

PENNSYLVANIA ASSIGNED RISK PLAN COMMERCIAL POLICY CHANGE REQUEST
 THIS POLICY CHANGE REQUEST FORM MUST BE PRINTED IN INK OR TYPED AND
 SUBMITTED TO THE PLAN.

FOR CARRIER'S USE ONLY

Name of Insured, Address and Legal Status (As shown on Policy Declarations)

Policy No. _____ Policy Effective Date _____

Producer's Name and Address _____ License No. _____ Telephone No. (Incl. Area Code) _____

1. VEHICLE DELETION

Vehicle No. _____ Year _____ Make _____ Vehicle Identification No. _____

How was vehicle disposed? Sold (Attach a copy of the bill of sale to this form when ICC/PUC filings have been made on behalf of the named insured.)
 Other (describe) _____

2. REPLACEMENT VEHICLE OR ADDED VEHICLE

IF ADDED VEHICLE, BOX NO. 5 MUST ALSO BE COMPLETED, IF APPLICABLE.

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

Check Applicable Box →	Bodily Injury Liability	Property Damage Liability	First Party Benefits				Extraordinary Med. Ben. Coverage	Uninsured Coverage	Underinsured Coverage	Comprehensive	Collision	Loss of Use
			Medical Benefits	Added First Party Benefits		Combination 1st Party Ben.						
				Income Loss	Funeral							
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Limits/Ded.	\$	\$	\$	\$	\$	\$	\$	\$	\$ Ded.	\$ Ded.	\$	
Premium	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	

Estimated Annual Premium \$ _____

Deposit (30% of Estimated Annual Premium or Pro Rata Premium for the remainder of policy period \$ _____

Prior to assignment, make check payable to Pennsylvania Assigned Risk Plan and mail to the Plan.

Subsequent to assignment, make check payable to Insurance Company and mail directly to the Insurance Company.

4. PHYSICAL DAMAGE Add Change Delete Applicable To Vehicle: _____ Year _____ Make _____ Vehicle Identification No. _____

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

4a. ADDITIONAL INSURED LESSOR Name _____ Street _____ City _____ State _____ Zip Code _____

5. OPERATOR INFORMATION

Delete Operator: Name _____

Name (Last, First, Middle Initial)	Date of Birth	License No. and State
1. _____	_____	_____
2. _____	_____	_____

Added Operators

5a. ACCIDENTS Have additional operators 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 a separate sheet.)

Name of Operator	Accident Date	Place of Accident	B.I. or Death Amount	Property Damage Amount	Physical Damage Amount

5b. 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 is an admission of guilt and therefore 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	Did Conviction arise as a result of an accident?	Nature of Conviction	Place of Conviction	Penalty	Was License suspended or revoked?
		<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No

6 CHANGE (Complete and attach Name and/or Ownership Change Form, if applicable.)

<input type="checkbox"/> Name/Ownership	New Name
<input type="checkbox"/> Address	New Address
<input type="checkbox"/> Legal Status	New Legal Status <input type="checkbox"/> Individual <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other

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) Other _____ U.S. Dot No. _____ State Regulation

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 _____ 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. POLICY CANCELLATION

Cancel policy

Reason for cancellation:

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 Pennsylvania Assigned Risk Plan.

Effective Date and Time _____ A.M. P.M. **IN NO EVENT SHALL ADDITIONAL COVERAGE BE EFFECTIVE PRIOR TO THE DATE AND HOUR OF COMPLETION OF THIS REQUEST FORM.**

Month Day Year Hour

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.

(Applicant's Signature)

If additional named insureds are to be added under this Policy Change Request Form, authorized signatures for each such additional named insured shall be provided below. Such additional named insureds agree to be bound by the statements made by the Applicant in this form.

_____ Date _____ Hour _____ A.M. P.M.

(Person Authorized to Sign for Additional Named Insured) (Title)

This Policy Change Request Form having been completed and duly executed shall be evidence of changes as specified subject to all the terms and conditions of the policy and the rules of the Pennsylvania Assigned Risk Plan. These changes shall be effective as follows:

- a) **For additional vehicles (Note: This does not apply to a change in coverages or addition/deletion of coverages):**
 The changes shall be effective in accordance with the provisions of the policy from the date of acquisition of an additional vehicle, provided that the company (or the Plan if no company has yet been assigned to the risk) is notified about the additional vehicle within 30 days of its acquisition, or at 12:01 a.m. on the day following receipt of this Form and the appropriate premium, if there is a failure to provide the notice within 30 days of acquisition;
 - b) **For any other changes, including additional coverages:**
 The effective date and time shown on this Policy Change Request Form shall apply only if this Policy Change Request Form is submitted with the appropriate premium to the Insurance Company (or the Plan if no insurance company has yet been assigned) no later than the first working day after this Form is completed. In no event shall additional coverage be effective prior to the date and hour of completion of this request form.
- 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 Pennsylvania Assigned Risk Plan.