**COMMERCIAL
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 |
| --- | --- | --- | --- | --- |
| | | | | |

| Street | City | State | Zip Code |
| --- | --- | --- | --- |
| | | | |

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

_______________________________ Signature _______________________________ Date

**1. ☐ VEHICLE DELETION**

| Veh. No. | Year | Make | Vehicle Identification No. |
| --- | --- | --- | --- |
| | | | |

How was vehicle disposed? ☐ Sold ☐ Other (describe)

**2. ☐ REPLACEMENT VEHICLE OR ☐ ADDED VEHICLE**

| Veh. No. | | | Load Capacity / State of Registration / Rating Territory | Type of Registration / Rating Classification | * Orig. Cost New | Comp. Symbol | Coll. Symbol | Gross Vehicle Weight (GVW) Trucks Only / Gross Comb. Weight (GCW) Truck-Trailers Only | Size (L-M-H-EH) / Purpose of Use (P or B) (S-R-C) | Radius (L-I-LD) / Spec. Ind. (M-T-FD-SD-WD-F-D-C-L-O) | Seating Capacity / Tank Capacity / Final Rating |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| | a. | Year, Trade Name, Body Type-Truck, Truck-Tractor Trailer, Semi-Trailer, Model No. | | | | | | | | | |
| | b. | Vehicle Identification No. | | | | | | | | | |
| | c. | Garaging Location (Town, State) | | | | | | | | | |
| | d. | Name of Registered Owner of Vehicle | | | | | | | | | |
| | a. | | | | | | | | | | |
| | b. | | | | | | | | | | |
| | c. | | | | | | | | | | |
| | d. | | | | | | | | | | |

* Chassis and Body including Special Equipment

Territory(ies) in which, or through which, vehicles are customarily operated_______________________________

Use of Vehicle_______________________________

☐ Supplemental Commercial Vehicle Schedule attached

**3. COVERAGES**
In Accordance with Plan Rules

Add ☐ Change ☐ Delete ☐ Applicable To Vehicle: Year Make Vehicle Identification No.

| Check Applicable Box ➔ | Liability Limit (Combined Single Limit) ☐ | Medical Payments Coverage ☐ | Uninsured Motorists Coverage ☐ | Other Than Collision Coverage ☐ | Collision Coverage ☐ |
| --- | --- | --- | --- | --- | --- |
| Limits/Ded. | $ | $ | $ | $ 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 Servicing Carrier, not the Plan Office.

**4. LOSS PAYEE**

Add ☐ Change ☐ Delete ☐ Applicable To Vehicle: Year Make Vehicle Identification No.

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

**5a. OPERATOR INFORMATION**

☐ Delete Operator: Name _______________________________

☐ Added Operators

| | Name (Last, First, Middle Initial) | Date of Birth | License No. and State |
| --- | --- | --- | --- |
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

**5b. ACCIDENTS**

Has insured, or anyone who usually drives the insured's 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.

| Name of Operator | Accident Date Mo./Day/Yr. | Place of Accident | | Bodily Injury or Death | Prop. Damage (incl. your own) Amount | Physical Damage Amount |
|---|---|---|---|---|---|---|
| | | City | State | | | |
| | | | | ☐ Yes ☐ No | $ | |
| | | | | ☐ Yes ☐ No | $ | |

**5c. CONVICTIONS** Have additional operators been convicted or forfeited bail at any time during the immediately preceding thirty-six months?
Note: A paid ticket or fine constitutes a conviction.
Convicted: ☐ Yes ☐ No Forfeited Bail: ☐ Yes ☐ No If "Yes", for either item, complete the following. (If necessary, use a separate sheet.)

| Name of Operator | Date of Conviction or forfeiture of bail Mo./Day/Yr. | Did Conviction arise as a result of an accident? | Nature of Conviction | Place of Conviction City/Town | Penalty Points | Was License suspended or revoked? |
|---|---|---|---|---|---|---|
| | | ☐ Yes ☐ No | | | | ☐ Yes ☐ No |
| | | ☐ Yes ☐ No | | | | ☐ Yes ☐ No |

**6. CHANGE**

| | |
|---|---|
| ☐ Name/Ownership* | New Name |
| ☐ Address | New Address |
| ☐ Legal Status* | New Legal Status ☐ Individual ☐ Corporation ☐ Partnership ☐ Other |

*Note: Name and/or Ownership Change Form must accompany this request.

**7. FILING OR CERTIFICATES**

Is filing or Specific Limits of Liability needed to comply with:

☐ Motor Carrier Act of 1980 Type ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Bus. Regulatory Act of 1982 ☐ ICC Regulation - Docket No. ______________________

☐ Local Ordinance (attach copy) ☐ State Regulation ☐ U.S. Dot No.________________________ ☐ Other ______________________________

If block(s) checked, list state(s) /province(s) and cities requiring filings or limits of liability required by law______________________________________________

________________________________________________________________________________________________________

Is applicant required to file evidence of financial responsibility? ☐ Yes ☐ No If "Yes", complete below.

Name ___________________________________________________________________ Tax ID or Social Security No. _________________________________

☐ Owner's (To allow for operation of owned vehicles) ☐ Operator's (To allow for operation of non-owned vehicles) ☐ Both

State where filing required_______________________________ Case of File No.___________________ Reason for filing ____________________________

________________________________________________________________________________________________________

**8. 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 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 Hour

**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)

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 or Person Authorized to Sign for Insured)

**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.**