NORTHEAST REGION
ALTERNATE APPLICATION REPORT FORM

(FOR USE WHEN A PRODUCER IS UNABLE TO USE EASi)

SECTION 1. PLAN (Check appropriate box)

☐ CONNECTICUT ☐ MAINE ☐ NEW HAMPSHIRE ☐ PENNSYLVANIA ☐ VERMONT

SECTION 2. PRODUCER/APPLICANT INFORMATION

a.	Producer Name or Agency Name	Telephone Number (include area code)	Extension	
	Signing Producer	License Number		
	Mailing Address	City	State	Zip Code
b.	Applicant Name	Applicant's Date of Birth (mm/dd/yyyy)		
	Address	City	State	Zip Code

SECTION 3. DATE AND TIME ALTERNATE APPLICATION PROCEDURE WAS USED

Date: ______________________________ Hour: _____________ ☐ A.M. ☐ P.M.

SECTION 4. REASON(S) ALTERNATE APPLICATION SUBMISSION PROCEDURE WAS USED

☐ Unable to connect with the internet. Internet-ISP Service provider: ____________________

☐ Other service provider had technical difficulties (Specify difficulties in Section 5.) Service provider: ____________________

☐ Severe weather conditions affected access/transmit data. (Specify location in Section 5.)

☐ EASi website unavailable. Provide error message given. ____________________

☐ Computer difficulties (Specify difficulties in Section 5.)

☐ Other (Specify in Section 5.)

SECTION 5. SPECIFY REASON(S) ALTERNATE APPLICATION SUBMISSION PROCEDURE WAS USED (Include specific details regarding incident which prohibited use of EASi. If necessary, attach separate sheet of paper.)

SECTION 6. PRODUCER STATEMENT AND SIGNATURE

I hereby certify that the above information is true and accurate to the best of my knowledge and belief. In the event the aforementioned information is found to be inaccurate, the agency/signing producer may be referred to the Plan Board of Governors/Govening Committee and/or the Insurance Regulator for appropriate action.

______________________________ ______________________________

Producer Signature Date

SECTION 7. PRODUCER INSTRUCTIONS

Attach this form to the paper application completed for the aforementioned applicant and mail both forms to the Plan Office as required by Plan language.

PRIVATE PASSENGER/MOTORCYCLE APPLICATION
PENNSYLVANIA ASSIGNED RISK PLAN

ANTI-FRAUD STATEMENT

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

SECTION 1. CERTIFIED PRODUCER OF RECORD

Producer Last Name/Agency Name		Producer First Name			MI
Mailing Address	Ste./Apt. No.	City		State	Zip Code
Producer License No.	Telephone No. (Incl. area code)		Fax No. (Incl. area code)		

SECTION 2. CERTIFIED SIGNING PRODUCER Complete if the producer completing and signing this application differs from Section 1.

Last Name	First Name	MI	Producer License No.

SECTION 3. APPLICANT

Last Name	First Name	MI	Home Telephone No. (Incl. area code)	Business Telephone No. (Incl. area code)
Co-Applicant's Last Name (if applicable)	First Name	MI		

Primary Residence Street Address (Location at which applicant resides at least 51% of the year.)	Ste./Apt. No.	City		
Township	County		State	Zip Code
Mailing Address if different from above	Ste./Apt. No.	City	State	Zip Code

Applicant's former primary addresses (past 3 years) (If necessary, use Remarks Section.)

Street Address	City	State	Zip Code

Is the owner/applicant a licensed operator? ☐ Yes ☐ No **If "No", attach a signed Driver Verification Form to this application.**

SECTION 4. OPERATOR INFORMATION List all operators in household and any other drivers.

Applicant, Operators, and All Other Residents Age 14 Years and Older	Relationship to Applicant	% Use of each Vehicle No.1	No.2	No.3	No.4	Birth Date Mo./Day/Yr.	Sex M/F	*MS	**Driver's License No. If licensed less than 3 yrs. in PA, list state and prior license No.	State	Licensed 3 Years? If "No", give date issued
APPLICANT	APPLICANT										☐ Yes ☐ No _________
											☐ Yes ☐ No _________
											☐ Yes ☐ No _________
											☐ Yes ☐ No _________

*MS Marital Status: S-Single, M-Married, W-Widowed, D-Divorced, P- Separated **If not licensed, explain in Remarks Section.

Applicant's Occupation	Nature of Business		Employer's Name	
Street Address		City	State	Zip Code
Other Driver's Occupation	Nature of Business		Employer's Name	
Street Address		City	State	Zip Code

Has every driver eligible for DRIVER TRAINING CREDIT qualified? ☐ Yes ☐ No If "Yes", submit school certificate.
If all named insureds are 55 years of age or older, have they successfully completed a motor vehicle driver improvement course meeting the standards of the Pennsylvania Department of Transportation? ☐ Yes ☐ No If "Yes", attach a copy of the certificate of course completion to this application.

Staple check here:

Send original signed application with check/money order and required attachments to:

Pennsylvania Assigned Risk Plan
PO Box 6530
Providence, RI 02940-6530

NOTE: For items where space is insufficient, use Remarks Section.

SECTION 5. VEHICLE 1 – VEHICLE INFORMATION AND VEHICLE USE

Year	Make	Model	Body Style	CCs/Cyl.	Purchased Mo./Yr.	☐ New ☐ Used	Cost New

Vehicle Identification No.	Registered Owner's Last Name	First Name

Registered Owner's Street Address (If leased, attach a copy of lease agreement.)

☐ Loss Payee ☐ Add'l Ins'd (Lessor)	Name	Street Address	City	State	Zip Code

☐ Pleasure ☐ To Work /To School ☐ Business ☐ Commercial* ☐ Farm * Applicable only for motorcycles used for commercial purposes.	Miles one way to work, school or transportation	Principal Street Address of Garaging

Applicant address as it appears on registration, if different from Section 3.	State Registered In	Territory	Rate Class	Symbols		Penalty Points
				Comp.	Coll.	

SECTION 5. VEHICLE 2 – VEHICLE INFORMATION AND VEHICLE USE

Year	Make	Model	Body Style	CCs/Cyl.	Purchased Mo./Yr.	☐ New ☐ Used	Cost New

Vehicle Identification No.	Registered Owner's Last Name	First Name

Registered Owner's Street Address (If leased, attach a copy of lease agreement.)

☐ Loss Payee ☐ Add'l Ins'd (Lessor)	Name	Street Address	City	State	Zip Code

☐ Pleasure ☐ To Work /To School ☐ Business ☐ Commercial* ☐ Farm * Applicable only for motorcycles used for commercial purposes.	Miles one way to work, school or transportation	Principal Street Address of Garaging

Applicant address as it appears on registration, if different from Section 3.	State Registered In	Territory	Rate Class	Symbols		Penalty Points
				Comp.	Coll.	

SECTION 5. VEHICLE 3 – VEHICLE INFORMATION AND VEHICLE USE

Year	Make	Model	Body Style	CCs/Cyl.	Purchased Mo./Yr.	☐ New ☐ Used	Cost New

Vehicle Identification No.	Registered Owner's Last Name	First Name

Registered Owner's Street Address (If leased, attach a copy of lease agreement.)

☐ Loss Payee ☐ Add'l Ins'd (Lessor)	Name	Street Address	City	State	Zip Code

☐ Pleasure ☐ To Work /To School ☐ Business ☐ Commercial* ☐ Farm * Applicable only for motorcycles used for commercial purposes.	Miles one way to work, school or transportation	Principal Street Address of Garaging

Applicant address as it appears on registration, if different from Section 3.	State Registered In	Territory	Rate Class	Symbols		Penalty Points
				Comp.	Coll.	

SECTION 5. VEHICLE 4 – VEHICLE INFORMATION AND VEHICLE USE

Year	Make	Model	Body Style	CCs/Cyl.	Purchased Mo./Yr.	☐ New ☐ Used	Cost New

Vehicle Identification No.	Registered Owner's Last Name	First Name

Registered Owner's Street Address (If leased, attach a copy of lease agreement.)

☐ Loss Payee ☐ Add'l Ins'd (Lessor)	Name	Street Address	City	State	Zip Code

☐ Pleasure ☐ To Work /To School ☐ Business ☐ Commercial* ☐ Farm * Applicable only for motorcycles used for commercial purposes.	Miles one way to work, school or transportation	Principal Street Address of Garaging

Applicant address as it appears on registration, if different from Section 3.	State Registered In	Territory	Rate Class	Symbols		Penalty Points
				Comp.	Coll.	

NOTE: For items where space is insufficient, use Remarks Section.

SECTION 6. COVERAGES AND PREMIUMS	As provided by Rules of the Plan.			
Check appropriate boxes for coverage.				
☐ **Clean Risk Rate** ☐ **Other Than Clean Risk Rate**				
The Applicant Elects The Following Tort Option: ☐ **Limited Tort** ☐ **Full Tort Option** **Appropriate Tort Option Selection Notice current form PA-1000 must be signed by the applicant and attached to this application.**	Estimated Vehicle 1 Premiums	Estimated Vehicle 2 Premiums	Estimated Vehicle 3 Premiums	Estimated Vehicle 4 Premiums
Liability (Same limits of liability must be purchased for all vehicles.) ☐ $15,000/30,000 Bodily Injury $5,000 Property Damage ☐ $25,000/50,000 Bodily Injury $10,000 Property Damage ☐ $50,000/100,000 Bodily Injury $25,000 Property Damage ☐ $100,000/300,000 Bodily Injury $50,000 Property Damage Coverage applies to: ☐ Veh. 1 ☐ Veh. 2 ☐ Veh. 3 ☐ Veh. 4				
Medical Benefit (Required) ☐ $5,000 ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ $100,000 Coverage applies to: ☐ Veh. 1 ☐ Veh. 2 ☐ Veh. 3 ☐ Veh. 4				
EXTRAORDINARY MEDICAL BENEFIT COVERAGE (EMBC): Unless the applicant signs the statement provided below, no extraordinary medical benefits coverage will be provided. I request extraordinary medical benefit coverage. **X**____(APPLICANT'S SIGNATURE)				
Income Loss Benefit (Optional) ☐ None ☐ $1,000/$5,000 ☐ $1,000/$15,000 ☐ $1,500/$25,000 ☐ $2,500/$50,000 Coverage applies to: ☐ Veh. 1 ☐ Veh. 2 ☐ Veh. 3 ☐ Veh. 4				
Funeral Benefit (Optional) ☐ None ☐ $1,500 ☐ $2,500 Coverage applies to: ☐ Veh. 1 ☐ Veh. 2 ☐ Veh. 3 ☐ Veh. 4				
Accidental Death Benefit (Optional) ☐ None ☐ $5,000 ☐ $15,000 ☐ $25,000 Coverage applies to: ☐ Veh. 1 ☐ Veh. 2 ☐ Veh. 3 ☐ Veh. 4				
Combination First Party Benefit ($177,500) ☐ Yes ☐ No				
Uninsured Motorist Coverage (Optional) (Not to exceed Bodily Injury Limits) ☐ None ☐ $15,000/$30,000 ☐ $25,000/$50,000 ☐ $50,000/$100,000 ☐ $100,000/$300,000 If "None" is checked, attach a signed Rejection of Uninsured Motorist Protection statement found on current Form PA-2000A to this application. Proceed to Underinsured Motorist Coverage. If uninsured motorist protection is selected and the uninsured motorist limits checked are lower than the Bodily Injury Limits, attach a signed current Form PA-4000UM to this application. Since uninsured motorist protection is selected, d**oes the applicant accept stacked limits of Uninsured Motorist Coverage? ☐ Yes ☐ No If "No", attach a signed Rejection of Stacked Uninsured Coverage Limits statement found on current Form PA-2000B to this application.**				
Underinsured Motorist Coverage (Optional) (Not to exceed Bodily Injury Limits) ☐ None ☐ $15,000/$30,000 ☐ $25,000/$50,000 ☐ $50,000/$100,000 ☐ $100,000/$300,000 If "None" is checked, attach a signed Rejection of Underinsured Motorist Protection statement found on current Form PA-3000A to this application. Proceed to Damage To Your Auto Coverage. If underinsured motorist protection is selected and the underinsured motorist limits checked are lower than the Bodily Injury Limits, attach a signed current Form PA-4000UIM to this application. Since underinsured motorist protection is selected, **does the applicant accept stacked limits of Underinsured Motorist Coverage? ☐ Yes ☐ No If "No", attach a signed Rejection of Stacked Underinsured Coverage Limits statement found on current Form PA-3000B to this application.**				

 NOTE: For items where space is insufficient, use Remarks Section.

SECTION 6. COVERAGES AND PREMIUMS (Continued)	Estimated Vehicle 1 Premiums	Estimated Vehicle 2 Premiums	Estimated Vehicle 3 Premiums	Estimated Vehicle 4 Premiums
Check appropriate boxes for coverage.				
Damage To Your Auto Coverage Comprehensive Deductibles $100 $200 $250 $500 $1,000 Veh. 1 __________ Veh. 2 __________ Veh. 3 __________ Veh. 4 __________				
Collision Deductibles $100 $200 $250 $500 $1,000 Veh. 1 __________ Veh. 2 __________ Veh. 3 __________ Veh. 4 __________				
Any existing damage to vehicle? Veh. 1 ☐ Yes ☐ No Veh. 2 ☐ Yes ☐ No **(If "Yes", state in Remarks Section)** Veh. 3 ☐ Yes ☐ No Veh. 4 ☐ Yes ☐ No				
Loss Of Use Coverage applies to: ☐ Veh. 1 ☐ Veh. 2 ☐ Veh. 3 ☐ Veh. 4				
Customization Of Buy Back (If "Yes", attach schedule of equipment.) Coverage applies to: ☐ Veh. 1 ☐ Veh. 2 ☐ Veh. 3 ☐ Veh. 4				
Extended Non Owned Auto Coverage (If requested, complete Section 6.a.)				
Estimated Total Premium Per Vehicle				
Total Estimated Premium For Vehicles 1 – 4				
Certified Risks - Financial Responsibility ☐ Yes ☐ No (If required, complete Section 8)				
Total Estimated Premium (Discounts and credits reflected. See appropriate section on application.)				

SECTION 6.a. EXTENDED NON OWNED AUTO COVERAGE – PERSONAL AUTO COVERAGE

Is the auto furnished to the individual, spouse, or resident individual for their regular use? ☐ Yes ☐ No
Is primary liability insurance in effect for the auto furnished for regular use? ☐ Yes ☐ No

Name of individual to be covered ____

SECTION 7. PAYMENT PLANS

As applicable.

- ☐ Option 1 - Full Annual Premium
- ☐ Option 2 - Advance Premium Payment of 30% as provided by the Rules of the Plan. (Balance of annual premium to be paid within 30 days after receipt of the policy or notice of premium due.)
- ☐ Option 3 - Installment Premium Payment of 30% as provided by the Rules of the Plan. (Balance of annual premium to be paid in five (5) monthly installments to be completed six (6) months after the policy effective date. A $4.00 installment charge must be paid with each installment.)

In order to ensure timely and proper credit, installment premium payments should be made only to the assigned carrier. Please note that neither the Pennsylvania Assigned Risk Plan nor the producer of record are agents of the assigned carrier.
The assigned carrier may, in certain circumstances, apply the applicant's deposit premium to outstanding earned premium from prior coverage.

Amount Submitted with Application $

SECTION 8. FINANCIAL RESPONSIBILITY

Is applicant or other eligible operator required to file evidence of financial responsibility? ☐ Yes ☐ No

Name	Relationship to Applicant	Resides with Applicant	State where Filing required	Case or File No.	Reason for Filing	Type of Filing*
		☐ Yes ☐ No				
		☐ Yes ☐ No				
		☐ Yes ☐ No				
		☐ Yes ☐ No				

☐ *Owner's (operation of owned vehicles) ☐ Operator's (operation of non-owned vehicles) ☐ Both

SECTION 9. INSURANCE RECORD

Has applicant had insurance in the past? ☐ Yes ☐ No If "Yes", complete the following.
Is there a premium balance due a previous carrier? ☐ Yes ☐ No

Name of applicant's latest carrier	Policy No.	Termination date

Was coverage through Plan? ☐ Yes ☐ No	Was 3 year assignment completed? ☐ Yes ☐ No	If "No", give reason terminated.

SECTION 10. ACCIDENTS

Has applicant/operator or anyone in the household, or anyone who usually drives the applicant's motor vehicle(s), been involved, either as owner or operator, in **ANY** motor vehicle accident during the past THIRTY-SIX months? ☐ Yes ☐ No If "Yes", complete the following. (If necessary, use Remarks Section.)

Name of Operator	Accident Date	Place of Accident	Bodily Injury or	Total Claim Payment

NOTE: For items where space is insufficient, use Remarks Section.

		Town	State	Property Damage	Amount
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	

If the answer to any of the following is "Yes", check "Yes" box and give date of accident.		Date(s) of Accident(s)
1. Applicant's motor vehicle lawfully parked.	☐ Yes	______________
2. Applicant reimbursed by or on behalf of person responsible for the accident or has judgment against such person.	☐ Yes	______________
3. Other person involved in accident was convicted. Applicant or operator was not convicted.	☐ Yes	______________
4. Damaged by "Hit-and-Run" driver and accident reported to police within 24 hours from time of accident.	☐ Yes	______________
5. Other type of accident – non-chargeable under provisions of the Plan. If "Yes", describe in Remarks Section.	☐ Yes	______________

SECTION 11. CONVICTIONS

Has the applicant/operator or anyone in the household, or anyone who usually drives the applicant's motor vehicle(s) been CONVICTED of a TRAFFIC VIOLATION or FORFEITED BAIL at any time during the immediately preceding THIRTY-SIX months? ☐ Yes ☐ No If "Yes", complete the following. (If necessary, use Remarks Section.)

NOTE: A paid ticket or fine is an admission of guilt and therefore constitutes a conviction.

Name of Operator	Date of Conviction	Type of Violation	Place of Conviction	
			Town	State

SECTION 12. REVOCATIONS/SUSPENSIONS

At any time during the immediately preceding THIRTY-SIX months has operator's license or registration of applicant, or anyone who usually drives the applicant's motor vehicle, been suspended or revoked? ☐ Yes ☐ No If "Yes", give details in Remarks Section.

SECTION 13. NON-OWNER

Complete if application is for a non-owner policy.

A. Type of vehicle applicant will operate: ☐ Private Passenger ☐ Commercial ☐ Taxi/Bus ☐ Other (describe)______________________________
B. Vehicle will be operated in applicant's occupation or business? ☐ Yes ☐ No
C. Is vehicle owned by applicant or member of household? ☐ Yes ☐ No
D. If answer to B or C is "Yes", give name of insurance company providing liability coverage. ____
E. Is applicant excluded? ☐ Yes ☐ No

SECTION 14. EVIDENCE OF INSURANCE AND EFFECTIVE DATE OF COVERAGE

This application having been completed and duly executed shall be, from the effective date and time shown below, evidence of insurance in the limits and coverages specified, subject to the following conditions:

Is EASi immediate binding coverage requested? ☐ Yes ☐ No

1. Coverage is effective at the time and on the date shown below, provided the EASi Immediate Binding Procedure authorized by Section 9 of the Pennsylvania Assigned Risk Plan has been utilized. You must make proper payment in accordance with Sections 6 and 7 of this application. The applicant is required to sign this application in the presence of the producer of record. If EASi Immediate Binding is utilized, confirmation of the effective date is established by the EASi Reference Number.
2. If immediate binding coverage is not required, then the effective date of Plan coverage will be as given below in accordance with the provisions of Pennsylvania Plan Section 9.
3. A premium charge will be made for these coverages if the policy, when and as issued, is not accepted by the insured.
4. The insurance afforded hereunder shall be subject to all the terms and conditions of the policy form prescribed for use in accordance with the rules of the Pennsylvania Assigned Risk Plan.

Requested Effective Date and Time: (Not to exceed 30 days from the date of application submission) ______________________________________ Example: 07/01/2002 01:30 PM	DEPOSIT PREMIUM CHECK OR MONEY ORDER NO. (PLEASE PROVIDE LAST 5 DIGITS)

PREMIUM DETERMINATION

I understand that the premium shown on this application and on the PA-1000 Tort Selection Form is an **estimated** premium. The company reserves the right the adjust the premium either prior to or after the issuance of the policy, whenever applicable, as permitted by the Rules and Rates approved by the Pennsylvania Insurance Department. In accordance with Pennsylvania Insurance Department regulations, cash cannot be accepted by the Producer of Record. Premium monies to the Producer of Record shall be only in the form of a bank/postal money order, cashier's check, certified check, premium finance check, or personal check made payable to the Pennsylvania Assigned Risk Plan.

IN NO EVENT SHALL COVERAGE BE EFFECTIVE PRIOR TO THE DATE AND HOUR OF COMPLETION OF THIS APPLICATION

X ______________________________________ Date: ________________________Time:____________☐ A.M. ☐ P.M.
(Applicant's Signature)

PRODUCER OF RECORD STATEMENT

NOTE: For items where space is insufficient, use Remarks Section.

I hereby certify that I am a licensed broker/agent of the State of Pennsylvania, and certified by the Pennsylvania Plan. I have read the Pennsylvania Assigned Risk Plan, have explained the provisions to the applicant, and have included in this application all required information given to me by the applicant. In the event the policy is cancelled or a change is made resulting in a return premium to the insured, I agree to return the unearned commission portion of such return premium.

My signature hereon represents certification of the Producer of Record Statement above AND I certify this application is submitted pursuant to the effective date provisions contained in the Pennsylvania Assigned Risk Plan and accompanied by all coverage/acceptance rejection forms mandated by Act 6.

X ____ Date: ______________________________Time:_____________☐ A.M. ☐ P.M.

(Producer's Signature)

FAIR CREDIT REPORTING ACT NOTICE

In addition to routine verification of information pertinent to the insurance applied for, if the application is by an individual for insurance primarily for personal or family purposes, the insurer to which it is assigned may have an investigative consumer report made including information bearing on character, general reputation, personal characteristics or mode of living and, upon the individual's written request, will disclose in writing the nature and scope of the investigation requested, if such report is procured.

IMPORTANT NOTICE

Insurance companies operating in the Commonwealth of Pennsylvania are required by law to make available for purchase the following benefits for you, your spouse or other relatives or minors in your custody or in the custody of your relatives, residing in your household, occupants of your motor vehicle or persons struck by your motor vehicle:

(1) Medical benefits, up to at least $100,000.

(1.1) Extraordinary medical benefits, from $100,000 to $1,100,000 which may be offered in increments of $100,000.

(2) Income loss benefits, up to at least $2,500 per month up to a maximum benefit of at least $50,000.

(3) Accidental death benefits, up to at least $25,000.

(4) Funeral benefits, $2,500.

(5) As an alternative to paragraphs (1), (2), (3) and (4), a combination benefit, up to at least $177,500 of benefits in the aggregate or benefits payable up to three years from the date of the accident, whichever occurs first, subject to a limit on accidental death benefit of up to $25,000 and a limit on funeral benefit of $2,500, provided that nothing contained in this subsection shall be construed to limit, reduce, modify or change the provisions of section 1715(d) (relating to availability of adequate limits).

(6) Uninsured, underinsured and bodily injury liability coverage up to at least $100,000 because of injury to one person in any one accident and up to at least $300,000 because of injury to two or more persons in any one accident or, at the option of the insurer, up to at least $300,000 in a single limit for these coverages, except for policies issued under the Assigned Risk Plan. Also, at least $5,000 for damage to property of others in any one accident.

Additionally, insurers may offer higher benefit levels than those enumerated above as well as additional benefits. However, an insured may elect to purchase lower benefit levels than those enumerated above.

Your signature on this notice or your payment of any renewal premium evidences your actual knowledge and understanding of the availability of these benefits and limits as well as the benefits and limits you have selected.

If you have any questions or you do not understand all of the various options available to you, contact your agent or company.

If you do not understand any of the provisions contained in this notice, contact your agent or company before you sign.

X ____

(Applicant's Signature)

NOTE: For items where space is insufficient, use Remarks Section.

SECTION 15. APPLICANT'S STATEMENT

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES. **I DECLARE AND CERTIFY THAT:**

1. I have tried and failed to obtain automobile insurance in this state within the 60 days prior to the date of application.
2. To the best of my knowledge and belief all statements contained in this application are true.
3. I do not owe any insurance company for automobile premiums due or contracted during the past 12 months.
4. I designate as Producer of Record for this insurance the producer named in this application and I understand he is not acting as an agent of the Pennsylvania Assigned Risk Plan or any company for the purposes of this insurance.
5. I agree that no coverage will be effective if my premium remittance, which accompanies the application and is forwarded to the assigned carrier, is justifiably dishonored by the financial institution.
6. My primary residence as defined in Section 3 is Pennsylvania.

The producer of record has been unable to obtain coverage for you through the voluntary market. This application is for coverage through the Pennsylvania Assigned Risk Plan. Within twenty (20) days of receipt of this application, you may request in writing that the Insurance Department review the reasons why you were unable to obtain coverage through the voluntary market.

X ____ Date: ___________________________Time:_____________☐ A.M. ☐ P.M.

(Applicant's Signature)

NOTICE TO APPLICANT AND PRODUCER

In the event acknowledgement of coverage is not received with 30 days, notify the Plan Office, PO Box 6530, Providence, RI 02940-6530. Please give application case number.

DISCOUNTS AND CREDITS SECTION

Does Driver Improvement Course Discount apply? ☐ Yes ☐ No

Discounts and Credits by Operator	Driver Training Credit
Operator 1	☐ Yes
Operator 2	☐ Yes
Operator 3	☐ Yes
Operator 4	☐ Yes

Discounts and Credits by Vehicle	Restraint System Passive Seat Belt	Restraint System One Airbag on Operator's side	Restraint System Two Airbags	Passive Anti-Theft Device (see Plan Manual Rule 41)	Limited Drive to Work
Vehicle 1	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes
Vehicle 2	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes
Vehicle 3	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes
Vehicle 4	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes

ATTACHMENTS

COPY OF VEHICLE REGISTRATION **MANDATORY** FOR EACH VEHICLE
COPY OF DRIVERS LICENSE FOR EACH OPERATOR
APPROPRIATE COVERAGE ACCEPTANCE/REJECTION FORMS
SIGNATURE REQUIREMENTS FOR THE FOLLOWING SECTIONS OF THE APPLICATION:
- SECTION 6. COVERAGES
- PREMIUM DETERMINATION SECTION
- IMPORTANT NOTICE SECTION
- SECTION 15. APPLICANT'S SIGNATURE

DEPOSIT PREMIUM
COPY OF PREMIUM FINANCE CONTRACT
COPY OF FOREIGN DRIVER'S LICENSE*
COPY OF INTERNATIONAL DRIVING PERMIT*
*IF THE ABOVE ARE CHECKED, ATTACH A COPY OF ONE OF THE FOLLOWING:
(1) A VALID PASSPORT
(2) A VALID ALIEN REGISTRATION RECEIPT (GREEN CARD)
(3) A VALID EMPLOYMENT AUTHORIZATION CARD ISSUED BY THE UNITED STATES DEPARTMENT OF HOMELAND SECURITY
(4) A VALID PROOF OF NONIMMIGRANT CLASSIFICATION ISSUED BY THE UNITED STATES DEPARTMENT OF HOMELAND SECURITY

NOTE: For items where space is insufficient, use Remarks Section.

REMARKS SECTION

NOTE: For items where space is insufficient, use Remarks Section.