PERSON WHO KNOWINGLY MAKES AN APPLICATION FOR MOTOR VEHICLE INSURANCE COVERAGE CONTAINING ANY STATEMENT THAT THE APPLICANT RESIDES OR IS DOMICILED IN ONE OF THE APPROVED COUNTIES WHEN, IN FACT, THE APPLICANT RESIDES OR IS DOMICILED IN A COUNTY NOT YET APPROVED FOR THIS PROGRAM, IS SUBJECT TO CRIMINAL PENALTIES.**

**ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.**

Producers shall submit their IRS Tax Identification Number or Social Security Number to enable insurers to prepare a Form 1099 for commission amounts paid to the producer. Should the producer fail to provide his or her Tax Identification Number or Social Security Number, the insurer may defer payment of commission until the proper identification number is provided.

Applicants are required to provide their Social Security Number to allow for verification of income. California Insurance Code Section 11629.73 establishes income eligibility requirements, which must be satisfied for the purchase of a low cost automobile insurance policy. California Insurance Code Section 11629.74 provides that, to demonstrate financial eligibility, an applicant shall present a copy of the applicant's federal or state income tax return for the previous year or other reliable evidence from a governmental agency or governmental mean-tested program of the applicant's gross annual household income. Applicants who do not provide a Social Security Number may be found to be ineligible to purchase a Low Cost automobile insurance policy.

**NOTE:** Following an assignment of an EASi reference number and prior to mailing the completed, signed application to the Plan, you are not permitted to alter or in any way change any information on the application. Please refer to the Retraction Procedures outlined in the Plan manual if you need to retract an application submitted through EASi.

**ATTACHMENTS**

- |   |   |
|---|---|
| <input type="checkbox"/> Copy of Driver's License for Applicant & All Operators                                     | <input type="checkbox"/> Deposit Premium Payment                                  |
| <input type="checkbox"/> Copy of Foreign Country Driver's License if only 18 months driving experience in US/Canada | <input type="checkbox"/> Income Verification Document(s)                          |
| <input type="checkbox"/> Copy of Vehicle Registration or Proof of Ownership   | <input type="checkbox"/> Copy of Declaration Page from any other owned vehicle(s) |

**REMARKS**

**Complaints about Insurance Companies, agents or brokers can be directed to the California Department of Insurance, Consumer Services Division at 800-927-HELP (4357).**

## NOTICE

INSURANCE COVERAGE PROVIDED IN THE POLICY YOU ARE BUYING CONTAINS REDUCED LIABILITY COVERAGE FOR PERSONAL INJURIES OR PROPERTY DAMAGE RESULTING FROM THE OPERATION OF THE INSURED VEHICLE. IF LOSSES FROM AN AUTOMOBILE ACCIDENT EXCEED THE COVERAGE PROVIDED BY THIS POLICY, YOU CAN BE HELD PERSONALLY LIABLE AND RESPONSIBLE FOR THOSE LOSSES.

THIS POLICY PROVIDES LIABILITY COVERAGE FOR INJURIES OR DEATH CAUSED TO OTHER PERSONS IN THE TOTAL AMOUNT OF TEN THOUSAND DOLLARS (\$10,000) PER PERSON IN ANY ONE ACCIDENT, AND UP TO A TOTAL AMOUNT OF TWENTY THOUSAND (\$20,000) FOR ALL PERSONS IN ANY ONE ACCIDENT. THE POLICY ALSO PROVIDES UP TO A TOTAL AMOUNT OF THREE THOUSAND DOLLARS (\$3,000) IN LIABILITY COVERAGE FOR PROPERTY DAMAGE IN ANY ONE ACCIDENT.

IF YOU WANT MORE LIABILITY INSURANCE COVERAGE, YOU MUST REQUEST A DIFFERENT POLICY. THIS POLICY ALSO DOES NOT COVER DAMAGE TO YOUR OWN VEHICLE, LOSSES RESULTING FROM YOUR BODILY INJURY OR DEATH, OR COVERAGE FOR PROPERTY DAMAGE LOSSES CAUSED BY AN UNINSURED OR UNDERINSURED DRIVER. HOWEVER, THESE OTHER COVERAGES MAY BE AVAILABLE AT EXTRA COST THROUGH OTHER INSURERS.

THIS POLICY MAY ALSO CONTAIN UNINSURED MOTORIST BODILY INJURY COVERAGE IN THE TOTAL AMOUNT OF TEN THOUSAND DOLLARS (\$10,000) PER PERSON IN ANY ONE ACCIDENT AND UP TO A TOTAL AMOUNT OF TWENTY THOUSAND (\$20,000) FOR ALL PERSONS IN ANY ONE ACCIDENT, IF YOU SO CHOOSE. IN ADDITION, THIS POLICY MAY ALSO CONTAIN MEDICAL PAYMENTS COVERAGE IN THE AMOUNT OF ONE THOUSAND DOLLARS (\$1,000) PER PERSON IN ANY ONE ACCIDENT IF YOU SO CHOOSE.

THIS POLICY DOES NOT COVER ANY OTHER DRIVER IN YOUR HOUSEHOLD WHO:

- (a) IS UNDER 19 YEARS OF AGE; OR
- (b) HAS LESS THAN 3 YEARS OF CONTINUOUSLY LICENSED DRIVING EXPERIENCE; OR
- (c) HAS MORE THAN ONE OF EITHER, OR BOTH, OF THE FOLLOWING: A PROPERTY DAMAGE ONLY ACCIDENT IN WHICH THE DRIVER WAS PRINCIPALLY AT FAULT. A POINT FOR A MOVING VIOLATION; OR
- (d) HAS IN THE PREVIOUS 3 YEARS AN AT FAULT ACCIDENT INVOLVING BODILY INJURY OR DEATH; OR
- (e) HAS A FELONY OR MISDEMEANOR CONVICTION FROM A VIOLATION OF THE VEHICLE CODE ON HIS OR HER MOTOR VEHICLE RECORD.

X \_\_\_\_\_ Date: \_\_\_\_\_ Hour: \_\_\_\_\_  A.M.  P.M.  
Applicant's Signature

# CALIFORNIA LOW COST AUTOMOBILE INSURANCE PROGRAM

## PRIVACY WAIVER


The undersigned waives the privacy benefit of sections 1094 and 1095 of the California Unemployment Insurance Code and the California Information Practices Act (California Civil Code Section 1798, et seq.) for a period not to exceed 30 days from the date this waiver is signed.

The undersigned authorizes Employment Development Department to furnish or verify confidential employment information about the subject person or employer to the request identified below, for the purposes also stated below.

### EMPLOYER/EMPLOYEE/CLAIMANT INFORMATION (PLEASE PRINT OR TYPE)

Name:		Valid CA Drivers Lic.#
Mailing or Street Address:		SSN — <b>Only if no Valid CDL #</b>
City:	State:	Zip Code:
Employer Name:		State Employer ID No.:
NAME AND TITLE, IF APPLICABLE (Owner, Partner, Corporate Officer Or Other Authorized Person)		
Mailing or Street Address:		
City:	State:	Zip Code:
Telephone No.:		FAX No.:
Signature (must match name listed above):		Date:

### REQUESTER INFORMATION (Include all names authorized to receive confidential information)

Requesters Name, (first, last/MI): <b>RICHARD J. MANNING</b>		Telephone No.: <b>415-765-6767</b>
Organization or Company Name: <b>CALIFORNIA AUTOMOBILE ASSIGNED RISK PLAN</b>		
Mailing or Street Address: <b>595 Market St., Suite 1250</b>		
City: <b>San Francisco</b>	State: <b>CA</b>	Zip Code: <b>94105</b>
Signature (must match name listed above): 		Date:

### PURPOSE OF THIS REQUEST (Request must be included)

#### Verification of Income

\*California Insurance Code Section 11629.73 establishes income eligibility requirements, which must be satisfied for the purchase of a low cost automobile insurance policy. California Insurance Code Section 11629.74 provides that, to demonstrate financial eligibility, an applicant shall present a copy of the applicant's federal or state income tax return for the previous year or other reliable evidence from a government agency or governmental mean-tested program of the applicant's gross annual household income. Applicants who do not currently possess a valid California Drivers License must provide their Social Security Number to allow for verification of income. Applicants who provide neither a California Drivers License Number nor a Social Security Number may be found to be ineligible to purchase a low cost automobile insurance policy.