

CALIFORNIA AUTOMOBILE ASSIGNED RISK PLAN COMMERCIAL POLICY CHANGE REQUEST
THIS POLICY CHANGE REQUEST FORM MUST BE PRINTED IN INK OR TYPED

NOTICE: PRODUCER MUST READ THIS STATEMENT BEFORE PROCEEDING

Applicants requiring filings or a limit of liability in excess of \$750,000 combined single limit will be subject to a 15-day delay in the effective date as specified in Section 46 of the California Automobile Assigned Risk Plan.

Name of Insured, Address and Legal Status (As shown on Policy Declarations)

Policy No.		Policy Effective Date	Name of Insurer	
Producer's Name/Agency Name		Producer's Mailing Address		
License No.		Fax No. (incl. area code)	Telephone No. (incl. area code)	
Signing Producer (If the producer completing and signing this application is the producer of record, indicate SAME)		First Name	MI	Signing Producer License No.

1. <input type="checkbox"/> VEHICLE DELETION	Veh. No.	Year	Make	Vehicle Identification No.
	How was vehicle disposed? <input type="checkbox"/> Sold <input type="checkbox"/> Other (describe)			

2. <input type="checkbox"/> REPLACEMENT VEHICLE OR <input type="checkbox"/> ADDED VEHICLE	Veh. No.	a. Year, Trade Name, Body Type-Truck, Truck-Tractor Trailer, Semi-Trailer, Model No.	Load Capacity	Type of Registration	Gross Vehicle Weight Rating (GVWR) Trucks Only	Spec. Ind. (M-T-FD-SD-WD-F-D-C-L-O)	Seating Capacity		
		b. Vehicle Identification No.		State of Registration	Rating Classification	Size (L-M-H- EH-HT- EHT)	Gross Comb. Weight (GCW) Truck-Trailers Only	For Size Bus. Rad. (L-I-LD)	Tank Capacity
		c. Garaging Location (City/State/Zip)						Final Rating	How veh. Is licensed
		d. Name of Registered Owner of Vehicle		Rating Territory					
	1.	a.							
		b.							
		c.							
		d.							

Territory(ies) in which, or through which, vehicles are customarily operated _____
 Use of Vehicle _____
☐ Supplemental Commercial Vehicle Schedule attached.

3. COVERAGES <small>In Accordance with Plan Rules</small>	Add <input type="checkbox"/>	Change <input type="checkbox"/>	Delete <input type="checkbox"/>	Applicable To Vehicle:	Year	Make	Vehicle Identification No.
Check Applicable Box →	Bodily Injury Liability <input type="checkbox"/>	Property Damage Liability <input type="checkbox"/>	Medical Payments (PPA's only) <input type="checkbox"/>	Uninsured Motorists Coverage - BI <input type="checkbox"/>	Uninsured Motorists Coverage - PD (PPA's only) <input type="checkbox"/>		
Limits/Ded.	\$	\$	\$1,000	\$	\$		
Premium	\$	\$	\$	\$	\$		

☐ Hired Car Coverage Estimated Annual Cost of Hire \$ _____ Estimated Premium \$ _____
☐ Nonowned Auto Liability – No. of employees using their autos on business _____ Estimated Premium \$ _____
 Estimated Annual Premium \$ _____
 Deposit (40% of Estimated Annual Premium or Pro Rata Premium for the remainder of Policy Period, whichever is less) \$ _____
 Make check payable to insurer and mail directly to Insurance Company, not to the Plan.
Payment must be submitted in the form of a producer's trust account check, certified check, bank check, money order, or premium finance company check or draft.
Note: If MCS 90, MCS 90B, FMCSA, Bus Regulatory Act, state or local filings are required of this risk, check may be a producer's trust account check, certified check, bank check, or money order payable to the servicing carrier. Make check payable to servicing carrier and mail directly to the servicing carrier, not to the Plan.
 When federal filings or endorsements are required, a CAIP Inspected Units Form must be completed and accompany this Policy Change Request Form.

NOTE: BI AND PD LIMITS WILL BE ISSUED AT MINIMUM FINANCIAL RESPONSIBILITY LIMITS REQUIRED BY LAW FOR THE RISK INSURED.

3.a COVERAGE FOR ACTS OF UNINSURED MOTORISTS: 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, their 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 subdivision (p) of Section 11580.2 of the Insurance Code.

REDUCTION OF COVERAGE: The Uninsured Motorists provisions also permit the insurer and the applicant to agree to provide the coverage in an amount less than that required by subdivision (m) of Section 11580.2 of the Insurance Code but not less than the financial responsibility requirements.

DAMAGE TO YOUR VEHICLE: (This provision Applies Only to Private Passenger Vehicles That Are Subject to Commercial Assignment) In addition, the California Insurance Code requires insurers to offer coverage for damage to your vehicle caused by an uninsured motor vehicle to the extent that you, the insured party, are legally entitled to recover from the owner or operator of the uninsured motor vehicle. Such property damage coverage will either: (1) pay the collision deductible on the insured motor vehicle, if it is covered by collision insurance, or (2) pay for damage to the insured motor vehicle, if it is not covered by collision insurance. This coverage will not pay for damage to personal property other than the vehicle or for loss of use of the vehicle, and it will not exceed the smallest of any the following: (1) The amount of the collision deductible; (2) the actual cash value of the insured motor vehicle; or (3) \$3,500. You may reject uninsured motorist coverage completely or reject it only when an insured motor vehicle is operated by a natural person or persons that you designate by name. If you reject uninsured motorist coverage for bodily injury, you must also reject uninsured motorist coverage for property damage; however, you may elect to obtain uninsured motorist bodily injury coverage without obtaining uninsured motorist property damage coverage.

ALL RISKS: It shall be presumed that an application for a policy of bodily injury liability insurance containing uninsured motorist coverage if an amount less than that required by Insurance Code Section 11580.2, Subdivision (m), signed by you (the named insured) and approved by the insurer, shall be a valid agreement as to the amount of uninsured motorist coverage to be provided.

3.b. REJECTION OF UNINSURED MOTORISTS 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 or of damage to my motor vehicle. I have applied this day for coverage under an automobile liability insurance policy, and the company providing such coverage and I have agreed as follows to delete uninsured motorist coverage from that insurance policy:

1. ☐ I elect to delete completely uninsured motorist coverage for all insureds.
2. ☐ I elect to retain uninsured motorist coverage at reduced limits of \$15,000 per person or \$30,000 per accident.
3. ☐ I elect to retain uninsured motorist coverage at reduced limits of \$25,000 per person or \$50,000 per accident.

The following elections apply to applicants wishing to insure at least one private passenger vehicle that is subject to commercial assignment:

4. ☐ I elect to delete uninsured motorist coverage for property damage coverage but retain uninsured motorist coverage for bodily injury.
5. ☐ I elect to delete uninsured motorist coverage for property damage but retain uninsured motorist coverage for bodily injury at reduced limits of \$15,000 per person or \$30,000 per accident.
6. ☐ I elect to delete uninsured motorist coverage for property damage but retain uninsured motorist coverage for bodily injury at reduced limits of \$25,000 per person or \$50,000 per accident.

Applicant's Signature **X** _____ Date _____ Hour _____ ☐ A.M. ☐ P.M.

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.

4. OPERATOR INFORMATION	<input type="checkbox"/> Delete Operator: Name _____							
	Name (Last, First, Middle Initial)		Date of Birth		License No. and State			
	1. _____		_____		_____			
	2. _____		_____		_____			
4a. ACCIDENTS Have additional operators been involved, either as owner or operator, in any motor vehicle accident during the past thirty-six months? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", complete the following. (If necessary, use a separate sheet.)								
Name of Operator		Accident Date Mo./Day/Yr.	Place of Accident City State		B.I. or Death Amount	Property Damage Amount	Physical Damage Amount	
4b. CONVICTIONS Have additional operators been convicted or forfeited bail at any time during the immediately preceding thirty-six months? Note: A paid ticket or fine is an admission of guilt and therefore constitutes a conviction. Convicted: <input type="checkbox"/> Yes <input type="checkbox"/> No Forfeited Bail: <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", for either item, complete the following. (If necessary, use a separate sheet.)								
Name of Operator		Date of Conviction or Forfeiture of Bail Mo./Day/Yr.	Did Conviction arise as a result of an accident?	Nature of Conviction		Place of Conviction City State	Penalty	Was License suspended or revoked?
			<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

5. CHANGE

<input type="checkbox"/> Name/Ownership*	New Name				
<input type="checkbox"/> Address	New Address				
<input type="checkbox"/> Legal Status*	New Legal Status	<input type="checkbox"/> Individual	<input type="checkbox"/> Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> Other _____

*Note: Name and/or Ownership Change Form must accompany this request.

6. FILING OR CERTIFICATES

NOTE: When federal filings or endorsement are required, a CAIP Inspected Units Form must be completed and accompany this Policy Change Request Form. The insured's name must be identical to the name as it appears on the Department of Transportation (DOT) or Department of Public Safety (DPS) permit to avoid rejection.

Is a federal filing of specific limit(s) of liability needed? ☐ Yes ☐ No If "Yes" to comply with:

(Answering "Yes" to any of the 4 filings below will require completion of the CAIP Inspected Units form.)

☐ Motor Carrier Act of 1980 Type: ☐ 1 ☐ 2 ☐ 3 ☐ 4☐ Bus Regulatory Act of 1982 ☐ Motor Carrier No.☐ U. S. DOT No. _____

Is a state or local filing or specific limit(s) of liability needed? ☐ Yes ☐ No If "Yes" to comply with:

☐ Local Ordinance (attach copy) ☐ State Regulation☐ PUC No. _____ ☐ Other _____

If block(s) are checked, list state(s) and city(ies) requiring filings or limits of liability required by law.

Is applicant required to file evidence of financial responsibility? ☐ Yes ☐ No If "Yes", complete below:

Name _____ Social Security No. _____

☐ Owner's (To allow for operation of owned vehicles) ☐ Operator's (To allow for operation of non-owned vehicles) ☐ Both

State where filing required _____ Case of File No. _____ Reason for filing _____

7. POLICY CANCELLATION

☐ Cancel policy Reason for cancellation:

When a CAARP Commercial Auto Insurance Policy is cancelled, the premium refund determined in accordance with Plan rules may be based on .90 of the pro rata unearned premium for the period of coverage, subject to a minimum premium of \$250 per policy, whichever is greater.

Applicants requiring filings or a limit of liability in excess of \$750,000 combined single limit will be subject to a 15-day delay in the effective date as specified in Section 46 of the California Automobile Assigned Risk Plan.

8. FRAUD STATEMENT

ANY PERSON WHO KNOWINGLY MAKES AN APPLICATION FOR MOTOR VEHICLE INSURANCE COVERAGE CONTAINING ANY STATEMENT THAT THE APPLICANT RESIDES OR IS DOMICILED IN THIS STATE WHEN, IN FACT, THE APPLICANT RESIDES OR IS DOMICILED IN A STATE OTHER THAN THIS STATE, IS SUBJECT TO CRIMINAL PENALTIES.

FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM.

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

9. EFFECTIVE DATE: This request form having been completely and duly executed shall be, from the effective date and time shown below, evidence of changes as specified subject to all the term and conditions of the policy and the rules of the CA Automobile Assigned Risk Plan.

Effective Date and Time _____ ☐ A.M. **IN NO EVENT SHALL ADDITIONAL COVERAGE BE EFFECTIVE PRIOR TO THE**
 _____ ☐ P.M. **DATE AND HOUR OF COMPLETION OF THIS REQUEST FORM.**

IN NO EVENT SHALL ADDITIONAL COVERAGE BE EFFECTIVE PRIOR TO THE DATE AND HOUR OF COMPLETION OF THIS REQUEST FORM.

By _____ Date _____ Hour _____ ☐ A.M. ☐ P.M.
(Producer's Signature)

I declare and certify that, to the best of my knowledge and belief, all statements contained in this Policy Change Request are true.

By _____ Date _____ Hour _____ ☐ A.M. ☐ P.M.
(Applicant's Signature)

(Person Authorized to Sign for Additional Named Insured) _____ Date _____ Hour _____ ☐ A.M. ☐ P.M.
(Title)

This form is not, in and of itself, a binding commitment to provide the coverages requested herein. Such coverages are to be provided only as required by the rules of the CA Automobile Assigned Risk Plan.

10. ATTACHMENTS

Include the following attachments, if applicable

1. Deposit Premium Payment
2. Copy of Vehicle Payment
3. Copy of Driver's License
4. Supplemental Operator Schedule
5. Supplemental Vehicle Schedule
6. CAIP Inspected Units Form

11. REMARKS