

Aug. 7. 2014_11:05AM Licensing Services



COMMON CARRIER OF PROPERTY
(Including Household Goods Carriers and Brokers)

1515 South Boulevard, Suite 300
Richmond, VA 23220
Phone: 800.664.1772
Fax: 804.516.1211
Website: www.doi.state.va.us
Registration Number: 10000000000000000000000000000000

APPLICATION FOR REINSTATEMENT -- FEE \$100.00
(Per VAAC 480-14-220)

Applications for Reinstatement of a Cancelled Common Carrier permit must be within 10 months of the cancellation date of the permit. If over 10 months, you must submit a new application form.

Common Carrier # 062488 to be reinstated.

Legal Name: ITUNACIO AYALA

Trade Name(s), dba(s), if any: SABWAYO TRUCKING

Business (Mailing) Address: 640 S. MYLDE RD. OFFICE
WA. 98344

Physical Address (if different): SOME

Phone number: 509-488-2084

Email address: N/A USDOT #: 1932605

Unified Business Identifier Number (UBI): 602-648-360

Type of Business Structure:

Individual Partnership Limited Liability Company Corporation State of Inc. _____

NAME	TITLE	ADDRESS	PERCENTAGE OF SHARES
ITUNACIO AYALA	OWNER	640 S MYLDE RD. OFFICE, WA. 98344	100%

For Official Use Only 111-0266-200-02	Receipt Date: <u>08/17</u>	ID: <u>A94145</u>
	Insurance:	Docket TV: <u>173314</u>
Receipt ID:	Payment ID:	

Rec'd 9/9



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
9/17/2014

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Sloan-Leavitt Insurance Agency, Inc. PO Box 449 91 South 6th Ave. Othello WA 99344		CONTACT NAME: kristine Madera PHONE (A/C No. Ext): (509) 488-9623 FAX (A/G. No): (509) 488-2143 E-MAIL ADDRESS: kristine-madera@leavitt.com PRODUCER CUSTOMER ID #: 00003099	
INSURED IGNACIO AYALA DBA: SAHUAYO TRUCKING 640 S Taylor Rd Othello WA 99344		INSURER(S) AFFORDING COVERAGE INSURER A: Progressive NAIC # 024260 INSURER B: INSURER C: INSURER D: INSURER E: INSURER F:	

COVERAGES **CERTIFICATE NUMBER: CL129302813** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL. SUBR INSR	WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	GENERAL LIABILITY <input type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC						EACH OCCURRENCE	\$
							DAMAGE TO RENTED PREMISES (Ea occurrence)	\$
							MED EXP (Any one person)	\$
							PERSONAL & ADV INJURY	\$
							GENERAL AGGREGATE	\$
							PRODUCTS - COMP/OP AGG	\$
								\$
A	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input checked="" type="checkbox"/> ALL OWNED AUTOS <input checked="" type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> NON-OWNED AUTOS			03262854-0	09/03/2014	09/03/2015	COMBINED SINGLE LIMIT (Ea accident)	\$ 750,000
							BODILY INJURY (Per person)	\$ 750,000
							BODILY INJURY (Per accident)	\$
							PROPERTY DAMAGE (Per accident)	\$
							Business Auto	\$
							Underinsured Motorist	\$ 300,000
	UMBRELLA LIAB <input type="checkbox"/> OCCUR EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DEDUCTIBLE RETENTION \$						EACH OCCURRENCE	\$
							AGGREGATE	\$
								\$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below		Y/N	N/A			WC STATUTORY LIMITS	OTH-ER
							E.L. EACH ACCIDENT	\$
							E.L. DISEASE - EA EMPLOYEE	\$
A	Cargo			03262854-0	09/03/2014	09/03/2015	E.L. DISEASE - POLICY LIMIT	\$
								10,000
							Ded.	1,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

CERTIFICATE HOLDER (360) 586-1181 WUTC 1300 S. Evergreen Park Drive PO BOX 47250 Olympia, WA 98504-7250	CANCELLATION SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. AUTHORIZED REPRESENTATIVE Darling Veliz/DAVELI
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