CLEAR FORM

ALASKA PLAN MISCELLANEOUS POLICY CHANGE REQUEST FORM

Complete all applicable sections and mail to:

Alaska Automobile Insurance Plan
PO Box 6530
Providence, RI 02940-6530

Insured Name			**POLICY NUMBER**
Last Name	First Name	MI	

Producer Name	**Phone Number**	**Producer License**

Driver Information ☐ Delete Driver: Name:

☐ Added Drivers *List Below:*

Name	Relationship to Insured	% Use of Veh 1	% Use of Veh 2	Birth Date Mo	Birth Date Day	Birth Date Yr	Sex M-F	Marital Status	Driver's License No.	ST	Licensed 3 Yrs? Yes	Licensed 3 Yrs? No	If No, Give License Date
								S			☐	☐	
								S			☐	☐	

Added Drivers Occupation:

Change

Indicate Change in the Space Below

☐ Name
☐ Address
☐ Garaging
☐ Mailing
☐ Phone

Vehicle Suspension

Vehicle Being Suspended or Reinstated →	Year	Make	Model	Vehicle Identification Number

Check coverages to be suspended or reinstated:
☐ Bodily Injury ☐ Property Damage ☐ Medical Payments ☐ UM ☐ Collision

Suspension Date:

Reinstatement Date:

(Note: Comprehensive coverage can not be suspended)

☐ **CANCEL POLICY**

Remarks:

This request form having been completed and duly executed shall be, from the effective date and time shown below, evidence of changes as specified subject to all the terms and conditions of the policy and the rules of the Alaska Automobile Insurance Plan.

Effective Date and Time ____ Month ____ Day ____ Year ____ Hour ❒A.M. ❒P.M.

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

Producers Signature _____ Date:_____ Hour: _____ ❒ A.M. ❒ P.M.

I declare and certify that: To the best of my knowledge and belief that all statements contained in this Policy change Request are true.

ALASKA: I (WE) authorize the Department of Public Safety, Division of Motor Vehicles to release the driving record of any operator of these vehicles to the Alaska Automobile Insurance Plan and/or the company.

Applicants Signature: _____ Date: _____ Hour: _____ ❒ A.M. ❒ P.M.

AIP-1341 (Rev. 1/22)