

Appointment Transfer Change Termination Additional Agency No.

MASTER AGENCY INFORMATION

Master Producer # _____

Agency Name: _____ Agency License # _____

Tax Name (as is appears on tax return): _____ Date Agency Established _____

Income Tax Return Form # 1040 1120 K7 FEIN or Social Security #
 Sole Proprietor Partnership Corporation LLC

Former Agency Name: _____
Put "NA" if you've always had the same name

Put "same" if same as physical

Physical Address _____	Mailing Address _____
City/State _____	City/State _____
Zip _____ County _____	Zip _____ County _____
Business Phone _____	Business Fax _____

Agency Contact: _____	<u>Name</u> _____	<u>Contact's E-Mail</u> _____
Personal Lines Manager: _____	_____	_____

Agency Principal (s): (All persons having an ownership interest in agency; and any investors especially if not licensed insurance producers, agents or brokers)

Name:	_____	_____	_____
Address:	_____	_____	_____
City/State/Zip:	_____	_____	_____
Title:	_____	_____	_____
S. S. N.:	_____	_____	_____
Date of Birth:	_____	_____	_____
Year Licensed:	_____	_____	_____
Licensed In PC:	Yes No	Yes No	Yes No
Active in Agency:	Yes No	Yes No	Yes No

Agency or Individuals Licensed in: Indiana Kansas Missouri Arkansas Oklahoma
Percentage of auto business in each state: _____% _____% _____% _____% _____%

- Within the last two years have there been:**
- A** Change in Name? [] Yes [] No
 - B** Agency Cluster Arrangements? [] Yes [] No
 - C** Changes in agency ownership? [] Yes [] No
 - D** Is this a new Agency? [] Yes [] No
 - E** Individual License Terminations? [] Yes [] No
 - F** Mergers w/or purchases of other agencies? [] Yes [] No
- If you answered yes to any please attach an explanation*

Do you own, own any interest, operate or have affiliation with any of the following:

Claim Adjuster Service:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Auto Dealership:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Insurance Company:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Auto Repair Facility:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Auto Salvage Facility:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bank or Savings & Loans:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Law Firm:	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

If Yes, please attach a description of the business.

AGENCY CARRIER INFORMATION

List top 3 Non Standard Auto Companies (in order of annual volume and attached 3 years loss ratio figures)

Company	Written Premium	Loss Ratio	SR-22 Authority
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you or anyone in or affiliated with your agency been sued concerning any insurance related activity? Yes No

Have you or anyone in or affiliated with your agency had their license suspended or revoked? Yes No

If yes, please describe: _____

Agency Rater Yes No
Which rater do you use? _____

Any use of an agency management system? Yes No
Which agency management system? _____

IVANS "Y" Account & Mailbox ID: _____

AGENCY BUSINESS PROFILE

MULTI-LINE AGENCY **SPECIALTY LINE AGENCY**

Non-Standard Auto Volume:	By Premium	App by Week	App by Month	App by Year:
_____	_____	_____	_____	_____

Percentage of Agency Lines of Business by Premium Volume:

Personal Lines Auto	_____ %	Commercial Lines	_____ %
Standard	_____ %	Commercial Auto	_____ %
Non-Standard	_____ %	Other Commercial Lines	_____ %
Other Personal Lines	_____ %		

PRODUCER'S (S) LICENSE INFORMATION

(You must attach a copy of the license)

Name _____
Home Address _____
City/State/Zip _____
Social Security Number _____
Date of Birth _____
License # _____

PRODUCER'S (S) LICENSE INFORMATION

(You must attach a copy of license)

Name _____
Home Address _____
City/State/Zip _____
Social Security Number _____
Date of Birth _____
License # _____

***If you have additional producers please add them on the Addendum

Agency Principal: _____

Signature

Date

Print Name

Thank you for completing the Traders Appointment Form. Page 3 is Optional

TRADERS GENERAL AGENCY AGENCY APPOINTMENT/CHANGE FORM

Date: _____

Please note: This form is only needed if you have additional staff or locations

ADDITIONAL LOCATION/STAFF ADDENDUM

OPTIONAL

ADDITIONAL LOCATION INFORMATION

of Additional Locations: _____

Are the Following Offices Under Direct Control of the Agency?

Yes No

FEIN ID # (if different): _____

FEIN ID # (if different): _____

Agency Name _____

Agency Name _____

Address _____

Address _____

City/State _____

City/State _____

Zip _____ County _____

Zip _____ County _____

Piggy Back to Master Producer # _____

Piggy Back to Master Producer # _____

Agency Volume _____

Agency Volume _____

Agency Contact _____

Agency Contact _____

Business Phone _____

Business Phone _____

Business Fax _____

Business Fax _____

Total # of Employees _____

Total # of Employees _____

Total Licensed _____

Total Licensed _____

ADDITIONAL STAFF INFORMATION

PRODUCER'S LICENSE INFORMATION

(You must attach a copy of license)

Name _____

PRODUCER'S LICENSE INFORMATION

(You must attach a copy of license)

Name _____

HomeAddress _____

HomeAddress _____

City/State/Zip _____

City/State/Zip _____

Social Security Number _____

Social Security Number _____

Date of Birth _____

Date of Birth _____

License # _____

License # _____

Please list other employees, whether or not licensed in the space provided: _____

Do you have independent agents, not employed by your agency placing business through your agency? _____

If yes please provide detail: _____

PLEASE PROVIDE COMPLETED FORMS ALONG WITH THE FOLLOWING:

- _____ ACH form for sweep set up
- _____ Voided Check
- _____ Background form *(In KS & MO only the Agency Principals need to complete)*
- _____ Agency License
- _____ Individual Licenses *(please put SS# and DOB on license)*
- _____ E & O dec page

EMAIL ALL DOCUMENTS TO: marketing@tradersauto.com



**TRADERS GENERAL AGENCY
Authorized Agreement for Automatic
Withdrawals (ACH Debits)**

I hereby authorize Traders General Agency, (Traders Insurance Company Premium Trust Account) hereinafter called the Company, to initiate debit and credit entries to my

Checking Account **Savings Account** *(please check one)*

Indicated below at the depository (Bank or Savings & Loan, etc.) named below, hereinafter called Depository, for the purpose of collecting insurance premiums and fees deposited by me in that same such account. In the event of an over or under withdrawal to my account, I grant to the Company the right to make an adjusting entry to my account up to the amount of the adjustment.

Agency Number	
Agency Name	
Street	
City/State/Zip	

Bank Name	
Bank Mailing Address	
City/State/Zip	
Bank Telephone Number	
Bank Routing & Transit # (ABA)	
My Account Number	
My Account Name (legal business name)	

_____	_____
Print Name	Authorization Date

Signature	

Please include the date that you want the change to become effective. If there is no date entered, we assume it is the date that we received the form.

A COPY OF A VOIDED CHECK MUST BE ATTACHED TO THIS FORM

PLEASE SEND TO:
 If this is a change form:
 Fax Attention- Alyssa Larson (918) 516-0403
 If this is a new appointment:
 marketing@tradersauto.com



**TRADERS GENERAL AGENCY
 DIRECT DEPOSIT COMMISSIONS ACCOUNT
 Authorized Agreement for Direct
 Deposit (ACH Credits)**

I hereby authorize Traders General Agency, (Traders General Agency Commission Account) hereinafter called the Company, to initiate debit and credit entries to my

Checking Account **Savings Account** (please check one)

Indicated below at the depository (Bank or Savings & Loan, etc.) named below, hereinafter called Depository, for the purpose of depositing commissions earned in that account. In the event of an over or under withdrawal to my account, I grant to the Company the right to make an adjusting entry to my account up to the amount of the adjustment.

Agency Number	
Agency Name	
Street	
City/State/Zip	

Bank Name	
Bank Mailing Address	
City/State/Zip	
Bank Telephone Number	
Bank Routing & Transit # (ABA)	
My Account Number	
My Account Name (legal business name)	

_____	_____
Print Name	Authorization Date

Signature	

Please include the date that you want the change to become effective. If there is no date entered, we assume it is the date that we received the form.

A COPY OF A DEPOSIT SLIP MUST BE ATTACHED TO THIS FORM

PLEASE SEND TO:

If this is a change form:
 Fax Attention- Alyssa Larson (918) 516-0403
 If this is a new appointment:
 marketing@tradersauto.com

AGENT BACKGROUND CHECK FORM

Date

Agency Name

Agency Code

Agency Location

I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by Traders Insurance Company at any time after receipt of this authorization and throughout my employment, if applicable.

To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by A-Check Global, 1501 Research Park Drive, Riverside, CA, 92507, 877-345-2021, www.acheckglobal.com, and/or Employer itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

Do you have any convictions, guilty pleas, pleas of no contest, or pending charges for criminal offenses, including but not limited to, non-expunged felonies and misdemeanors which occurred within the past [7] years or resulted in a prison release or parole period that extended into the last seven [7] years? _____ **YES / NO**

SIGNATURE:

First Name Middle Name Last Name Suffix Nickname State & License Number

Home Address

City

State

ZIP Code

Residence Start Date Approx. Month/Year

Email Address

Home or Cell Phone Number

Male

Female

DOB

Social Security Number

