RHODE ISLAND AUTOMOBILE INSURANCE PLAN COMMERCIAL POLICY CHANGE REQUEST
THIS POLICY CHANGE REQUEST FORM MUST BE PRINTED IN INK OR TYPED

Name of Insured, Address and Legal Status (As shown on Policy Declarations)				
Policy No.		Policy Effective Date		
Producer's Name and Address	License No.	Social Security No.	IRS. 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) ☐ Other (describe)

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

* Chassis & 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

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

Check Applicable Box ➔	Liability (Combined Single Limit)	Medical Payments Coverage*	Uninsured Motorists Coverage		Other Than Collision Coverage	Collision Coverage
	☐	☐	☐ BI***	☐ PD**	☐	☐
Limits/Ded.	$	$	$		$	$
Premium	$	$	$		$	$

* ☐ I Reject Medical Payments Coverage_____
Applicant's Signature

** ☐ I Reject UM Property Damage Coverage for all vehicles

OR

I Reject UM Property Damage Coverage for the following vehicle(s)
☐Veh. 1 ☐ Veh. 2 ☐Veh. 3 ☐Veh. 4 ☐Veh. 5

_____
Applicant's Signature

******* ☐ I Reject the limits of UMBI which would have been equal to the limit for BI and select the limits as shown above._____
Applicant's Signature

Estimated Annual Premium $ _____
Deposit (30% of Estimated Annual Premium or Pro Rata Premium for the remainder of Policy Period, whichever is less $ _____
Make check Payable to Insurance Company and mail directly to Insurance Company, not to 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

5. OPERATOR INFORMATION	
☐ Added Operators	☐ Delete Operator: Name _____

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

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	Chargeable
						Yes ☐ No ☐
						Yes ☐ No ☐

Give Reason(s) if the above Accident(s) not chargeable under the Rules of the Plan in Remarks Section 8.

5.b. CONVICTIONS Have additional operators been Convicted or Forfeited Bail 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?
		☐ Yes ☐ No				☐ Yes ☐ No
		☐ 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) ☐ 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 all the terms and conditions of the policy and the rules of the Automobile Insurance Plan of this State.

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 or Person Authorized to Sign for Applicant)

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 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 Rhode Island Automobile Insurance Plan.