POLICY CHANGE REQUEST
AUTOMOBILE INSURANCE PLAN
PRIVATE PASSENGER /COMMERCIAL
Complete all applicable sections and Mail to Insurance Company.

Name of Insurance Company

Policy Number

Name of Insured and Registered Owner

Producer	Telephone No. (Incl. Area Code)	Producer's License Number	Producer's Tax ID Number

Street City State Zip Code

1. VEHICLE DELETION ☐

No. 1 Year Make Vehicle Identification No.

No. 2 Year Make Vehicle Identification No.

2. a. Private Passenger

Year	Make	Model Name & Body Style	Vehicle Identification No.	Cyls.

Replacement Vehicle ☐ Added Vehicle ☐

H.P./Cu. In./CC	Purchased Mo. Yr.	New ☐	Used ☐	Leased ☐	Cost New	Damaged * Yes ☐ No ☐	Altered * Yes ☐ No ☐	Damaged Glass * Yes ☐ No ☐

Use and Classification

Pleasure ☐	Business ☐	Comm. ** ☐	Farm ☐	Work/School ☐	Principal Place of Garaging	Miles to Work/School or to Transportation	State of Registration	Cust Equp ACV above $1,500 (VA only)

* If yes, detail in Remarks section.

** Applicable only for motorcycles used for commercial purposes.

☐ Loss Payee ☐ Lessor	Name and Address	Territory	Rate Class	Penalty Points	Symbols Comp.	Symbols Coll.	Age Group

Principal Operator's Name % of Use

Additional Drivers Name(s) % of Use

b. Commercial

Replacement Vehicle ☐ Added Vehicle ☐

Year	Vehicle Identification No.	Load Capacity	Type of Registration	Gross Vehicle Weight Rating (GVWR) Trucks only	Spec. Industry (M-T-FD-SD-WD-F-D-C-L-O)	Seating Capacity
Trade Name/ Model No.	Garage Location (City/State)	State of Registration	Rating Classification	Gross Comb. Weight (GCW) Trucks-Tractors only	For Size Bus. Rad. (L-I-LD)	Tank Capacity
Type (1)	Name of Registered Owner of Vehicle	Rating Territory (2)	Orig. Cost New (3) / Comp. Symbol	Coll. Symbol / Size (L-M-H-EH-HT-EHT)	Final Rating	Purpose of Use (S-R-C)

List all cities through and in which vehicles operate

(1) Type - Truck=T, Truck-Tractor=TT, Trailer=TR, Semi-Trailer=ST, Public Auto=PA (2) For public automobiles, use the highest rated territory where the vehicles pick up or discharge passengers. (3) Chassis and Body including Special Equipment.

c. If Public Auto, give: Use of Vehicle (e.g. taxi, limo, van pools) _____

Territory(ies) in which, or through which, vehicles are customarily operated _____

3. COVERAGES In Accordance with Plan Rules

Add ☐ Change ☐ No Change ☐ Delete ☐ Applicable To Vehicle: Year Make Vehicle Identification No.

	Vehicle 1 Limit/Deductibles	Vehicle 1 Premiums	Vehicle 2 Limit/Deductibles	Vehicle 2 Premiums
Bodily Injury Liability				
Property Damage Liability				
Personal Injury Protection				
☐ Full Coverage ☐ $250 ☐ $500 ☐ $1,000 Deductible (DE)****				
☐ Restricted ☐ Unrestricted (Motorcycles only, DE)****				
Medical Expense Benefits $50,000 or $100,000 (DC)				
Work Loss Benefits $12,000 or $24,000 (DC)				
Funeral Benefits $4,000 (DC)				
Medical Payments Coverage (WV) *****				
Medical Expense*				
Loss of Income**				
Uninsured Motorists Coverage +***				
Alternative Uninsured Motorists Coverage +***				
Underinsured Motorists Coverage ++				
Comprehensive and Collision				
Comprehensive				
Collision				
Loss of Use Coverage (DE) +++				
Estimated Premium $			Estimated Premium $	

☐ I Accept ☐ Reject Transportation Expenses (private passenger only – up to $600) (VA ONLY)

3. COVERAGES (continued)

*(VA ONLY) Medical Expense: ☐ $500 ☐ $1000 ☐ $2000 ☐ $5000

**(VA ONLY) Loss of Income Payments with $100 Weekly Disability Coverage

***(VA ONLY) ☐ I reject the limits of UM/UIM equal to the liability limits and select the above. ☐ I elect Alternative UM Coverage

Named Insured's Signature_____

Rejection of Additional Uninsured Motorists Coverage (UM) by any named insured shall be binding on all insureds under the policy.

Election of Alternative Uninsured Motorists Coverage by any named insured shall be binding on all insureds under the policy

**** (DE ONLY) For Deductibles please check one box.
☐ Applicable to Named Insured Only.
☐ Applicable to Named Insured and Members of Household.

+I ☐ Accept ☐ Reject UM Coverage (DE only)

++I ☐ Accept ☐ Reject UIM Coverage (DC, DE and WV)

*****(WV ONLY) Medical Payments ☐ $1,000 ☐ $2,000 ☐ $5,000

+++I ☐ Accept ☐ Reject Loss of Use Coverage (DE only)

Does vehicle contain Customized Equipment? ☐ Yes ☐ No If "Yes", Stated Amount Premium for your Customized Equip. Coverage: $ _____

☐ Hired Auto Coverage: Estimated Annual Cost of Hire $_____ Estimated Premium $_____ (Truckers – If vehicles hired without operators include wages to $100 weekly per operator in cost.)

Nonowned Auto Liability Coverage: Total No. of Employees: ☐ 0-25 ☐ 26-100 ☐ 101-500 ☐ 501-1,000 ☐ over 1,000

Fast Food Delivery – Average number of employees who operate their own autos and primary bodily injury and property damage is in effect _____;

Average number of employees who operate their own autos and primary bodily injury and property damage is **not** in effect _____.

Social Service Agency (VA) – No. of employees _____; No. of volunteers _____

All Other Risks – Total number of employees for all locations _____

Estimated Annual Premium $_____ Deposit (In accordance with the rules of the Plan, or pro rata, whichever is less) $_____

*****(VA ONLY) If Alternative UM is elected, all applicants must read and sign the Virginia Uninsured Motorists Coverage (Alternative Coverage) Selection form VA 1005 07 23–found at https://www.aipso.com/PlanSites/Virginia This notice must be submitted with this application.**

4. Loss Payee/Lessor Additional Insured (DC & VA) Add ☐ Change ☐ Delete ☐ Applicable To Vehicle: Year Make Vehicle Identification No.

Name of Loss Payee/Additional Insured Street City State Zip Code

5. OPERATOR INFORMATION ☐ Delete Driver: Name:

*Marital Status: S-Single, M-Married, W-Widowed, D-Divorced, P-Separated, CU-Civil Union (DE Only) Sex** M-F-X (VA only)

☐ Added Drivers	Name	Occupation	Relationship to Insured	% Use of Veh. 1	% Use of Veh. 2	Birthdate Mo. Day Yr.	Sex M-F-X	Marital Status*	Drivers License No. and State	Licensed 3 Years Yes	Licensed 3 Years No, Give Date Issued

Is driver eligible for DRIVER TRAINING CREDIT? ☐ Yes ☐ No If "Yes", submit school certificate.

5a. ACCIDENTS HAVE ADDITIONAL DRIVERS BEEN INVOLVED AS OWNER OR OPERATOR IN ANY MOTOR VEHICLE ACCIDENT WITHIN 36 MONTHS?

☐ No ☐ Yes If Yes, complete the following

Accident Date	Place of Accident Town	Place of Accident State	Bodily Injury Or Death Yes	Bodily Injury Or Death No	Prop. Damage Amount (Incl. Your Own)	Chargeable Yes	Chargeable No
			☐	☐	$	☐	☐
			☐	☐	$	☐	☐
			☐	☐	$	☐	☐

Explain under "REMARKS," if the above Accident(s) Not Chargeable Under the Rules of the Plan.

5b. CONVICTIONS HAVE ADDITIONAL DRIVERS BEEN CONVICTED OR FORFEITED BAIL AT ANY TIME DURING THE IMMEDIATELY PRECEDING 36 MONTHS?
NOTE: A Paid Ticket or Fine is an Admission of Guilt and therefore Constitutes a Conviction.

☐ No ☐ Yes If Yes, complete the following

Date of Conviction	Did Conviction Arise as a Result of Accident Yes	Did Conviction Arise as a Result of Accident No	Nature of Violation	Place of Conviction Town	Place of Conviction State
	☐	☐			
	☐	☐			
	☐	☐			

6. FILING OR CERTIFICATE

NOTE: Producers completing this Section must be guided by the following: If a filing is requested, a CAIP Inspected Units Form must be completed, signed, and submitted for any applicant who requires a Federal Highway Administration (FHWA) or Federal Motor Carrier Safety Administration (FMCSA) filing or endorsement.

6. a. **FINANCIAL RESPONSIBILITY:** Is additional driver(s) required to file evidence of financial responsibility? ☐ Yes ☐ No If "Yes", explain in detail under "Remarks."

6. b. **FILING OR SPECIFIC LIMITS OF LIABILITY:** Are filings required? ☐ Motor Carrier No. ☐ PUC ☐ Other_____ (Explain in Remarks)

6. c. **MOTOR CARRIER ACT OF 1980:** **Type of Carriage** ☐ 1 ☐ 2 ☐ 3 ☐ 4
Do you have a tow truck that at any time crosses a state line when used in towing operations? ☐ Yes ☐ No
(If "yes," the vehicle is subject to the liability limits required by MCA 1980)

7. CHANGE ☐ Name ☐ Address — New Name Street Apt. City State Zip Code

Reason for Name Change: ☐ Marriage ☐ Divorce ☐ Legal Name Change ☐ Parties to a Civil Union (DE Only)

8. POLICY CANCELLATION

☐ Cancel policy Reason for cancellation:

9. REMARKS:

EFFECTIVE DATE: Coverage will be effective in accordance with the provisions of the Automobile Insurance Plan. IN NO EVENT SHALL ADDITIONAL COVERAGE BE EFFECTIVE PRIOR TO THE DATE AND HOUR OF COMPLETION OF THIS REQUEST FORM.

Effective Date and Time

_____ ☐ A.M. ☐ P.M.

Month Day Year Time

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)

APPLICANT'S STATEMENT

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

By _____ Date _____ Hour _____ ☐ A.M. ☐ P.M.

(Insured's Signature)

NOTE TO INSURED AND PRODUCER: IF ACKNOWLEDGEMENT OF POLICY CHANGE IS NOT RECEIVED WITHIN 30 DAYS, IMMEDIATELY NOTIFY THE PLAN.