

**ALASKA
AUTOMOBILE INSURANCE PLAN
COMMERCIAL POLICY CHANGE REQUEST**

Name of Insurance Company	Policy Number
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Complete all applicable sections and mail to Insurance Company.

Name of Insured	(Last Name, First Name, M.I.)
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Producer	Telephone (Incl. Area Code)	Producer's License Number
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Street	City	State	Zip Code
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1. VEHICLE DELETION	Vehicle No.1	Year	Make	Vehicle Identification No.
<input type="checkbox"/>	No.2			

2. VEHICLE ADDITION a. Private Passenger Type Replacement Vehicle <input type="checkbox"/> or Added Vehicle <input type="checkbox"/>	Year	Make	Model Name & Body Style	Vehicle Identification No.	Cyls.				
	H.P./Cu.In./CC		Purchased	New Used	Cost New	Damaged Yes No	Altered Yes No	Damaged Glass Yes No	Garaged Yes No
			Mo. Yr.	<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Use and Classification	Pleasure <input type="checkbox"/>	Business <input type="checkbox"/>	Comm <input type="checkbox"/>	Farm <input type="checkbox"/>	Principal Place of Garaging		Miles to Work or to Transportation	Estimated Annual Mileage	State of Registration
	Address of Applicant as Appears on Registration				Territory	Rate Class	Penalty Points	Symbols	Model Year/ Age Group
								Comp. Coll.	

* SEE PLAN MANUAL FOR EXPLANATION						Classes*/Factors						
b. Commercial Type Replacement Vehicle <input type="checkbox"/> or Added Vehicle <input type="checkbox"/>	Year, Trade Name, Body Type—Truck, Truck-Tractor Trailer, Semitrailer, Bus Seating Capacity, Model No.			Purpose of Use P&B = Pleas. & Bus. C = Commercial		Purchased Mo./Yr.	New Used	*Gross Vehicle Weight Rating (GVWR) Trucks Only	*Size (L-M-H-EH)	*Radius (L-I-L-D)	*For Size Bus Rad.	
				Rating Classification	Orig. Cost New **	Comp. Symbol	Coll. Symbol	*Gross Comb. Weight (GCW) Truck-Tractors Only	*Business Use (S-R-C)	*Spec. Ind. (C-T-FD-SD-WD-F-D-L-O)	Special Industry	Final Rating
	a. Identification No.		State of Registr.									
	c. Garaging Location (Town, State)		Rating Territory									
	a.							lbs.				
	b.											
	c.							lbs.				

** Chassis and Body including Special Equipment
b. (1) If Public Auto, give: Use of Vehicle (e.g. taxi, limo, van pool) _____

Territory (ies) in which or through which vehicle is customarily operated _____

3. LOSS PAYEE	Add <input type="checkbox"/>	Change <input type="checkbox"/>	Delete <input type="checkbox"/>	Applicable To Vehicle:	Year	Make	Vehicle Identification No.
Name of Loss Payee		Street			City		State Zip Code

4. COVERAGES In Accordance with Plan Rules	Add <input type="checkbox"/>	Change <input type="checkbox"/>	No Change <input type="checkbox"/>	Delete <input type="checkbox"/>	Applicable To Vehicle:	Year	Make	Vehicle Identification No.
Check Applicable Box →	Bodily Injury Liability	Property Damage Liability	Medical Payments Coverage	Uninsured Motorists Coverage	Underinsured Motorists Coverage	Uninsured Motorist Property Damage Coverage	Comprehensive And Collision	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Limits/Ded.	\$	\$	\$	\$	\$	\$	\$ Ded.	
Premium	\$	\$	\$	\$	\$	\$	\$	

Does the vehicle contain Custom Equipment other than original manufacturer equipment? ☐ Yes ☐ No
If "yes," insert Actual Cash Value above \$1,500 _____. Premium for Custom Equipment Coverage:\$_____.

Estimated Annual Premium \$	_____
Deposit (25% 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, not the Service Center.	

Coverage for Acts of Uninsured/Underinsured Motorists and Physical Damage Coverage for Damage to Rental Auto.

You must complete a Coverage for Acts of Uninsured/Underinsured Motorists and Physical Damage Coverage for Damage to Rental Auto Form (AIP 1364) for these coverage selections and rejections and submit the completed form with this Policy Change Request Form.

Driver Information Release Form

You must complete a Driver Information Release Form (AIP 1363) and submit the completed form with this Policy Changes Request Form.

AORDP Inspected Units Form

You must complete an AORDP Inspected Units Form and submit the completed form with this Policy Change Request Form when federal filings or endorsements are required.

5. DRIVER INFORMATION

☐ Delete Driver: Name: _____

<input type="checkbox"/> Added Drivers	Name	Relationship to Insured	% Use of		Birth Date			Sex M-F	Marital Status	Driver's License Number and State	Licensed 3 Yrs.	
			V 1	V 2	Mo.	Day	Yr.				Yes	No—Give Date Issued

5a. ACCIDENTS

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

<input type="checkbox"/> No <input type="checkbox"/> Yes Complete the following	Name of Operator	Accident Date	Place of Accident		Bodily Injury Or Death		Property Damage Amount	Chargeable	
			Town	State	Yes	No		Yes	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.

<input type="checkbox"/> No <input type="checkbox"/> Yes Complete the following	Name of Operator	Date of Conviction	Did Conviction Arise as a Result of Accident		Nature of Violation	Place of Conviction Town	State
			Yes	No			

6. FILING AND CERTIFICATES

NOTE: When federal filings or endorsement are required, a CAIP Inspected Units Form must be completed and accompany this Policy Change Request Form. The insured's name must be identical to the name as it appears on the Department of Transportation (DOT) or Department of Public Safety (DPS) permit to avoid rejection.

Is a federal filing or specific limit(s) of liability needed? ☐ Yes ☐ No If "Yes" to comply with:
(Answering "Yes" to any of the 4 filings below will require completion of the AORDP Inspected Units form.)

- ☐ Motor Carrier Act of 1980 Type: ☐ 1 ☐ 2 ☐ 3 ☐ 4
☐ Bus Regulatory Act of 1982 ☐ Motor Carrier No. _____
☐ U. S. DOT No. _____

Is a state or local filing or specific limit(s) of liability needed? ☐ Yes ☐ No If "Yes" to comply with:

- ☐ Local Ordinance (attach copy) ☐ State Regulation
☐ PUC No. _____ ☐ Other _____

If block(s) are checked, list state(s) and city(ies) requiring filings or limits of liability required by law.

Is the insured, or any additional operator, required to file evidence of insurance for any driver with any state? ☐ Yes ☐ No If "Yes", complete below:

Last Name _____ First Name _____ MI _____ Tax ID or Social Security No. _____

Type of Filing ☐ Owner's (operation of owned vehicles) ☐ Operator's (operation of nonowned vehicles) ☐ Both

State where filing required _____ Case of File No. _____ Reason for filing _____

Are any other vehicles owned or leased by the insured? ☐ Yes ☐ No

7. CHANGE

- ☐ Name
☐ Address

New Name _____ Street _____ Apt. _____ City _____ State _____ Zip Code _____

8. ATTACHMENTS

- ☐ Signed Application (by both producer and applicant) ☐ Deposit Premium
☐ Copy of Vehicle Registration (**MANDATORY for each vehicle**) ☐ Driver Information Release Form
☐ Supplemental Operator Schedule ☐ Supplemental Vehicle Schedule
☐ AORDP Inspected Units Form

9. REMARKS

EFFECTIVE DATE: 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 Automobile Insurance Plan of this State.

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.

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 the 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 Service Center and/or the insurance company to which this application is assigned.

_____ Date _____ Hour _____ ☐ A.M. ☐ P.M.
(Applicant's Signature)