

**PRIVATE PASSENGER POLICY CHANGE REQUEST  
PENNSYLVANIA  
ASSIGNED RISK PLAN**

**Complete all applicable sections**

Name of Insurance Company		Policy No.
Name of Insured		
Producer	Telephone No. (Incl. Area Code)	Producer's License No.
Address (if changed from Original Application)		City State Zip Code

<b>1. DELETE VEHICLE</b>	Year	Make	Vehicle Identification No.					
<input type="checkbox"/> Replacement Vehicle or <input type="checkbox"/> Added Vehicle	Year	Make	Model Name & Body Style		Vehicle Identification No.	CCs/Cyl.		
	Purchased Mo. Yr.	New Used <input type="checkbox"/> <input type="checkbox"/>	Cost New	Damaged Yes No <input type="checkbox"/> <input type="checkbox"/>	Altered Yes No <input type="checkbox"/> <input type="checkbox"/>	Passive AntiTheft Device (see Plan Manual Rule 29) <input type="checkbox"/> Yes <input type="checkbox"/> No	Restraint System (Check one) <input type="checkbox"/> None <input type="checkbox"/> Passive Seat Belts <input type="checkbox"/> One Airbag Driver's Side <input type="checkbox"/> Two Airbags	
	Does vehicle contain Customized Equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No							
	If "Yes", attach schedule of equipment and state cost of customized equipment: \$ Name and Address of Vehicle's Registered Owner - If leased, attach copy of lease agreement.							
<input type="checkbox"/> Use and Classification	Pleasure <input type="checkbox"/>	To Work <input type="checkbox"/>	Business <input type="checkbox"/>	Comm. <input type="checkbox"/>	Farm <input type="checkbox"/>	Principal Place of Garaging	Miles to Work, School or Transportation	State of Registration
	Principal Operator			Territory		Rate Class	Penalty Points	Symbols Comp. Coll.

<b>2. LOSS PAYEE</b>	Add <input type="checkbox"/>	Change To <input type="checkbox"/>	Delete <input type="checkbox"/>	Applicable To Vehicle: <input type="checkbox"/>	Year	Make	Vehicle Identification No.	
<input type="checkbox"/> Name of Loss Payee		Street		City		State		Zip Code
<input type="checkbox"/> Name of Additional Insured (Lessor)								

<b>3. COVERAGES</b> <small>In Accordance with Plan Rules</small>	Add <input type="checkbox"/>	Change To <input type="checkbox"/>	No Change <input type="checkbox"/>	Delete <input type="checkbox"/>	Applicable To Vehicle: <input type="checkbox"/>	Year	Make	Vehicle Identification No.						
Check Applicable Box →	Bodily Injury Liability	Property Damage Liability	Medical Benefits	First Party Benefits			Extraordinary Med. Ben. Coverage	Uninsured* Coverage	Underinsured* Coverage	Comprehensive	Collision	Loss Of Use		
				Added First Party Benefits		Combination 1st Party Ben.								
				Income Loss	Funeral	Accidental Death								
Limits/Ded.	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	Ded.	\$	Ded.	\$
Premium	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$

\*If applicable, attach appropriate forms.

**Estimated Annual Premium** \$ \_\_\_\_\_ **Deposit (30% of Estimated Annual Premium or Pro Rate Premium for the remainder of policy period, whichever is less.)** \$ \_\_\_\_\_ **Make check payable to insurance company and mail directly to insurance company.**  
**If no company has been assigned, make check payable to the PA Assigned Risk Plan and Mail directly to the Plan.**

<b>4. DRIVER INFORMATION</b>	<input type="checkbox"/> Delete Driver	Name	Reason for Deletion						
<input type="checkbox"/> Added Driver(s)	Name	Relationship to Insured	% Use of Veh. 1 Veh. 2		Birth Date Mo. Day Yr.	Sex M-F	Marital Status	Driver's License No. and State If licensed less than 3 years in PA, list state and prior license no (If not licensed, explain below.)	Licensed 3 Years In United States? Yes No, Give Date Issued
	1.								
	2.								

Has every driver eligible for DRIVER TRAINING CREDIT qualified?  Yes  No If "Yes", submit school certificate.

<b>4a. ACCIDENTS</b>	HAVE ADDITIONAL DRIVERS BEEN INVOLVED AS OWNER OR OPERATOR IN ANY MOTOR VEHICLE ACCIDENT WITHIN 36 MONTHS?							
<input type="checkbox"/> Yes <input type="checkbox"/> No  Complete the following	Name	Place of Accident Town State		Bodily Injury Or Death Yes No		Property Damage/Collision Amount	Chargeable Yes No	
				<input type="checkbox"/> <input type="checkbox"/>		\$	<input type="checkbox"/> <input type="checkbox"/>	
				<input type="checkbox"/> <input type="checkbox"/>		\$	<input type="checkbox"/> <input type="checkbox"/>	

Give Reasons(s) if the Above Accident(s) Not Chargeable Under the Rules of the Plan.

<b>4b. CONVICTIONS</b>	HAVE ADDITIONAL DRIVERS BEEN CONVICTED OF A TRAFFIC VIOLATION 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.	
<input type="checkbox"/> Yes <input type="checkbox"/> No  Complete the following	Date of Violation/Suspension	Nature of Violation/Suspension

<b>5. CHANGE</b>	<input type="checkbox"/> Name New Name	Street	Apt. City	State	Zip Code
	<input type="checkbox"/> Address				
	Reason for Name Change <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Legal Name Change				

**6. POLICY CANCELLATION**

Cancel policy

Reason for cancellation:

**REMARKS**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**EFFECTIVE DATE:** This request form having been completed and duly executed shall be, from the effective date and time shown below, evidence of change as specified subject to all the terms and conditions of the policy and the rules of the Pennsylvania Assigned Risk Plan.

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 all statements contained in this Policy Change Request are true and I have read both sides of this form.**

By \_\_\_\_\_ Date \_\_\_\_\_ Hour \_\_\_\_\_  A.M.  P.M.  
(Applicant's Signature)

**ATTACHMENTS**

**MANDATORY**  Copy of Vehicle Registration(s)

PLEASE PROVIDE COPIES OF ALL OPERATORS' LICENSES.

**IMPORTANT INFORMATION BELOW**

This Policy Change Request Form having been completed and duly executed shall be evidence of changes as specified subject to all the terms and conditions of the policy and the rules of the Pennsylvania Assigned Risk Plan. These changes shall be effective as follows:

a) **For additional vehicles (Note: This does not apply to a change in coverages or addition/deletion of coverages):**

The changes shall be effective in accordance with the provisions of the policy from the date of acquisition of an additional vehicle, provided that the company (or the Plan if no company has yet been assigned to the risk) is notified about the additional vehicle within 30 days of its acquisition, or at 12:01 a.m. on the day following receipt of this Form and the appropriate premium, if there is a failure to provide the notice within 30 days of acquisition;

b) **For any other changes, including additional coverages:**

The effective date and time shown on this Policy Change Request Form shall apply only if this Policy Change Request Form is submitted with the appropriate premium to the Insurance Company (or the Plan if no insurance company has yet been assigned) no later than the first working day after this Form is completed. In no event shall additional coverage be effective prior to the date and hour of completion of this request form.