

NEW MEXICO MOTOR VEHICLE INSURANCE PLAN ALTERNATE APPLICATION REPORT FORM

(FOR USE WHEN A PRODUCER IS UNABLE TO USE EASi)

SECTION 1. PLAN Check appropriate box

☐ PRIVATE PASSENGER

☐ COMMERCIAL

SECTION 2. PRODUCER/APPLICANT INFORMATION

a.	Producer Last Name/Agency Name	Telephone Number (include area code)	Extension	
	Signing Producer (If different from Producer of Record)	License Number		
	Mailing Address	City	State	Zip Code
b.	Applicant Name	Applicant's Date of Birth (mm/dd/yyyy)		
	DBA Name			
	Address	City	State	Zip Code
	Mailing Address	City	State	Zip Code

SECTION 3. EFFECTIVE DATE AND TIME ALTERNATE APPLICATION SUBMISSION PROCEDURE USED

Date: _____ Hour: _____ ☐ A.M. ☐ P.M.

SECTION 4. REASON(S) ALTERNATE APPLICATION SUBMISSION PROCEDURE USED

- ☐ Unable to connect with the internet. Internet-ISP Service provider: _____
- ☐ Other service provider had technical difficulties (Specify difficulties in Section 5.) Service provider: _____
- ☐ Severe weather conditions/natural disaster affected access to/transmittal of data. (Specify location in Section 5.)
- ☐ EASi website unavailable. Provide error message given. _____
- ☐ Computer difficulties (Specify difficulties in Section 5.)
- ☐ Other (Specify in Section 5.)

SECTION 5. SPECIFY REASON(S) ALTERNATE APPLICATION SUBMISSION PROCEDURE WAS USED (Include specific details regarding incident which prohibited use of EASi, if necessary, attach separate sheet of paper.)

SECTION 6. PRODUCER STATEMENT AND SIGNATURE

I hereby certify that the above information is true and accurate to the best of my knowledge and belief. In the event the aforementioned information is found to be inaccurate, the producer/signing producer may be referred to the New Mexico Governing Committee and/or the New Mexico Insurance Department for appropriate action.

Producer Signature

Date

SECTION 7. PRODUCER INSTRUCTIONS

Attach this form to the paper application completed for the aforementioned applicant and mail both forms to the Plan Office in accordance with the application Alternate Application Submission Procedures in the New Mexico Plan of Operation.

COMMERCIAL APPLICATION NEW MEXICO MOTOR VEHICLE INSURANCE PLAN

NOTICE: PRODUCER MUST READ THIS STATEMENT BEFORE PROCEEDING

Applicants requiring filings or a limit of liability in excess of \$500,000 Combined Single Limits will be subject to a 15-day delay in the effective date as specified in Section 23 of the New Mexico Motor Vehicle Insurance Plan.

SECTION 1. PRODUCER OF RECORD

Producer Last Name/Agency Name		Producer First Name		MI
Mailing Address		Ste./Apt. No.	City	State Zip Code
Tax ID or Social Security No.	Producer License No.	Telephone No. (inc. area code)		Fax No. (inc. area code)

SECTION 2. SIGNING PRODUCER

Complete if the producer completing and signing this application differs from Section 1.

Last Name	First Name	MI	Signing Producer License No.
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SECTION 3. APPLICANT

Last Name		First Name		MI
DBA				Self Employed <input type="checkbox"/> Yes <input type="checkbox"/> No
Home Telephone No. (inc. area code)	Business Telephone No. (inc. area code)		Tax ID No.	
Street Address	Ste./Apt. No.	City	State	Zip Code
Headquarters Street Address (if different from above)	Ste./Apt. No.	City	State	Zip Code
Business of Applicant/Nature of Operation				

SECTION 4. OWNERSHIP AND CONTROL OF APPLICANT'S ORGANIZATION

Named insured is a: <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietor		State of Incorporation	Date of Incorporation	Date actual operations commenced
<input type="checkbox"/> Other _____				
Management, Ownership and Control (List names of principals and also anyone with more than a 10% ownership interest.)				
President			Date in Position	Percent Ownership
Vice President				
Secretary				
Treasurer				
General Manager				
Others				
List all affiliated companies				

Staple check here: ➔

Send original, signed application with check/money order and required attachments to:

New Mexico Motor Vehicle Insurance Plan
PO Box 6530
Providence, RI 02940-6530

SECTION 5. OPERATOR INFORMATION			List all full-time, part-time, and all other operators that usually drive a vehicle.		TOTAL OPERATORS	
Last Name	First Name	MI	Birth Date Mo./Day/Yr.	Driver's License No.	State	

For applicants with more than four operators, all additional operators must be listed on an AIP3502 Supplemental Operator Schedule and mailed with the original application to the Plan.

SECTION 6. ACCIDENTS							
Has applicant, or anyone who usually drives the applicant's vehicle(s), been involved, either as owner or operator, in <u>ANY</u> motor vehicle accident during the past THIRTY-SIX months? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", complete the following.							
Name of Operator	Accident Date Mo./Day/Yr.	Code*	Place of Accident		Bodily Injury or Death	Prop. Damage (incl. your own) Amount	Penalty Points
			City	State			
					<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	\$	

*Accident Codes
1. Applicant's motor vehicle lawfully parked.
2. Damaged by "Hit and Run" driver and accident reported to police within 24 hours from time of accident.
3. Applicant reimbursed by or on behalf of person responsible for the accident or has judgment against such person.
4. Other person involved in accident was convicted. Applicant or operator was not convicted.
5. Police or Fire Department or First Aid Squad responding to an emergency call.
6. Other type of accident - non-chargeable under provisions of the Plan. Describe accident in space provided below.

SECTION 7. CONVICTIONS							
Has the applicant or anyone who usually drives the applicant's vehicle(s) been CONVICTED or FORFEITED BAIL at any time during the immediately preceding THIRTY-SIX months? Convicted <input type="checkbox"/> Yes <input type="checkbox"/> No Forfeited Bail <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", for either item, complete the following. NOTE: A paid ticket or fine is an admission of guilt and therefore constitutes a conviction.							
Name of Operator	Date of Conviction or bail forfeiture Mo./Day/Yr.	Did Conviction Arise as a Result of an Accident?	Nature of Conviction	Place of Conviction		Penalty Points	Was License Suspended or Revoked?
				City	State		
		<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
		<input type="checkbox"/> Yes <input type="checkbox"/> No					<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 8. COMMODITIES TRANSPORTED					
Identify any hazardous materials, waste or substances being hauled.					
Identify radius of operations. (Number of straight-line, air miles from garaging to furthest destination to which vehicle travels in one direction on a "regular basis". "Regular" is defined as two or more trips per month per vehicle.)					
Trips From Place of Origin To Place of Destination	% of Revenues	No. per Month	Principal Cities entered	Commodities Carried	

SECTION 9. GROSS RECEIPTS		Required for Motor Carriers of Property or Passengers whether or not the policy is to be written on Gross Receipts basis.				
Gross Receipts	Current Year	1st Prior Year	2nd Prior Year	3rd Prior Year	4th Prior Year	
Other than Truckers	\$	\$	\$	\$	\$	
Truckers excluding receipts from trip leased equipment	\$	\$	\$	\$	\$	

SECTION 10. VEHICLE INFORMATION AND USE											TOTAL VEHICLES:
Veh No.	Year	Vehicle Identification No.	Load Capacity (2)	Type of Registration	Gross Vehicle Weight (GVW) Trucks only		Spec. Industry (M-T-FD-SD-WD-F- D-C-L-O)	Seating Capacity	Loss Payee Name		
	Trade Name/ Model No.	Garage Location (Town/State, ZIP Code)	State of Registration	Rating Classification	Gross Comb. Weight (GCW) Trucks-Tractors only		For Size Bus. Rad. (L-LD)	Tank Capacity	Loss Payee Address		
	Type (1)	Name of Registered Owner of Vehicle	Rating Territory (3)	Orig. Cost New (4)	Comp. Symbol	Coll. Symbol	Size (L-M-H- EH-HT- EHT)	Final Rating	How veh. is licensed	Loss Payee City, State, Zip Code	
	List where vehicle is permitted to operate				For Public and Long Distance, list all cities through and in which vehicles operate						
V eh 1											
V eh 2											
V eh 3											
V eh 4											
V eh 5											

(1) Type - Truck=T, Truck-Tractor=TT, Trailer=TR, Semi-Trailer=ST, Public Auto=PA
(2) Truck-Type vehicles with Private Passenger or Combination registration and load capacities of 1500 pound or less are eligible for Basic Reparatons Benefits coverage.
(3) For public automobiles, use the highest rated territory where the vehicles pick up or discharge passengers. (4) Chassis and Body including Special Equipment.

For applicants with more than five vehicles, all additional vehicles must be listed on an AIP3500 Supplemental Vehicle Schedule and mailed with the original application to the Plan.

SECTION 11. COVERAGES AND PREMIUMS		As provided by the Rules of the Plan.				
All vehicles written under the same policy shall have the same Limits of Liability. Check appropriate boxes to indicate limits/deductibles		Vehicle 1 Est. Prem.	Vehicle 2 Est. Prem.	Vehicle 3 Est. Prem.	Vehicle 4 Est. Prem.	Vehicle 5 Est. Prem.
Bodily Injury <input type="checkbox"/> \$25,000/\$50,000 <input type="checkbox"/> Other _____						
Property Damage <input type="checkbox"/> \$10,000 <input type="checkbox"/> Other _____						
UM/UIM - BI – (Complete Sections 11.a. and b. if requested) <input type="checkbox"/> \$25,000/50,000 <input type="checkbox"/> \$50,000/100,000 <input type="checkbox"/> \$100,000/300,000 Stacked/Non-Stacked Options <input type="checkbox"/> Stacked Limits <input type="checkbox"/> Non-Stacked Limits UM/UIM - PD – (Complete Sections 11.a. and b. if requested) <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000 Property Damage Coverage is subject to \$250 Deductible Stacked/Non-Stacked Options <input type="checkbox"/> Stacked Limits <input type="checkbox"/> Non-Stacked Limits						
Nonowned Auto Liability Coverage – (Complete Section 11.c. if requested)						
Hired Car Coverage – (Complete Section 11.d. if requested)						
Medical Payments Coverage (PPA's only) <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$5,000						
Physical Damage – Comprehensive - Deductibles \$100 \$200 \$250 Veh. 1 _____ Veh. 2 _____ Veh. 3 _____ Veh. 4 _____ Veh. 5 _____						
Physical Damage – Collision - Deductibles \$100 \$200 \$250 Veh. 1 _____ Veh. 2 _____ Veh. 3 _____ Veh. 4 _____ Veh. 5 _____						
Estimated Total Premium per vehicle		\$	\$	\$	\$	\$
Total Estimated Premium for vehicles 1 - 5						\$
Total Estimated Premium for supplemental vehicles						\$
Total Estimated Premium for all vehicles						\$

SECTION 11.a. SELECTION OF UNINSURED MOTORISTS INCLUDING UNDERINSURED MOTORISTS COVERAGES

DO NOT SIGN UNTIL YOU READ

Uninsured Motorists including ☐ I ACCEPT ☐ I REJECT
 Underinsured Motorists Coverage: ☐ I SELECT LOWER UM/UIM LIMITS THAN MY POLICY LIMITS

IF YOU REJECT THESE COVERAGES OR SELECT LOWER LIMITS, YOU MUST COMPLETE AND SIGN AIP 1864 (10/12) AND SUBMIT WITH THIS APPLICATION. FORM AIP 1864 IS THE NEXT TO LAST PAGE OF THIS APPLICATION.

I understand and agree that selection of any of the above options applies to my liability insurance policy and future renewals or replacements of such policy, which are issued at the same Bodily Injury Liability Limits. If I decide to select another option at some future time, I must let the company or my producer know in writing.

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

SECTION 11.b. SELECTION OF UNINSURED MOTORISTS INCLUDING UNDERINSURED MOTORISTS COVERAGES LIMITS - STACKED OR NON-STACKED

DO NOT SIGN UNTIL YOU READ

I have selected Uninsured Motorists including Underinsured Motorists Coverages and understand that the option to "stack" or non-stack" limits is available. I have made the decision to select:

(One of the following boxes must be checked.)

- ☐ Stacked Uninsured Motorists including Underinsured Motorists Coverages Limits
☐ Non-Stacked Uninsured Motorists including Underinsured Motorists Coverages Limits

IF YOU REJECT STACKED LIMITS UNINSURED MOTORISTS INCLUDING UNDERINSURED MOTORIST COVERAGES, YOU MUST COMPLETE AND SIGN AIP 1862 (10/12) AND SUBMIT WITH THIS APPLICATION. FORM AIP 1862 IS THE LAST PAGE OF THIS APPLICATION.

I understand and agree that selection of any of the above options applies to my liability insurance policy and future renewals or replacements of such policy unless I notify the company in writing that I have changed my option selection.

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

SECTION 11c. NONOWNED AUTO LIABILITY COVERAGE					
Are any other vehicles owned by the Applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" complete the following.			Are any vehicles hauling exclusively for one firm/carrier? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", complete the following.		
Name of Insurance Company		Policy No.	Name of Firm/Carrier		
Address of Insurance Company			Type of Business		
Description of any owned, leased, hired, and non-owned vehicles, which are <i>not</i> to be insured.					
Year		Trade Make	Body Type		Vehicle Identification No.
Total No. Employees:	What % of the applicant's employees operate their vehicles in the business?		FAST FOOD DELIVERY ONLY ⇨		Average No. Drivers:
SECTION 11.d. HIRED CAR COVERAGE					
<input type="checkbox"/> Check here if desired .		Estimated Annual Cost of Hire	Rates Per \$100		Estimated Premium
			B.I.	P.D.	B.I.
SECTION 11.e. COST OF HIRE					
For policies rated under Trucker's Cost of Hire.) All risks for which a broad form filing or MCS-90 endorsement has been issued.					
		Current Year	1st Prior Year	2nd Prior Year	3rd Prior Year
Indicate the total Cost of Hire, including cost and wages, for vehicles leased or hired on a long-term basis (over 6 months) and specifically insured by applicant as an owned automobile.		\$	\$	\$	\$
Indicate the total Cost of Hire, including cost and wages, for automobiles, which are <i>not</i> specifically insured by the applicant as an owned vehicle but are to be insured as hired automobiles.		\$	\$	\$	\$
Cost of Hire – Represents Total Long and Short Term Cost of Hire.		\$	\$	\$	\$
SECTION 12. FILINGS OR CERTIFICATES					
NOTE: All owned and operated vehicles must be described in this application. All risks for which a filing has been made (except SR-22) are subject to cost of hire rating and nonowned auto liability coverage. If a filing is requested here, the Cost of Hire and Nonowned Auto Liability Coverage sections must be completed. Applicant's name must be identical to name as it appears on ICC or Dept. of Public Safety (DPS) permit to avoid rejection! Is filing or specific limit(s) of liability needed? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" to comply with: <input type="checkbox"/> Motor Carrier Act of 1980 Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> Bus Regulatory Act of 1982 <input type="checkbox"/> ICC Regulation - Docket No. _____ <input type="checkbox"/> Local Ordinance (attach copy) <input type="checkbox"/> State Regulation <input type="checkbox"/> U. S. DOT No. _____ <input type="checkbox"/> Other _____ If block(s) are checked, list state(s) and city(ies) requiring filings or limits of liability required by law.					
Is applicant required to file evidence of financial responsibility (SR-22)? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", complete the following.					
Last Name		First Name		MI	Social Security Number
Type of Filing <input type="checkbox"/> Owner's (operation of owned vehicles) <input type="checkbox"/> Operator's (operation of non-owned vehicles) <input type="checkbox"/> Both					
State where Filing required	Case or file No.	Reason for Filing			
Name any party requiring a certificate of insurance or additional insured endorsement.					
SECTION 13. PAYMENT PLANS					
GROSS DEPOSIT PREMIUMS MUST BE SUBMITTED WITH APPLICATION.					
<input type="checkbox"/> Option 1 - Full Annual Premium <input type="checkbox"/> Option 2 - Premium Deposit with Single Bill Balance <input type="checkbox"/> Option 3 - Installment Premium Payments * ⇨ 5 installments with \$4.00 per installment charge <input type="checkbox"/> Premium to be Financed – Name of Premium Finance Company ** _____		Payment by: <input type="checkbox"/> Cash <input type="checkbox"/> Check		Check/Draft No.	
		Total Estimated Premium		\$	
		Amount Submitted with Application		\$	
		* Not Available on Premium Financed Policies. ** Attach a copy of Premium Finance contract.			
NOTICE TO PREMIUM FINANCE COMPANY – Unearned Premium is based on actual premium, not estimated premium.					

SECTION 14. PREVIOUS AUTOMOBILE INSURANCE CARRIERInformation for the past three years. (If a fleet, information for the past five years required.) **Attach loss statements from previous carrier.**

Name of latest carrier	Policy No.	Termination Date
Was coverage through Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes", give reason terminated.	

Complete the following for carriers of property and passengers:

	Policy No.	Policy Period		Name of Insurance Company
		From	To	
1st Prior Year				
2nd Prior Year				
3rd Prior Year				
4th Prior Year				

SECTION 15. EVIDENCE OF INSURANCE AND REQUESTED EFFECTIVE DATE OF COVERAGE

The Applicant hereby authorizes any insurer that may previously have provided coverage to the Applicant or to additional named insureds to provide records, data or information concerning prior coverage to the Plan or any servicing carrier designated by the Plan. The Applicant agrees that a reproduction of this authorization shall be considered as effective and valid as the original.

1. The application must be fully completed and duly executed.
2. **Specific applicants requiring financial responsibility filings or a limit of liability in excess of \$500,00 combined single limit will be subject to a 15-day delay in the effective date as specified in the New Mexico Motor Vehicle Insurance Plan. Coverage under this evidence of automobile insurance for these specific applicants is to be effective for a period not to exceed 30 days from the effective date of coverage.**
3. Otherwise, coverage under this evidence of automobile insurance is to be effective for a period not to exceed 45 days from the effective date and time stated herein. Within such 45-day period, coverages under this evidence of automobile insurance will terminate immediately upon: (a) the issuance of the policy applied for, (b) the issuance of any policy affording similar insurance, or (c) the cancellation of the insurance coverages afforded hereunder in accordance with the rules of the New Mexico Motor Vehicle Insurance Plan.
4. A premium charge will be made for these coverages if the policy is not accepted.
5. The insurance afforded hereunder shall be subject to all the terms and conditions of the Plan and the policy form prescribed for use.
6. The producer of record must forward this application to the Plan in accordance with Plan rules.

EASi Applications: The original, completed, signed, paper EASi application, deposit, and supporting documentation must be mailed or delivered to the Plan and must be received by the Plan no later than 15 calendar days following the date of transmittal of the EASi application. In the event the EASi application does not meet this submission requirement, coverage will become effective at 12:01 A.M. on the day following the date of mailing as evidenced by the postmark on the envelope accompanying the application or hand-delivery to the Plan. If the postmark is illegible, there is no postmark, or there is a metered mail stamp (without a USPS postmark), coverage will become effective at 12:01 A.M. on the day following receipt by the Plan.

Alternate Application Submission Procedure Applications: The producer of record must forward the original, completed, signed, paper application, deposit, and supporting documentation to the Plan no later than two working days after the application is written. If the application is not submitted within two working days or if the postmark is illegible, there is no postmark, or there is a metered mail stamp (without a USPS postmark), coverage will become effective at 12:01 A.M. on the day following receipt by the Plan.

Note: The postmark to be recognized by the Plan shall be the postmark of the United States Postal Service (USPS). A metered mail stamp (without USPS postmark), electronic stamp, or other postage service or stamp shall not be considered a postmark of the United States Postal Service for the purpose of effecting coverage. Working day shall mean a day on which business is conducted, Monday through Friday, except for legal holidays when the United States Post Office is closed.

Applicants requiring filings or a limit of liability in excess of \$500,000 Combined Single Limits will be subject to a 15-day delay in the effective date as specified in Section 23 of the New Mexico Motor Vehicle Insurance Plan.

Requested Effective Date and Time:
(Not to exceed 45 days from the date of application submission)

Example: 09/ 01/15 11:30 A.M.

IN NO EVENT SHALL COVERAGE BE EFFECTIVE PRIOR TO THE DATE AND HOUR OF COMPLETION OF THIS APPLICATION.

SECTION 16. PRODUCER OF RECORD STATEMENT

YOUR SIGNATURE CERTIFIES THE FOLLOWING.
DO NOT SIGN WITHOUT READING.

I hereby certify that I am a licensed broker/agent of the State of New Mexico. I have read the New Mexico Motor Vehicle Insurance Plan and have explained the provisions to the applicant. I acknowledge that I am acting on behalf of the applicant in submitting this application and have no authority to establish or revise the terms or conditions of coverage. This application includes all required information given to me by the applicant. In the event of cancellation or change to the policy resulting in a reduction of premium, I agree to return the unearned premium to the insured (net of any minimum premium due the carrier) and also to return to the carrier unearned compensation for this insurance received by me as required by the Plan.

My signature hereon represents certification of the Producer of Record Statement AND I certify this application is submitted pursuant to the effective date provisions contained in the New Mexico Motor Vehicle Insurance Plan.

Date: _____ Hour: _____ ☐ AM ☐ PM
Producer's Signature

SECTION 17. APPLICANT'S STATEMENT

YOUR SIGNATURE CERTIFIES THE FOLLOWING. DO NOT SIGN WITHOUT READING.

I, the Applicant, declare and certify that:

1. I have tried and failed to obtain automobile insurance in this state within the preceding 60 days.
2. To the best of my knowledge and belief all statements contained in this application are true and that these statements are offered as an inducement to the Company to issue the policy for which I am applying.
3. I realize that any misleading information or failure to disclose required information will not be considered good faith on my part and may void the application or cause cancellation of my coverage.
4. I hereby agree to pay all premiums when due.
5. I hereby certify that I do not owe any insurance company for automobile premiums due or contracted.
6. I designate as Producer of Record for this insurance the producer or firm named in this application. I may designate a substitute producer at any time and, upon designation, shall be the Producer of Record. I understand that any designated Producer cannot act as an agent of the New Mexico Motor Vehicle Insurance Plan or any carrier for the purpose of this insurance and that the Producer has no authority to establish alter or amend terms or conditions of coverage.
7. I duly authorize the undersigned to execute this application on my behalf if the Applicant is not a natural person.
8. I agree that no coverage will be in effect, if the premium remittance, which accompanies this application, is justifiably dishonored by any financial institution.
9. I understand that the premiums shown on this application are estimated premiums. The carrier reserves the right to adjust the premium either prior to or after the issuance of the policy, whenever applicable.
10. **I understand that if I owe money for a prior New Mexico Motor Vehicle Insurance Plan policy which I have not formally appealed to the New Mexico Motor Vehicle Insurance Plan Governing Committee, the money that I submit with this application for a new New Mexico Motor Vehicle Insurance Plan policy will be applied to that prior policy, and I am not entitled to a refund of the money I have submitted with this application, even if coverage for this new policy is terminated, until I pay the full amount owed for all current and prior New Mexico Motor Vehicle Insurance Plan policies.**
11. When the insurance is to be written on a basis requiring final adjustment of the premium after expiration of the policy I will maintain a complete record of its financial transactions in any reasonable form and manner as the insurer may require. I will also make this record available for inspection by the insurer at a designated place and at all reasonable times.

Date: _____ Hour: _____ ☐ AM ☐ PM_____
Named Applicant's or Corporate Officer's Signature**NOTICE TO APPLICANT AND PRODUCER**In the event acknowledgement of coverage is not received within 45 days, notify the Plan Office at **800-227-4659**.**FAIR CREDIT REPORTING ACT NOTICE**

In addition to routine verification of information pertinent to the insurance applied for, if the application is by an individual for insurance primarily for personal or family purposes, the insurer to which it is assigned may have an investigative consumer report made including information bearing on character, general reputation, personal characteristics or mode of living and, upon the individual's written request, will disclose in writing the nature and scope of the investigation requested, if such report is procured.

REMARKS SECTION

NEW MEXICO MOTOR VEHICLE INSURANCE PLAN

UNINSURED MOTORISTS INCLUDING UNDERINSURED MOTORISTS COVERAGES SELECTION/REJECTION FORM

DO NOT SIGN UNTIL YOU READ

You have a legal right to purchase Uninsured Motorists including Underinsured Motorists Coverages with your automobile liability policy. Uninsured Motorists including Underinsured Motorists Coverages protects you, your family and your passengers for bodily injury or death and for property damage caused by a negligent motorist who does not have liability coverage or enough liability coverage to pay for injuries or damage caused. For a more detailed explanation of this coverage, refer to your policy.

You have a right to purchase Uninsured Motorists including Underinsured Motorists Coverages at limits equal to your policy's liability limit or at limits lower than your policy's liability limits but not less than the minimum financial responsibility limits of New Mexico law; or, you may reject that coverage entirely.

Property Damage coverage is subject to a \$250 deductible.

To select limits lower than your policy's liability limits or to reject Uninsured Motorists including Underinsured Motorist Coverages, you must sign and date this form and it must be made a part of your policy.

Without this form attached, your policy will provide X and you will be charged for X Uninsured Motorists including Underinsured Motorists Coverages at your policy's liability limits.

☐ **I do not wish to purchase Uninsured Motorists including Underinsured Motorists Coverages at limits equal to my liability coverage and I select lower limits of X.**

Please indicate your choice by initialing next to the appropriate item and signing below.

Rejection of Uninsured Motorists including Underinsured Motorists Coverages at Limits Equal to Liability Coverage Limits.

I reject Uninsured Motorists including Underinsured Motorists Coverages at limits equal to the limits of my liability coverage and I select the following lower limits:

Choose one UM/UIM Bodily Injury Limit option AND one UM/UIM Property Damage Limit option from the following.

Initials	UM/UIM Bodily Injury Limit	Premium
	\$25,000/50,000	
	\$50,000/100,000	
	\$100,000/300,000	
	Other:	

Initials	UM/UIM Property Damage Limit	Premium
	\$10,000	
	\$25,000	
	\$50,000	
	Other:	

☐ **I do not wish to purchase Uninsured Motorists including Underinsured Motorists Coverages as part of my Automobile Insurance Policy.**

I understand and agree that this selection/rejection of coverage applies to future renewals or replacements of such policy unless I notify the company in writing that I have changed my option selection.

DO NOT SIGN UNTIL YOU READ

Signed _____
(Named Insured)

Date _____

Attached to policy with an effective date of _____

This selection/rejection form must be endorsed, attached, stamped, or otherwise made a part of the policy to be effective.

NEW MEXICO MOTOR VEHICLE INSURANCE PLAN

UNINSURED MOTORISTS INCLUDING UNDERINSURED MOTORISTS COVERAGES STACKED LIMITS REJECTION FORM

DO NOT COMPLETE THIS FORM IF YOU HAVE REJECTED UNINSURED MOTORISTS INCLUDING UNDERINSURED MOTORISTS COVERAGES.

By signing this waiver, I am rejecting stacked limits of uninsured motorists including underinsured motorists coverages under the policy for myself and the members of my household under which the limits of coverage available would be the sum of limits for each motor vehicle insured under the policy. Instead, the limits of coverage that I am purchasing shall be reduced to the limits stated in the policy.

To reject stacked limits uninsured motorists including underinsured motorists coverages, I must sign and date this form and it must be made a part of my policy.

Because I have elected to purchase Uninsured Motorists including Underinsured Motorists Coverages, if this form is not attached, my policy will provide X and I will be charged for X Stacked Limits Uninsured Motorists including Underinsured Motorists Coverages.

I knowingly and voluntarily reject the stacked limits of coverage. I understand that my premiums will be reduced if I reject this coverage.

I understand and agree that this rejection of Stacked Limits Uninsured Motorists including Underinsured Motorist Coverages applies to future renewals or replacements of such policy unless I notify the company in writing that I have changed my option selection.

DO NOT SIGN UNTIL YOU READ

Signed _____ Date _____
(Named Insured)

Attached to policy with an effective date of _____

This rejection form must be endorsed, attached, stamped, or otherwise made part of the policy to be effective.

AIP 1862 NM UNINSURED/UNDERINSURED MOTORISTS COVERAGE STACKED LIMITS REJECTION FORM (Rev. 10/12)