



# INSURANCE BINDER

DOCKET # A-0011168C0301

(Do not use a binder for Claims-Made Policy, Business Catastrophe or Fidelity and Surety.)

TYPE OF INSURANCE:  PRIV. PASS. AUTO.  GARAGE  PERSONAL LIABILITY  COMMERCIAL LIABILITY  WORKERS COMP.  
 COMMERCIAL AUTO.  PERSONAL PROPERTY  COMMERCIAL PROPERTY

SEE INSTRUCTIONS ON REVERSE SIDE BEFORE COMPLETING  
 NAME AND ADDRESS OF AGENCY AGENT'S NO. AA4353  
 Nesmith Insurance Agency  
 PO Box 746  
 201A Penna Ave W.  
 WARREN, PA 16345

COMPANY:  ERIE INSURANCE EXCHANGE  
 ERIE INSURANCE COMPANY  
 ERIE INSURANCE PROPERTY & CASUALTY COMPANY  
 FLAGSHIP CITY INSURANCE COMPANY  
 If Auto in OH or WV:  Preferred  Standard

EFFECTIVE (TIME) 3:00P M 6/16/2003 A Binder may not be in force for more than 30 days. (60 days for VA 1-4 family dwellings.)  
 EXPIRES (TIME) 12:01AM 7/15/2003  
 Agent must mail Home Office copy of this Binder to the Home Office within 24 hours of the effective time above.

NAME AND MAILING ADDRESS OF INSURED  
 OMNI BUSINESS SERVICES CORP  
 10 Werner Dr  
 Russell PA 16345

DESCRIPTION OF OPERATION/VEHICLE(S)- incl. Year, Make & complete VIN no./Property  
 CONTRACT CARRIER  
 1992 Ford Pickup  
 1FTDF1543NCA27259

NAME OF POLICY (Family Personal Auto, Broadcover HP, etc.)  
 COMMERCIAL AUTO

COVERAGE / PERILS / FORMS (Bldg., Personal Property, etc.)	AMOUNT OF INSURANCE	DED.	COINS. %
	\$		

OCCUPANCY AND LOCATION OF PROPERTY  
 (If Home Protector, Homeowner, also indicate Liab. and Med. Payments below.)

COVERAGE / FORMS	LIMITS OF INSURANCE	
Each Occurrence Limit	\$	,000
Damage to Premises Rented to Others	\$	,000 Any One Premises
Medical Expense Limit	\$	,000 Any One Person
Personal & Advertising Injury Limit	\$	,000 Any One Person or Organization
General Aggregate Limit	\$	,000
Products/Completed Operations Aggregate Limit	\$	,000

TYPE OF INSURANCE  
 PREMISES/OPERATIONS INC. PERSONAL & ADVERTISING INJURY  
 PRODUCTS/COMPLETED OPERATIONS  
 CONTRACTUAL  
 OTHER (Specify Below)  
 MED. PAY \$ \_\_\_\_\_ ANY ONE PERSON

COVERAGES LIMITS OF PROTECTION  
 LIABILITY (Commercial Auto/Garage:  Owned  Hired  Non-Owned)  
 COMPREHENSIVE \$ 100 DEDUCTIBLE  
 COLLISION \$ 500 DEDUCTIBLE  
 MEDICAL PAYMENTS (MED. EXP.-VA) \$ \_\_\_\_\_,000 Each Person  
 STATUTORY UNINS. MOT. (NY ONLY) \$ 10,000 Each Person \$ 20,000 Each Accident  
 SUM (SUPPL. UNINS./UNDERINS. MOTORISTS-NY ONLY) \$ \_\_\_\_\_,000 Each Person \$ \_\_\_\_\_,000 Each Accident  
 UNINS./UNDERINS. MOTORISTS-(BI) \$ 100,000 Each Person \$ 300,000 Each Accident  
 (IF APPLICABLE)-(PD) \$ \_\_\_\_\_,000 Each Accident \$ \_\_\_\_\_ Deductible  
 STACKED  UNSTACKED (PA ONLY)  
 FIRST PARTY BENEFITS (PA ONLY)  Med 5,000.  Loss \_\_\_\_\_,000  Comb. Pkg.  
 Funeral \_\_\_\_\_,000.  Acc'l Death \_\_\_\_\_,000;  Extraordinary Medical  
 PERSONAL INJURY PROTECTION \$ \_\_\_\_\_  
 ADDITIONAL PIP (NY ONLY) \$ \_\_\_\_\_  
 OBEL (NY ONLY) \$ 25,000.  
 ROAD SERVICE  OTHER (Specify): \_\_\_\_\_

COVERAGE	LIMITS OF PROTECTION	
	Each Person	Each Accident
BODILY INJURY	\$ _____,000	\$ _____,000
PROPERTY DAMAGE		\$ _____,000
COMBINED SINGLE LIMIT (CSL)		\$ 300,000
COMBINED SINGLE LIMIT (CSL)		\$ _____,000
COMBINED SINGLE LIMIT (CSL)		\$ _____,000

WORKERS COMPENSATION - Specify State(s): \_\_\_\_\_  
 EMPLOYERS LIABILITY -  Statutory Limits  Other: \$ \_\_\_\_\_

OTHER COVERAGES/ COMMENTS:

NAME AND ADDRESS OF:  MORTGAGEE OR LIENHOLDER  CERTIFICATE HOLDER  
 James J. McNulty, Secretary  
 Pennsylvania Public Utility Commission  
 PO Box 3265  
 Harrisburg, PA 17105-3265  
 DOCKET: A-0011168C0301

IS ABOVE INSURED PRESENTLY A POLICYHOLDER?  
 YES  NO  
 IF YES, POLICY NO. \_\_\_\_\_  
 Signature of Authorized Agent: *James J. McNulty* Date: 6/16/03

SECRETARY'S BUREAU JUN 28 AM 9:18

**FINANCIAL RESPONSIBILITY IDENTIFICATION CARD**

INSURANCE COMPANY NAME NAIC CODE

ERIE INSURANCE EXCHANGE 26271

POLICY NUMBER EFFECTIVE UNTIL  
 Q98-78-13111 06-16-03 12-16-03  
 NOT VALID MORE THAN SIX MONTHS FROM EFFECTIVE DATE

YOU NEED THE I.D. CARD FOR VEHICLE INSPECTION AND OTHER PA STATE REQUIREMENTS—SEE BACK OF CARD.

YOUR AUTO POLICY IS EFFECTIVE FROM 06-16-03 TO 06-16-04

TO COMPLY WITH PENNSYLVANIA LAW, WE WILL:  
 1. Issue a 6 month I.D. card on the policy effective date.  
 2. Six months later issue another 6 month I.D. card.  
 3. Issue a card for replacement or additional vehicle(s).

92 FORD 1FTDF15Y3NCA27259  
 Year Make V.I.N. If only 5 digits, they are last 5.

NAMED INSURED  
 OMNI BUSINESS SERVICES CORP  
 10 WERNER DR

YOUR AGENT PHONE: 814-726-2630  
 NESMITH INSURANCE AGENCY AA3  
 201-A PA AVE W  
 WARREN, PA 16365

RUSSELLN, PA 16345

SEE IMPORTANT MESSAGE ON REVERSE SIDE



ERIE INSURANCE GROUP  
 100 Erie Ins. Pl.  
 Erie, PA 16530

*Jeffrey A. Redwood*  
 Authorized Signature

FOLD AND DETACH CARD AT PERFORATION

CLAIM SERVICE—For Claim Service anywhere in U.S. or Canada, call YOUR AGENT or, using the list below, call the Claim Office NEAREST YOUR HOME.

State	Claim Office	Call Toll Free	State	Claim Office	Call Toll Free
DC	SILVER SPRING	800-492-2709	TN	KNOXVILLE	888-922-3743
IL	PEORIA	888-335-3743	VA	RICHMOND	800-322-3743
IN	FORT WAYNE	800-892-5655	WA	ROANOKE	800-533-3743
IN	INDIANAPOLIS	800-624-1620	WI	WAYNESBORO	800-542-2250
MD	SILVER SPRING	800-492-2709	WV	WALKESHA	877-750-3743
MD	HAGERSTOWN	800-533-5602	WV	PARKERSBURG	800-642-1948
NC	CHARLOTTE	800-473-3882			
NC	RALEIGH	800-533-3982			
NY	ROCHESTER	800-333-0823			
NY	CANTON	800-362-6541			
OH	COLUMBUS	800-282-1702			
OH	ALLENTOWN/BETH	800-322-9026			
PA	ERIE	877-771-3743			
PA	HOME OFFICE (ERIE)	800-458-0811			
PA	HARRISBURG	800-382-1304			
PA	JOHNSTOWN	800-241-4209			
PA	MURRYSVILLE	800-553-3367			
PA	PHILADELPHIA	800-821-2902			
PA	WARRENDALE	800-922-1824			

\*Our phones answer 24 hours a day, 7 days a week!  
 To report your claim after hours (5:30 p.m. to 8:00 a.m.) or on weekends, please call your Agent or our Alter Hours Claims Service  
 Toll Free at 1-800-367-3743

**FRAUD FINDERS HOTLINE**  
 To confidentially report information on insurance fraud activities, call our FRAUD FINDERS HOTLINE Toll-Free at 1-800-369-6696

To report an auto glass claim, call EIGlass  
 Toll-Free at 1-800-552-ERIE

THIS CARD MUST BE CARRIED FOR PRODUCTION UPON DEMAND.  
IT IS SUGGESTED THAT YOU CARRY THIS CARD IN THE INSURED VEHICLE.

**WARNING:**

Any owner or registrant of a motor vehicle who drives or permits a motor vehicle to be driven in this State without required financial responsibility may have his/her registration suspended or revoked.

**IN THE EVENT OF AN ACCIDENT OR LOSS**

- Help any injured. Get names, addresses, auto license plate numbers of involved, including all witnesses.
- Do not discuss an accident with anyone except the police or our representative.
- Protect your auto and any property from further damage.
- Promptly call the police if someone is injured, damage is extensive, or in case of theft. In case of "hit-and-run," you must report the accident to the police within 24 hours or as soon as possible.
- Notify your Agent or The ERIE of the accident or loss.

**FRAUD FINDERS HOTLINE**

To confidentially report information on insurance fraud activities,  
call our **FRAUD FINDERS® HOTLINE**  
Toll-Free 1-800-368-6696.

**IMPORTANT NOTICE**  
Regarding your Financial Responsibility/Insurance Identification Card

The ERIE INSURANCE COMPANY is required by Pennsylvania Law to send you an I.D. card. The card shows that an insurance policy has been issued for the vehicle(s) described satisfying the financial responsibility requirements of the law.

If you lose the card, contact your insurance company for a replacement.

The I.D. card information may be used for vehicle registration and replacing license plates. If your liability insurance policy is not in effect, the I.D. card is no longer valid.

You are required to maintain financial responsibility on your vehicle. It is against Pennsylvania Law to use the I.D. card fraudulently such as using the card as proof of financial responsibility after the insurance policy is terminated.

**NOTE: THIS CARD IS REQUIRED WHEN:**

- (1) You are involved in an auto accident.
- (2) You are convicted of a traffic offense other than a parking offense that requires a court appearance.
- (3) You are stopped for violating any provision of the Vehicle Code (75 Pa. C.S. §101-9910) and requested to produce it by a police officer.
- (4) You take the described vehicle to an inspection station to be inspected.

You must provide a copy of this card to the Department of Transportation when you request restoration of your operating privilege and/or registration privilege which has been previously suspended or revoked.

WAS THIS RISK RATED BY QUOTE UNIT OR DSM?  YES  NO IF "YES," ATTACH COPY OF QUOTE.

PLEASE DO NOT WRITE OR STAPLE IN THIS SPACE

**10** COMMERCIAL  
NON-FLEET/FLEET  
AUTO APPLICATION

ERIE INSURANCE GROUP  
100 Erie Insurance Place Erie, PA 16530

— FOR HOME OFFICE USE ONLY —

The Applicant applies for insurance and represents the following to be true.

APPLICATION TO:  ERIE INSURANCE EXCHANGE  
 ERIE INSURANCE PROPERTY & CASUALTY COMPANY

IS POLICY A REWRITE OF A CURRENT "ERIE" POLICY?  YES  NO IF YES, GIVE POLICY NUMBER

1 TIME EFF: 3:00 P.M. FROM (EFF. DATE) 6-16-03 TO 6-16-04

2 AGENT'S NO: AA4353 AGENT'S NAME: NERSON, INS / VIRGINIA CHULY AGENT'S PHONE NO: (814) 726-6230

3 NAME OF APPLICANT: OMNI BUSINESS SERVICES CORP

NUMBER AND STREET: 10 WERNER DR CITY: RUSSELL STATE: PA ZIP CODE: 16354

TWR: PINE GROVE CO: WARREN

HOME: 814 757-9373

IF LESS THAN TWO YEARS, GIVE PREVIOUS ADDRESS OF A TWO-YEAR DURATION (NOT MILITARY) ADDRESS: TOTAL NO. OF EMPLOYEES?

Year	Make, Type, Model Trailer—list semi or trailer (If dealer plates, list Nos.)	Copy Full V.L.R. Exactly as Listed on Registration Card	COST NEW (Do not deduct trade)	Mo./Yr. Bought	N. Mileage Limitation	Size, Type GVW Gst. Cap Seat. Cap	H. O. Use	Ter. Sym.	H. O. Use	Use Class (5, 6 etc.)
1992	FORD Pickup	VFD F15V3NCA27255			450					

Medical Liability	Personal Injury	FIRST-PARTY BENEFITS (PA ONLY)				Uninsured/Underinsured Motorists PA, WI & WV Only	Uninsured/Underinsured Motorists DC, PA, WI & WV ONLY	Social Services	Collision	OTHER	TOTALS
		MEDICAL	INCOME LOSS	Acc.	OTHER						
<input type="checkbox"/> 20M-40M <input type="checkbox"/> 25M-50M <input type="checkbox"/> 50M-100M <input type="checkbox"/> 100M-300M <input type="checkbox"/> 250M-500M <input checked="" type="checkbox"/> 300 <input checked="" type="checkbox"/> CSL	<input type="checkbox"/> 5M <input type="checkbox"/> 10M <input type="checkbox"/> 25M <input type="checkbox"/> 50M <input type="checkbox"/> 100M <input type="checkbox"/> 250M <input type="checkbox"/> With Worker's Comp.	<input type="checkbox"/> 1M-5M <input type="checkbox"/> 1M-15M <input type="checkbox"/> 1.5M-25M <input type="checkbox"/> 2.5M-50M <input type="checkbox"/> 5M-100M	<input type="checkbox"/> 5M <input type="checkbox"/> 1.5M <input type="checkbox"/> 2.5M <input type="checkbox"/> Comb. Pkg. 5177.500 <input type="checkbox"/> Exce- or Injury Medical	<input type="checkbox"/> Personal Injury Ex. Person <input type="checkbox"/> MD Only If waived FIP is purchased at ch proper form. <input checked="" type="checkbox"/> Medical Payments Ex. Person	<input type="checkbox"/> Stacked <input checked="" type="checkbox"/> Unstacked <input type="checkbox"/> 10M <input type="checkbox"/> 15M (PA Only) <input type="checkbox"/> 20M-40M <input type="checkbox"/> 25M-50M <input type="checkbox"/> 50M-100M <input type="checkbox"/> 100M-300M <input type="checkbox"/> 250M-500M	<input type="checkbox"/> Stacked <input checked="" type="checkbox"/> Unstacked <input type="checkbox"/> 10M <input type="checkbox"/> 20M-40M <input type="checkbox"/> 25M-50M <input type="checkbox"/> 50M-100M <input type="checkbox"/> 100M-300M <input type="checkbox"/> 250M-500M	<input type="checkbox"/> 50 <input checked="" type="checkbox"/> 100 <input type="checkbox"/> 250 <input type="checkbox"/> 500 <input type="checkbox"/> Stated Amt.	<input type="checkbox"/> 100 <input type="checkbox"/> 200 <input checked="" type="checkbox"/> 500 <input type="checkbox"/> Stated Amt.	<input type="checkbox"/> Fire-1 Auto <input type="checkbox"/> PD-2 Family <input type="checkbox"/> PD-3 Express <input type="checkbox"/> Non-Cover Auto <input type="checkbox"/> Trans. Exp. <input type="checkbox"/> Auto <input type="checkbox"/> Crim. <input type="checkbox"/> Collision	<input type="checkbox"/> Total <input type="checkbox"/> per <input type="checkbox"/> Auto	

7: COMMERCIAL PASSENGER Auto 1 Auto 2 Auto 3 Auto 4

Usage: Pleasure Business Work/School Farm

OTHER COVERAGES

8 APPLICANT'S BUSINESS (IF FARM, SHOW NO. OF ACRES)

HOW ARE COMMERCIAL VEHICLES USED?

9 LIABILITY CERT. ADD'L INSURED — WHY?

Name(s) and Address(es)

PAYMENT PLAN: A B C D Monthly Billing

Acc'l Premium \$

Total Premium \$

Payment \$

Balance \$

DRIVER	PLEASE LIST DRIVER'S NAME AND LICENSE NO. EXACTLY AS IT APPEARS ON DRIVER'S LICENSE	CLASS	SEX	DOB	M=Married S=Single W=Widowed	1=Uninsured 2=Partial (Restricted) 3=Stacked w/other policy	4=Insured 5=Student 6=Other	7=Employed 8=Parent 9=Other	10=Other CO=Comp. Other	11=Occupation	12=Occupation	13=Occupation	14=Occupation	15=Occupation	16=Occupation	17=Occupation	18=Occupation	19=Occupation	20=Occupation
	List All Drivers																		

ARE THERE ANY RESTRICTIONS ON ANY DRIVER'S LICENSE?  YES  NO IF "YES," LIST RESTRICTION CODE UNDER "R" AND EXPLAIN ON REVERSE SIDE (Section 20).

WERE MVR/CLUES ORDERED ON ANY/ALL DRIVERS?  YES  NO IF "YES," ATTACH COPIES.

\*\*\*LIST NAME AND ADDRESS OF VEHICLE OWNER IF DIFFERENT FROM APPLICANT (AUTO # \_\_\_\_\_):

(AUTO # \_\_\_\_\_):

\*\*\*IF LICENSE LESS THAN A YEAR IN THIS STATE, FURNISH PREVIOUS LICENSE NUMBER (incl. State):

H. O. USE:  REPORT  O  YM  YF  F-M-M  MY

UF-1931 8/02  WL  MW  CLUE ACCEPTED ERIE BY \_\_\_\_\_ ENTERED BY \_\_\_\_\_

11 ARE THERE HOUSEHOLD RESIDENTS OF DRIVING AGE NOT LISTED IN NUMBER 10?  YES  NO IF "YES," LIST NAME \_\_\_\_\_  
DO THEY HAVE THEIR OWN AUTO?  YES  NO DO THEY HAVE THEIR OWN INSURANCE?  YES  NO

12 WHAT COMMODITIES ARE TRANSPORTED? MILEAGE RADIUS? DESTINATION? HOW OFTEN? \_\_\_\_\_

13 DOES THIS APPLICATION INSURE ALL MOTOR VEHICLES AND TRAILERS OWNED BY APPLICANT?  
(Applicable only when Hired Car & Non-owned coverage included.)  YES  NO If "NO," give year, make and VIN of owned vehicles not to be insured. \_\_\_\_\_

14 AUTO(S) WILL BE PRINCIPALLY USED IN THE LOCALITY INDICATED IN ITEM 3. EXCEPT: \_\_\_\_\_

15 A. ARE FHWA AND/OR STATE FILINGS REQUIRED?  YES  NO  
IF "YES," GIVE SINGLE STATE OF REG., STATE(S) AND DOCKET NO.(S) AND ATTACH COPY OF RIGHTS. \_\_\_\_\_

B. IS VEHICLE USED TO HAUL GOODS OF OTHERS FOR A FEE?  YES  NO

16 IS APPLICANT REQUIRED TO COMPLY WITH MOTOR CARRIER ACT OF 1980?  YES  NO IF "YES," EXPLAIN WHY: \_\_\_\_\_

17 ARE VEHICLES LEASED TO OTHERS?  YES  NO IF "YES," DESCRIBE CIRCUMSTANCES AND ATTACH COPY OF CONTRACT. \_\_\_\_\_

**18 WARNING: An incorrect answer, intentional or not, to any question below may jeopardize the acceptance of this application.**  
If the answers to any of the following are "Yes," give driver's name and requested details below. (Attach additional sheet if necessary.)

Has any driver:	YES	NO	(f) Had a physical or mental impairment or disability or other medical infirmity? Identify any such condition (e.g., heart, diabetes, epilepsy, hearing/sight/limb loss, back condition or other medical infirmity), its duration and treatment obtained and/or medication prescribed.	YES	NO
(a) Had any auto insurance refused, cancelled or expired in past five years or been excluded or restricted on a policy in past five years? In either case, give name of Company, Policy No., date, reason if known	<input type="checkbox"/>	<input type="checkbox"/>	(g) Had any comprehensive losses (fire, theft, etc.) in past five years? (Describe)	<input type="checkbox"/>	<input type="checkbox"/>
(b) Been required to file evidence of financial responsibility in past five years? (Give date and reason)	<input type="checkbox"/>	<input type="checkbox"/>	(h) Refused to submit to a chemical test in the past three years?	<input type="checkbox"/>	<input type="checkbox"/>
(c) Had driver's license revoked or suspended in past five years? (Give date and reason)	<input type="checkbox"/>	<input type="checkbox"/>	(i) While driving a motor vehicle, been involved in an accident during past five years? If yes, describe all accidents, regardless of who was at fault, under No. 18 below.	<input type="checkbox"/>	<input type="checkbox"/>
(d) Received a ticket for speeding or any other vehicle code violation within the past five years? (If "Yes," give date and description of violation(s). If speeding, include your actual speed and the speed limit.)	<input type="checkbox"/>	<input type="checkbox"/>	NOTE FOR DC APPLICANTS: Question 17 (a) not applicable and for questions 17 (b) & (c) ask for three years record only.		
(e) Ever been arrested for ANY reason? (Give date and place of arrest, conviction and penalty)	<input type="checkbox"/>	<input type="checkbox"/>	NOTE FOR MD APPLICANTS: Question 17 (a), (b) & (c) ask for three years record only. Also ask 17 (h).		
			NOTE FOR WI APPLICANTS: Question 17 (f) not applicable.		

19 Accident Date	DRIVER'S NAME	DRIVES AUTO	DDP	DESCRIBE ACCIDENT (ANY LOSS OTHER THAN COMPREHENSIVE - EXAMPLE: SLIDING INTO A DITCH.) LIST \$ AMOUNT OF DAMAGE, WHO PAID, VEHICLE'S OWNER, ETC. IF NOT SUBJECT TO DDP, EXPLAIN WHY.
		#	Y N	
		J	Y N	
		J	Y N	

AGENT: If this application causes changes on an existing ERIE policy, attach change form. If you contacted the Home Office about this risk, list individual contacted and date.

If applying for other coverage (Priv. Pass., Auto, HomeProtect, WC) at this time, list type of policy(ies)

WARNING: Do not bind risks that have been previously cancelled or declined or not renewed. Do not bind risks with a physical or mental impairment or disability. An unbound application may be submitted for these risks.

DO YOU CONSIDER THIS AN ACCEPTABLE RISK? \_\_\_\_\_ I certify that I have read to the Applicant all of the questions as they are printed on this application. I further certify that I have included all answers as given by the Applicant.

Agent's Signature Wegman & Chuby Date 6/16/03

20 INSURANCE RECORD Current auto insurer \_\_\_\_\_  
Policy No. \_\_\_\_\_  
--- If no current insurer, list company last insured with and when \_\_\_\_\_  
--- If previously insured with "ERIE," when \_\_\_\_\_ Policy No. \_\_\_\_\_  
Name in which policy was written \_\_\_\_\_  
--- If residing with other "ERIE" Policyholder or applicant, name \_\_\_\_\_, relationship \_\_\_\_\_  
Policy No. \_\_\_\_\_  
--- Policy No. of any in-force policy(ies) issued to the Applicant by The ERIE \_\_\_\_\_, Effective date(s) \_\_\_\_\_

21 OTHER PERTINENT INFORMATION \_\_\_\_\_

**DC APPLICANT(S) PLEASE READ** WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

**PA APPLICANT(S) PLEASE READ** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS THE PERSON TO CRIMINAL AND CIVIL PENALTIES.

**TW & VA APPLICANT(S) PLEASE READ** IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

**ALL OTHER APPLICANT(S) PLEASE READ** ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

APPLICANT(S) TO ERIE INSURANCE PROPERTY & CASUALTY COMPANY SIGN HERE

I certify that I have given true and complete answers to the questions in this application.

APPLICANT'S SIGNATURE \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

**APPLIES TO EXCHANGE ONLY**

The Subscriber ("you" or "your") agrees with the other Subscribers at ERIE INSURANCE EXCHANGE ("ERIE"), a Reciprocal Inter-Insurance Exchange, and with their Attorney-in-Fact, the Erie Indemnity Company ("we" or "us"), a Pennsylvania corporation with its Home Office in Erie, Pennsylvania, in the following:

- You agree to pay your policy premiums and to exchange with other ERIE Subscribers policies providing insurance for any insured loss as stated in those policies.
- You appoint us as Attorney-in-Fact with the power to: a) exchange policies with other ERIE Subscribers; b) take any action necessary for the exchange of such policies; c) issue, change, non-renew or cancel policies; d) obtain reinsurance; e) collect premiums; f) invest and reinvest funds; g) receive notices and proofs of loss; h) appear for, compromise, prosecute, defend, adjust and settle losses and claims under your policies; i) accept service of process on behalf of ERIE as insurer; and j) manage and conduct the business and affairs of ERIE its affiliates and subsidiaries. This power of attorney is limited to the purposes described in this Agreement.
- You agree that as compensation for us: a) becoming and acting as Attorney-in-Fact; b) managing the business and affairs of ERIE; and c) paying general administrative expenses, including sales commissions, salaries and employee benefits, taxes, rent, depreciation, supplies and data processing, we may retain up to 25% of all premiums written or assumed by ERIE. The rest of the premiums will be used for losses, loss adjustment expenses, investment expenses, damages, legal expenses, court costs, taxes, assessments, licenses, fees, any other governmental fines and charges, establishment of reserves and surplus, and reinsurance, and may be used for dividends and other purposes we decide are to the advantage of Subscribers.
- You agree that this Agreement, including the power of attorney, shall have application to all insurance policies for which you apply at ERIE, including changes in any of your coverages.
- You agree to sign and deliver to us all papers required to carry out this Agreement.
- This Agreement, including the power of attorney, shall not be affected by your subsequent disability or incapacity.
- This Agreement is and shall be binding upon you, us, and all executors, administrators, successors and assigns.

I certify that I have given true and complete answers to the questions in this application.

APPLICANT(S) TO ERIE INSURANCE EXCHANGE SIGN HERE

SUBSCRIBER'S SIGNATURE J. T. Bohan Pres Title \_\_\_\_\_ Date 6/16/03



ERIE INSURANCE GROUP  
Home Office • Erie, Pennsylvania 16530

## NOTICE OF INSURANCE INFORMATION PRACTICES

As part of our procedure for processing your insurance application, personal information such as a credit report, prior insurance claims report, and/or motor vehicle record may be obtained concerning you and other individuals proposed for coverage.

No information from our files will be given to anyone without your written consent, except as allowed by law in order to conduct our business.

You have the right to know the kind of information we have in your file, to have access to that information, and to request correction of information you believe is inaccurate.

We will provide a more detailed description of our information practices, if you so request.