

SERFF Tracking Number: AOIC-125793494 State: Arkansas
Filing Company: Auto-Owners Insurance Company State Tracking Number: EFT \$50
Company Tracking Number: PPA-AR-01-08/28/2008-79157
TOI: 19.0 Personal Auto Sub-TOI: 19.0001 Private Passenger Auto (PPA)
Product Name: Personal Automobile
Project Name/Number: PPA/79157 PPA

Filing at a Glance

Company: Auto-Owners Insurance Company

Product Name: Personal Automobile

TOI: 19.0 Personal Auto

Sub-TOI: 19.0001 Private Passenger Auto (PPA)

Filing Type: Form

SERFF Tr Num: AOIC-125793494

SERFF Status: Closed

Co Tr Num: PPA-AR-01-08/28/2008-79157

Co Status:

Authors: Claudia Stewart, Carol Mitchell, Jessica Turner

Date Submitted: 08/27/2008

State: Arkansas

State Tr Num: EFT \$50

State Status: Fees verified and received

Reviewer(s): Alexa Grissom, Betty Montesi, Brittany Yielding

Disposition Date: 08/28/2008

Disposition Status: Approved

Effective Date (New): 08/28/2008

Effective Date (Renewal):

Effective Date Requested (New): On Approval

Effective Date Requested (Renewal): On Approval

State Filing Description:

General Information

Project Name: PPA

Project Number: 79157 PPA

Reference Organization:

Reference Title:

Filing Status Changed: 08/28/2008

State Status Changed: 08/28/2008

Corresponding Filing Tracking Number:

Filing Description:

FORM FILING: 79157 (06-08) - Arkansas Personal Automobile Application

Status of Filing in Domicile: Not Filed

Domicile Status Comments:

Reference Number:

Advisory Org. Circular:

Deemer Date:

Form Attaches To: Automobile Coverage Form

Use: Provides information necessary for underwriting and policy issuance of Private Passenger, Utility, and Specialty Vehicle policies.

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Product Name: Personal Automobile
Project Name/Number: PPA/79157 PPA

Revisions to the form include: Formatting Changes

Submitted for your approval is the above-referenced form.

If you have any questions, please feel free to contact one of the following:

Manager:

AMY KLEIN, AIS, API, MANAGER
PERSONAL AUTOMOBILE UNDERWRITING - SOUTH
KLEIN.AMY@AOINS.COM (emails without attachments)
perslinesund@aoins.net (emails with attachments)
517-703-8981

Underwriter:

LYNN BOOMSMA
BOOMSMA.LYNN@AOINS.COM
(517) 323-1444

Company and Contact

Filing Contact Information

Amy Klein, Manager klein.amy@aoins.com
PO Box 30660 (800) 346-0346 [Phone]
Lansing, MI 48909-8160 (517) 391-1903[FAX]

Filing Company Information

Auto-Owners Insurance Company CoCode: 18988 State of Domicile: Michigan
P.O. Box 30660 Group Code: 280 Company Type: PC
Lansing, MI 48909-8160 Group Name: Auto-Owners Ins State ID Number:
Group
(800) 346-0346 ext. [Phone] FEIN Number: 38-0315280

SERFF Tracking Number: AOIC-125793494 State: Arkansas
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Filing Fees

Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? No
Fee Explanation: \$50 per filing
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Auto-Owners Insurance Company	\$50.00	08/27/2008	22161793

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Alexa Grissom	08/28/2008	08/28/2008

SERFF Tracking Number: AOIC-125793494 *State:* Arkansas
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TOI: 19.0 Personal Auto *Sub-TOI:* 19.0001 Private Passenger Auto (PPA)
Product Name: Personal Automobile
Project Name/Number: PPA/79157 PPA

Disposition

Disposition Date: 08/28/2008

Effective Date (New): 08/28/2008

Effective Date (Renewal):

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: AOIC-125793494 State: Arkansas
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 Product Name: Personal Automobile
 Project Name/Number: PPA/79157 PPA

Item Type	Item Name	Item Status	Public Access
Supporting Document	Uniform Transmittal Document-Property & Casualty	Approved	Yes
Form	Arkansas Personal Automobile Application	Approved	Yes

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Form Schedule

Review Status	Form Name	Form #	Edition Date	Form Type Action	Action Specific Data	Readability	Attachment
Approved	Arkansas Personal Automobile Application	79157	06-08	Application/ Replaced Binder/Enrollment	Replaced Form #: 79157 (08-07) Previous Filing #:		79157 (06-08).pdf

ARKANSAS PERSONAL AUTOMOBILE APPLICATION



- Auto-Owners Insurance Company
 Premier A+
 Standard

APPLICANT/AGENCY INFORMATION

Policy Number:	<input type="checkbox"/> New <input type="checkbox"/> Rewrite	<input type="checkbox"/> Annual <input type="checkbox"/> Semi-annual	Effective Date: Time:
Agency:	Producer Code:	Agency Code:	
Applicant Name(s):		Phone Number: _____ Email Address: _____	
Applicant Address: City: _____ County: _____ State: _____ Zip: _____		Primary Garaging Address (if different from Applicant Address): City: _____ County: _____ State: _____ Zip: _____	

SUPPORTING POLICIES

If the applicant has other Auto-Owners policies written in the Auto-Owners Group, please provide the policy types and numbers.

Policy Type: _____	Policy Number: _____	Policy Type: _____	Policy Number: _____
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POLICY ADJUSTMENTS

College graduate?

BILLING INFORMATION

ADD TO CURRENT BILLING ACCOUNT? : YES NO IF YES, BILLING ACCOUNT NUMBER: _____

PAYMENT PLAN:

<input type="checkbox"/> Agency Bill	<input type="checkbox"/> EZ Pay Semi-annual	<input type="checkbox"/> EZ Pay Quarterly	Initial Payment: \$ _____
<input type="checkbox"/> Full Pay	<input type="checkbox"/> Three Pay	<input type="checkbox"/> Monthly	Copy of Bill to Agency? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Semi-annual	<input type="checkbox"/> Quarterly	<input type="checkbox"/> EZ Pay Monthly	Mail Insured's Copy of Policy to Agency? <input type="checkbox"/> Yes <input type="checkbox"/> No

METHOD OF PAYMENT: Check Cash Credit Card Policyholder EFT Agency EFT (Sweep)

ALTERNATE BILLING ADDRESS: _____

COVERAGES AND LIMITS

COVERAGE	LIMIT OF LIABILITY
Bodily Injury Liability	\$ _____ each person/\$ _____ each occurrence
Property Damage Liability	\$ _____ each occurrence
Single Limit BI & PD Liability	\$ _____ each occurrence
Uninsured Motorist	\$ _____ each person/\$ _____ each occurrence
Underinsured Motorist	\$ _____ each person/\$ _____ each occurrence
Uninsured Motorist Property Damage	<input type="checkbox"/> Yes <input type="checkbox"/> No each occurrence deductible
Medical & Hospital Benefits	\$ _____ each person
Income Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No
Unlicensed Recreational Vehicle Liability	<input type="checkbox"/> Yes <input type="checkbox"/> No Medical Payments: \$500 Limit each person (excess basis)
Named Operator Policy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Personal Automobile Plus Package	<input type="checkbox"/> Yes <input type="checkbox"/> No

DRIVER AND HOUSEHOLD MEMBER INFORMATION

DRIVER INFORMATION

Drv #	Driver Name (as it appears on Driver's License)	Relation to Applicant	Gender	Date of Birth	Driver's License Number	Lic State	Years Driving	Princ. Driver Veh. #(s)	Occ. Driver Veh. #(s)

INSURANCE SCORING INFORMATION

Insurance Score: _____ Confirmation #: _____
 Score is based on driver #: _____ or applicant's name: _____ Social Security #: _____

ADDITIONAL DRIVER INFORMATION

Drv #	Driver Occupation/School	City of Employer/School	Driver Adjustments (discounts and/or surcharges)

LIST ALL ACCIDENTS/CLAIMS/VIOLATIONS FOR ALL DRIVERS IN THE LAST 5 YEARS

Has any driver shown above had any accidents, claims or violations within the last 5 years? Yes No If "Yes", include information below.

Drv #	Description of Accidents/Claims/Violations	Conviction Date	Amount Paid	At-Fault?
			\$	
			\$	
			\$	
			\$	

HOUSEHOLD MEMBER INFORMATION - Please complete for all Non-Driver Household Members

Household Member Name	Relation to Applicant	Gender	Date of Birth	Driver's License Number (If Individual is Licensed)	Lic State	Additional Information/Explanation

BROADENED COVERAGE FOR NAMED INDIVIDUALS - DRIVE OTHER CARS

Please include below the individual's name(s) and vehicle(s) to apply coverage to if this coverage is desired

Name: _____ Veh # _____ Name: _____ Veh # _____

EXTENDED COVERAGE - NON OWNED AUTOMOBILES FURNISHED OR AVAILABLE FOR REGULAR USE

Please include below the individual's name(s) and vehicle(s) to apply coverage to if this coverage is desired

Name: _____ Veh # _____ Name: _____ Veh # _____

PRIOR CARRIER INFORMATION

Please indicate below the name of your previous insurer, policy number and expiration date. If you were previously insured under someone else's policy, indicate the policyholder's name. If you did not have a previous insurer, or there is a lapse in coverage, please explain why in the REMARKS section.

Previous Insurer: _____ Policy Number: _____ Expiration Date: _____

PERSONAL AUTO SCHEDULE OF VEHICLES (ITEMS)
VEHICLE (ITEM) DESCRIPTION, USE, AND COVERAGE INFORMATION

* Use stated amount for Corvettes, converted vans, motor homes, trailers, antiques, classics, motorcycles and recreational vehicles.
 ** Miles to Work/School or Business/Farm/Pleasure.
 *** Examples: air bags, anti-lock brakes, anti-theft devices, multi-car discount, company car discount, physical damage plus coverage, etc.

Veh. #	Year:	Make/Model/Style:	Vehicle Identification Number (VIN):			
Vehicle (Item) Description (if motor home or trailer, please include length):			Cost New \$	Stated Amount* \$	Cost Symbol	Stat Code:
Garaging Address (only if different from Applicant and Primary Garage Location Addresses): City: State: Zip:			Vehicle Use: **			Territory:
Include Liability? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Comprehensive Ded \$ <input type="checkbox"/> Waiver of Glass Ded	<input type="checkbox"/> Collision Deductible \$ <input type="checkbox"/> UM Waiver of Ded.	<input type="checkbox"/> Road Trouble Service Limit \$	<input type="checkbox"/> Additional Expense Limit \$ /\$	<input type="checkbox"/> Motorcycle Medical Payments Limit \$	
Leinholder/Leaseholder Name and Address:			Lease Gap Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No		Loan Gap Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No	
Additional Vehicle (Item) Coverage, Adjustment, and/or Discount Information ***						

Veh. #	Year:	Make/Model/Style:	Vehicle Identification Number (VIN):			
Vehicle (Item) Description (if motor home or trailer, please include length):			Cost New \$	Stated Amount* \$	Cost Symbol	Stat Code:
Garaging Address (only if different from Applicant and Primary Garage Location Addresses): City: State: Zip:			Vehicle Use: **			Territory:
Include Liability? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Comprehensive Ded \$ <input type="checkbox"/> Waiver of Glass Ded	<input type="checkbox"/> Collision Deductible \$ <input type="checkbox"/> UM Waiver of Ded.	<input type="checkbox"/> Road Trouble Service Limit \$	<input type="checkbox"/> Additional Expense Limit \$ /\$	<input type="checkbox"/> Motorcycle Medical Payments Limit \$	
Leinholder/Leaseholder Name and Address:			Lease Gap Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No		Loan Gap Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No	
Additional Vehicle (Item) Coverage, Adjustment, and/or Discount Information ***						

Veh. #	Year:	Make/Model/Style:	Vehicle Identification Number (VIN):			
Vehicle (Item) Description (if motor home or trailer, please include length):			Cost New \$	Stated Amount* \$	Cost Symbol	Stat Code:
Garaging Address (only if different from Applicant and Primary Garage Location Addresses): City: State: Zip:			Vehicle Use: **			Territory:
Include Liability? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Comprehensive Ded \$ <input type="checkbox"/> Waiver of Glass Ded	<input type="checkbox"/> Collision Deductible \$ <input type="checkbox"/> UM Waiver of Ded.	<input type="checkbox"/> Road Trouble Service Limit \$	<input type="checkbox"/> Additional Expense Limit \$ /\$	<input type="checkbox"/> Motorcycle Medical Payments Limit \$	
Leinholder/Leaseholder Name and Address:			Lease Gap Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No		Loan Gap Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No	
Additional Vehicle (Item) Coverage, Adjustment, and/or Discount Information ***						

ADDITIONAL INSURED NAME AND INTEREST

NAME	INTEREST

UNDERWRITING QUESTIONS

Answer all questions - explain any "Yes" answers in the REMARKS section

YES NO

- 1. Has any Auto-Owners Group company provided coverage for this applicant in the past 5 years?
 If so, provide the policy number(s). _____
- 2. Does any driver require a financial responsibility filing?
- 3. Has any driver had a license suspension or revocation during the past 5 years?
- 4. Are there any drivers not listed on this application who operate any of these vehicles at any time?
- 5. Are there any other drivers in the household not listed on this application?
- 6. After physically inspecting all vehicles, is there existing damage or is any vehicle in an unsafe driving condition?
- 7. Are any of the vehicles to be insured owned by someone other than the applicant (except leased vehicles)?
- 8. Is any vehicle used in a business for transportation of merchandise or passengers for hire?
- 9. Has any vehicle been altered, modified or converted in any way or has any vehicle title been branded?
- 10. Has the applicant's insurance ever been canceled or nonrenewed? (non-payment or underwriting reasons)
- 11. Has any household member been convicted of other than a traffic violation in the last 5 years?
- 12. Does any driver have any physical impairment that may impact safe operation of the vehicle?
 If "Yes", explain how the impairment is compensated for.
- 13. Has the applicant been insured on a nonstandard policy within the last 12 months?
 If "Yes", please check eligibility guidelines prior to binding coverage.

AGENT'S REMARKS

REJECTION OF MEDICAL, HOSPITAL AND INCOME DISABILITY BENEFITS

Arkansas statute requires us to provide minimum Medical, Hospital and Income Disability Benefits for injuries, without regard to fault, to:

- 1. The named insured;
- 2. Family members residing in the same household;
- 3. Passengers while occupying the insured motor vehicle; and
- 4. Persons other than those occupying another vehicle struck by the insured motor vehicle,

You have the right to reject any or all of these coverages. In accordance with Arkansas law:

- I reject Medical and Hospital Benefits.
- I reject Income Disability Benefits.

X

Applicant's Signature

X

Date

OPTION TO MODIFY OR REJECT UNINSURED AND UNDERINSURED MOTORIST COVERAGES

Arkansas statute requires us to offer Uninsured Motorist Coverage in an amount not less than \$25,000 per person/ \$50,000 per occurrence for Bodily Injury and Uninsured Motorist Property Damage in an amount not less than \$25,000 per accident. I have been offered higher limits for these coverages but reject these higher limits with my signature provided here

Applicant's Signature

Arkansas statute allows you to reject Uninsured Motorist Coverage in its entirety or to reject only the property damage portion of the Uninsured Motorist Coverage. Uninsured Motorist Coverage provides protection for insured persons who are legally entitled to recover damages from owners or operators of an uninsured motor vehicle. Uninsured Motorist Property Damage provides coverage to the insured vehicle for losses in excess of \$200.

Arkansas statute allows you to reject Underinsured Motorist Coverage. Underinsured Motorist Coverage provides protection for insured persons who are legally entitled to recover damages for bodily injury from the owner or operator of an underinsured vehicle.

In accordance with Arkansas Insurance Laws:

- I reject both Uninsured Motorist Coverage and Underinsured Motorist Coverage.
- I reject Uninsured Motorist Property Damage Coverage only.
- I reject Underinsured Motorist Coverage only.

All other policy terms and conditions apply.

X

Applicant's Signature

X

Date

APPLICANT'S STATEMENT INSURANCE FRAUD/IMPORTANT NOTICE

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.

IMPORTANT NOTICE REGARDING THE FAIR CREDIT REPORTING ACT: In making this application for insurance, it is understood that as part of our underwriting procedure, we may develop information using one or more of the following: physical inspections of the vehicle(s), consumer reports, motor vehicle records and independently maintained records of previously filed claims. You will be notified whenever information from a consumer reporting agency results in an adverse action.

In connection with this application for insurance, we may review your credit report or obtain or use a credit based insurance score based on the information contained in that credit report. We may use a third party in connection with the development of your insurance score.

The facts stated on this application are true to the best of my knowledge and are to be relied upon by the Company for the purpose of issuing the insurance that I have requested, and any renewals of this insurance. I understand that if I am not eligible for a specific Company, program, or rating tier for which I have applied, my policy may be issued or renewed in a different program or rating tier or by another Company within the Auto-Owners Insurance Group: Auto-Owners Insurance Company, Home-Owners Insurance Company, Owners Insurance Company, Property-Owners Insurance Company and Southern-Owners Insurance Company (all companies may not be licensed in all states). I also understand that the rates and coverages may be different among the Auto-Owners Insurance Group Companies writing in this state. I have discussed my specific insurance needs with my agent in order to determine the most appropriate policy for my situation.

X

Applicant's Signature

X

Date

TO BE COMPLETED BY AGENT

The coverage requested in this application is subject to all terms and conditions of the policy regularly issued by the Company in this state. The coverage requested is bound only when the time and effective date are indicated on the front of the application.

Coverage is bound Coverage is not bound

X _____
Agent's Signature

X _____
Date

PROXY DESIGNATION

(applicable only to the Auto-Owners Company)

I designate R.H. Simon, J.F. Harrold, and R.J. Rupp, and each of them, my attorneys and proxies, with power of substitution and revocation to each, to vote as my proxy at all meetings of the Company, and at any and all adjournments thereof. The powers hereunder shall be exercised by a majority of said attorneys and proxies so present, but if only one is so present, then that one shall have full power to act.

X _____
Applicant's Signature

X _____
Date

SUPPLEMENTAL QUESTIONNAIRE FOR SPECIAL VEHICLES/ITEMS ONLY

The following are questions that apply to motorcycles, motor homes, recreational vehicles and trailers for each of these types of vehicles you may wish to be insured by our Company. Please answer ALL questions that pertain to the vehicle(s). If a motor home is over 5 years old, please submit a photo. Explain all "Yes" answers below.

Veh. #	Vehicle (Item) Description (if motor home or trailer, please include length):
YES NO	
<input type="checkbox"/> <input type="checkbox"/>	1. Is the vehicle used for commercial or business purposes?
<input type="checkbox"/> <input type="checkbox"/>	2. Is the vehicle a converted bus or converted van?
<input type="checkbox"/> <input type="checkbox"/>	3. Is the vehicle used as a principal residence?
<input type="checkbox"/> <input type="checkbox"/>	4. Is the vehicle rented or leased to others?
<input type="checkbox"/> <input type="checkbox"/>	5. Is the vehicle on a foundation or permanently installed?
PLEASE ANSWER THE QUESTIONS BELOW (IF APPLICABLE)	
1.	What is the annual mileage of the vehicle? _____ Miles
2.	How many years of driving experience does the applicant have with this type of vehicle? _____ Years
3.	What is the principal use of this vehicle? _____
4.	Who are the operators of the vehicle? _____

Veh. #	Vehicle (Item) Description (if motor home or trailer, please include length):
YES NO	
<input type="checkbox"/> <input type="checkbox"/>	1. Is the vehicle used for commercial or business purposes?
<input type="checkbox"/> <input type="checkbox"/>	2. Is the vehicle a converted bus or converted van?
<input type="checkbox"/> <input type="checkbox"/>	3. Is the vehicle used as a principal residence?
<input type="checkbox"/> <input type="checkbox"/>	4. Is the vehicle rented or leased to others?
<input type="checkbox"/> <input type="checkbox"/>	5. Is the vehicle on a foundation or permanently installed?
PLEASE ANSWER THE QUESTIONS BELOW (IF APPLICABLE)	
1.	What is the annual mileage of the vehicle? _____ Miles
2.	How many years of driving experience does the applicant have with this type of vehicle? _____ Years
3.	What is the principal use of this vehicle? _____
4.	Who are the operators of the vehicle? _____

Veh. #	Vehicle (Item) Description (if motor home or trailer, please include length):
YES NO	
<input type="checkbox"/> <input type="checkbox"/>	1. Is the vehicle used for commercial or business purposes?
<input type="checkbox"/> <input type="checkbox"/>	2. Is the vehicle a converted bus or converted van?
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<input type="checkbox"/> <input type="checkbox"/>	4. Is the vehicle rented or leased to others?
<input type="checkbox"/> <input type="checkbox"/>	5. Is the vehicle on a foundation or permanently installed?
PLEASE ANSWER THE QUESTIONS BELOW (IF APPLICABLE)	
1.	What is the annual mileage of the vehicle? _____ Miles
2.	How many years of driving experience does the applicant have with this type of vehicle? _____ Years
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<i>TOI:</i>	<i>19.0 Personal Auto</i>	<i>Sub-TOI:</i>	<i>19.0001 Private Passenger Auto (PPA)</i>
<i>Product Name:</i>	<i>Personal Automobile</i>		
<i>Project Name/Number:</i>	<i>PPA/79157 PPA</i>		

Rate Information

Rate data does NOT apply to filing.

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Product Name: Personal Automobile
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Supporting Document Schedules

Satisfied -Name: Uniform Transmittal Document-
Property & Casualty

Review Status: Approved 08/28/2008

Comments:

Attachment:

79157 Transmittal.pdf

Property & Casualty Transmittal Document

1. Reserved for Insurance Dept. Use Only	2. Insurance Department Use only a. Date the filing is received: b. Analyst: c. Disposition: d. Date of disposition of the filing: e. Effective date of filing: <table style="width: 100%; border: none;"> <tr> <td style="width: 60%; border: none;">New Business</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;">Renewal Business</td> <td style="border: none;"></td> </tr> </table> f. State Filing #: g. SERFF Filing #: h. Subject Codes	New Business		Renewal Business	
New Business					
Renewal Business					

3. Group Name	Group NAIC #

4. Company Name(s)	Domicile	NAIC #	FEIN #	State #

5. Company Tracking Number	
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Contact Info of Filer(s) or Corporate Officer(s) [include toll-free number]

6.	Name and address	Title	Telephone #s	FAX #	e-mail

7. Signature of authorized filer	
8. Please print name of authorized filer	

Filing information (see General Instructions for descriptions of these fields)

9. Type of Insurance (TOI)	
10. Sub-Type of Insurance (Sub-TOI)	
11. State Specific Product code(s)(if applicable)[See State Specific Requirements]	
12. Company Program Title (Marketing title)	
13. Filing Type	<input type="checkbox"/> Rate/Loss Cost <input type="checkbox"/> Rules <input type="checkbox"/> Rates/Rules <input type="checkbox"/> Forms <input type="checkbox"/> Combination Rates/Rules/Forms <input type="checkbox"/> Withdrawal <input type="checkbox"/> Other (give description)
14. Effective Date(s) Requested	New: <input type="text"/> Renewal: <input type="text"/>
15. Reference Filing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16. Reference Organization (if applicable)	
17. Reference Organization # & Title	
18. Company's Date of Filing	
19. Status of filing in domicile	<input type="checkbox"/> Not Filed <input type="checkbox"/> Pending <input type="checkbox"/> Authorized <input type="checkbox"/> Disapproved

Property & Casualty Transmittal Document—

20. This filing transmittal is part of Company Tracking #

21. Filing Description [This area can be used in lieu of a cover letter or filing memorandum and is free-form text]

22. Filing Fees (Filer must provide check # and fee amount if applicable)
[If a state requires you to show how you calculated your filing fees, place that calculation below]

Check #:
Amount:

Refer to each state's checklist for additional state specific requirements or instructions on calculating fees.

***Refer to the each state's checklist for additional state specific requirements (i.e. # of additional copies required, other state specific forms, etc.)

PC TD-1 pg 2 of 2

FORM FILING SCHEDULE

(This form must be provided ONLY when making a filing that includes forms)
 (Do not refer to the body of the filing for the forms listing, unless allowed by state.)

1.	This filing transmittal is part of Company Tracking #	
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2.	This filing corresponds to rate/rule filing number (Company tracking number of rate/rule filing, if applicable)	
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3.	Form Name /Description/Synopsis	Form # Include edition date	Replacement Or withdrawn?	If replacement, give form # it replaces	Previous state filing number, if required by state
01			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
02			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
03			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
04			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
05			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
06			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
07			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
08			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
09			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
10			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		

PC FFS-1

RATE/RULE FILING SCHEDULE

(This form must be provided ONLY when making a filing that includes rate-related items such as Rate; Rule; Rate & Rule; Reference; Loss Cost; Loss Cost & Rule or Rate, etc.)

(Do not refer to the body of the filing for the component/exhibit listing, unless allowed by state.)

1.	This filing transmittal is part of Company Tracking #	
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2.	This filing corresponds to form filing number (Company tracking number of form filing, if applicable)	
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Rate Increase
 Rate Decrease
 Rate Neutral (0%)

3.	Filing Method (Prior Approval, File & Use, Flex Band, etc.)	
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4a.	Rate Change by Company (As Proposed)						
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Company Name	Overall % Indicated Change (when applicable)	Overall % Rate Impact	Written premium change for this program	# of policyholders affected for this program	Written premium for this program	Maximum % Change (where required)	Minimum % Change (where required)

4b.	Rate Change by Company (As Accepted) For State Use Only						
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Company Name	Overall % Indicated Change (when applicable)	Overall % Rate Impact	Written premium change for this program	# of policyholders affected for this program	Written premium for this program	Maximum % Change	Minimum % Change

5. Overall Rate Information (Complete for Multiple Company Filings only)			
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		COMPANY USE	STATE USE
5a	Overall percentage rate indication (when applicable)		
5b	Overall percentage rate impact for this filing		
5c	Effect of Rate Filing – Written premium change for this program		
5d	Effect of Rate Filing – Number of policyholders affected		

6.	Overall percentage of last rate revision	
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7.	Effective Date of last rate revision	
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8.	Filing Method of Last filing (Prior Approval, File & Use, Flex Band, etc.)	
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9.	Rule # or Page # Submitted for Review	Replacement or withdrawn?	Previous state filing number, if required by state
01		<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	
02		<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	
03		<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	