PRIVATE PASSENGER/MOTORCYCLE POLICY CHANGE REQUEST INDIANA AUTOMOBILE INSURANCE PLAN
Complete all applicable sections

Name of Insurance Company | Policy Number

Name of Insured

Producer	Telephone No. (Incl. Area Code)	Fax No. (Incl. Area Code)	Producer's License No.	Producer's IRS or SSN

Street | City | State | Zip Code

☐ **POLICY CANCELLATION – Please cancel policy per insured's request, insured's signature required.**

Signature _____ Date _____

1. VEHICLE INFORMATION **DELETE VEHICLE** ☐

	Year	Make	Vehicle Identification No.		
Replacement Vehicle ☐ or Added Vehicle ☐	Year	Make	Model Name & Body Style	Vehicle Identification No.	Weight
	H.P. / Cu. In./CC/Cyls.	Purchased Mo. Yr. New ☐ Used ☐	Cost New	*Damaged Yes ☐ No ☐ *If yes, explain in Remarks section.	

☐ Use and Classification	Pleasure ☐	Business ☐	Comm. ☐	Farm ☐	Principal Place of Garaging	Miles to Work or School Transportation	Estimated Annual Mileage	State Registered In

	Name/Address of Insured as Appears on Application	Territory	Rate Class	Penalty Points	Symbols Comp.	Symbols Coll.	Age Group

2. LOSS PAYEE Add ☐ Change To ☐ Delete ☐ Applicable To Vehicle:

Year	Make	Vehicle Identification No.

Name of Loss Payee | Street | City | State | Zip Code

3. COVERAGES In Accordance with Plan Rules — Add ☐ Change To ☐ No Change ☐ Delete ☐ Applicable To Vehicle:

Year	Make	Vehicle Identification No.

Check Applicable Box ➔	Bodily Injury Liability ☐	Property Damage Liability ☐	Medical Payments Coverage ☐	Uninsured Motorist Coverage * ☐ Yes ☐ No	Underinsured Motorist Coverage ☐ Yes ☐ No	Comprehensive and Collision ☐
Limits/Ded.	$	$	$	$	$	$ Ded.
Premium	$	$	$	$	$	$

Other coverages requested (in accordance with Plan) _____

Estimated annual premium $ _____

Total submitted with Policy Change Request $ _____

Make check payable and mail directly to assigned company, not the Plan Office.

4. FINANCIAL RESPONSIBILITY: Is insured or other eligible operator required to file evidence of financial responsibility? Yes ☐ No ☐

If "Yes," complete below:

Name _____

Relationship To Applicant _____

Resides With Applicant ☐ Yes ☐ No

State where Filing Required _____

Case or File Number _____

Reason for Filing _____

Type

Owner's ☐ (to allow for operation of owned vehicles)

Operator's ☐ (to allow for operation of non-owned vehicles)

Both ☐

Do you own any other vehicle? Yes ☐ No ☐ If "Yes," give name of insurance company and policy number: _____

5a. OPERATOR INFORMATION ☐ Delete Operator — Name — Reason for Deletion

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

5b. ACCIDENTS

Has applicant, 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 Death	Prop. Damage (incl. your own) Amount
		City/Town	State		
				☐ Yes ☐ No	$
				☐ Yes ☐ No	$
				☐ Yes ☐ No	$
				☐ Yes ☐ No	$

5c. CONVICTIONS Motor Vehicle and Non-Motor Vehicle

Has the applicant, or anyone who usually drives the applicant's motor vehicle(s), been CONVICTED 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	Did Conviction Arise as a Result of an Accident?	Nature of Violation	Place of Conviction	
				City/Town	State
		☐ Yes ☐ No			
		☐ Yes ☐ No			
		☐ Yes ☐ No			
		☐ Yes ☐ No			

6. ADDRESS CHANGE Street Apt. City State Zip Code

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 Indiana Automobile Insurance Plan.

Effective Date and Time

_____ ☐ A.M. ☐ P.M.

Month Day Year Time

IN NO EVENT SHALL 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)

INSURED'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)

THIS FORM IS NOT, IN AND OF ITSELF, A BINDING COMMITMENT TO PROVIDE THE COVERAGES REQUESTED HEREIN. SUCH COVERAGES ARE TO BE PROVIDED ONLY AS REQUIRED BY THE RULES OF THE INDIANA AUTOMOBILE INSURANCE PLAN AND SHALL BECOME EFFECTIVE IN ACCORDANCE WITH THE RULES OF THE PLAN.