ALASKA AUTOMOBILE INSURANCE PLAN POLICY CHANGE REQUEST FOR
VEHICLE DELETION / COVERAGE CHANGES

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

Vehicle Deletion	❒	Year	Make	Model	Style	Vehicle Identification Number

Coverages	❒ Change ❒ Delete ❒ No Change						
	Bodily Injury Liability	Property Damage Liability	Medical Payments Coverage	UMBI*	UMPD	Comp & Collision	
Indicate Limits and/or Deductible						Deductible	

*** If deleting, adding or changing UM coverages YOU MUST complete Form AIP 1364 and ATTACH!!**

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.

Producer 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.

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

Remarks: