

# MINNESOTA AUTOMOBILE INSURANCE PLAN ALTERNATE APPLICATION REPORT FORM

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

## SECTION 1. TYPE OF APPLICATION (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		
	Street Address	City	State    Zip Code
	Mailing Address	City	State    Zip Code

## SECTION 3. DATE AND TIME ALTERNATE APPLICATION PROCEDURE WAS USED

Date: \_\_\_\_\_ Hour: \_\_\_\_\_  A.M.  P.M.

## SECTION 4. REASON(S) ALTERNATE APPLICATION SUBMISSION PROCEDURE WAS 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 affected access/transmit 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 Minnesota Plan Governing Committee and/or the Department of Commerce for appropriate action.

\_\_\_\_\_  
Producer Signature

\_\_\_\_\_  
Date

## SECTION 7. PRODUCER INSTRUCTIONS

Attach this form to the paper application completed for the aforementioned applicant and mail or deliver both forms to the Plan Office in accordance with the applicable Alternate Application Submission Procedures in the Minnesota AIP.

**PRIVATE PASSENGER NON-FLEET APPLICATION  
MINNESOTA AUTOMOBILE INSURANCE PLAN**

<b>SECTION 1. PRODUCER OF RECORD</b>												
Producer Last Name/Agency Name						Producer First Name				MI		
Mailing Address						Ste./Apt. No.		City		State	Zip Code	
Tax ID No.			Producer License No.			Telephone No. (incl. area code)			Fax No. (incl. area code)			
<b>SECTION 2. SIGNING PRODUCER</b> (Complete if the producer completing and signing this application differs from the Producer of Record.)												
Last Name				First Name				MI	Tax ID No. or Producer License No.			
<b>SECTION 3. APPLICANT</b>												
Applicant Last Name			First Name			Full Middle Name		Home Telephone No. (incl. area code)		Business Telephone No. (incl. area code)		
Street Address						Ste./Apt. No.	City		County		State	Zip Code
Mailing Address (if different from above)						Ste./Apt. No.	City		County		State	Zip Code
Co-Applicant's Last Name (if applicable)*			First Name			Full Middle Name		*Note: The Co-applicant must also sign the application.				
<b>SECTION 4. OPERATOR INFORMATION</b> (List all operators in household and any other drivers.)												
Applicant's former addresses (past 3 years)												
Year 1. Street Address							City		State	Zip Code		
Year 2. Street Address							City		State	Zip Code		
Year 3. Street Address							City		State	Zip Code		
Applicant and other Drivers	Relationship to Applicant	% of Use for Each Vehicle				Birth Date	Sex	*MS	Driver's License No.	State	Licensed 3 Years?	
		No.1	No.2	No.3	No.4	Mo/Day/Yr	M/F				If "No", give date issued	
APPLICANT	APPLICANT										<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	
*MS Marital Status: S-Single, M-Married, W-Widowed, P- Separated												
Applicant's Occupation					Nature of Business				Employer's Name			
Street Address						City		State		Zip Code		
Other Driver's Occupation					Nature of Business				Employer's Name			
Street Address						City		State		Zip Code		

Send the **original** of the completed application with check/money order and required attachments to:

**Minnesota Automobile Insurance Plan  
PO Box 6530  
Providence, RI 02940-6530**

Staple check here:  
➔

Include the following attachments, if applicable:

1. Check/Money Order payable to: Minnesota Automobile Insurance Plan
2. Copy of Foreign Driver's License
3. Copy of Finance Contract
4. Proof of purchase of: Customized Auto Equipment, Anti-theft Equipment
5. Copy of Accident Prevention Course Certificate

SECTION 5. VEHICLE 1 – VEHICLE INFORMATION AND VEHICLE USE										
Year	Make	Model			Body Style	Cyl	H.P./Cu. In./CC			
Vehicle Identification No.				Registered Owner's Last Name			First Name			
Purchased Mo./Yr.	<input type="checkbox"/> New <input type="checkbox"/> Used	Cost New	Damaged* <input type="checkbox"/> Yes <input type="checkbox"/> No	Altered* <input type="checkbox"/> Yes <input type="checkbox"/> No	Damaged Glass* <input type="checkbox"/> Yes <input type="checkbox"/> No	* If yes, detail in Remarks Section		Garaged <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Loss Payee <input type="checkbox"/> Lessor	Name		Street Address		City		State	Zip Code		
<input type="checkbox"/> Pleasure <input type="checkbox"/> To Work/School <input type="checkbox"/> Business <input type="checkbox"/> Farm		Principal Address of Garaging			Miles one way to work, school or transportation		Est. Annual Mileage			
If vehicle is a pick-up truck, is it equipped for attaching a snowplow blade? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", is any snow plowing done other than at the applicant's resident premises? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", describe usage in Remarks section.										
Applicant address as it appears on registration, if different from Section 3.			State Registered In	License Plate No.	Territory	Rate Class	Symbols Comp. Coll.		Penalty Points	Percent
SECTION 5. VEHICLE 2 – VEHICLE INFORMATION AND VEHICLE USE										
Year	Make	Model			Body Style	Cyl	H.P./Cu. In./CC			
Vehicle Identification No.				Registered Owner's Last Name			First Name			
Purchased Mo./Yr.	<input type="checkbox"/> New <input type="checkbox"/> Used	Cost New	Damaged* <input type="checkbox"/> Yes <input type="checkbox"/> No	Altered* <input type="checkbox"/> Yes <input type="checkbox"/> No	Damaged Glass* <input type="checkbox"/> Yes <input type="checkbox"/> No	* If yes, detail in Remarks Section		Garaged <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Loss Payee <input type="checkbox"/> Lessor	Name		Street Address		City		State	Zip Code		
<input type="checkbox"/> Pleasure <input type="checkbox"/> To Work/School <input type="checkbox"/> Business <input type="checkbox"/> Farm		Principal Address of Garaging			Miles one way to work, school or transportation		Est. Annual Mileage			
If vehicle is a pick-up truck, is it equipped for attaching a snowplow blade? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", is any snow plowing done other than at the applicant's resident premises? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", describe usage in Remarks section.										
Applicant address as it appears on registration, if different from Section 3.			State Registered In	License Plate No.	Territory	Rate Class	Symbols Comp. Coll.		Penalty Points	Percent
SECTION 5. VEHICLE 3 – VEHICLE INFORMATION AND VEHICLE USE										
Year	Make	Model			Body Style	Cyl	H.P./Cu. In./CC			
Vehicle Identification No.				Registered Owner's Last Name			First Name			
Purchased Mo./Yr.	<input type="checkbox"/> New <input type="checkbox"/> Used	Cost New	Damaged* <input type="checkbox"/> Yes <input type="checkbox"/> No	Altered* <input type="checkbox"/> Yes <input type="checkbox"/> No	Damaged Glass* <input type="checkbox"/> Yes <input type="checkbox"/> No	* If yes, detail in Remarks Section		Garaged <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Loss Payee <input type="checkbox"/> Lessor	Name		Street Address		City		State	Zip Code		
<input type="checkbox"/> Pleasure <input type="checkbox"/> To Work/School <input type="checkbox"/> Business <input type="checkbox"/> Farm		Principal Address of Garaging			Miles one way to work, school or transportation		Est. Annual Mileage			
If vehicle is a pick-up truck, is it equipped for attaching a snowplow blade? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", is any snow plowing done other than at the applicant's resident premises? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", describe usage in Remarks section.										
Applicant address as it appears on registration, if different from Section 3.			State Registered In	License Plate No.	Territory	Rate Class	Symbols Comp. Coll.		Penalty Points	Percent
SECTION 5. VEHICLE 4 – VEHICLE INFORMATION AND VEHICLE USE										
Year	Make	Model			Body Style	Cyl	H.P./Cu. In./CC			
Vehicle Identification No.				Registered Owner's Last Name			First Name			
Purchased Mo./Yr.	<input type="checkbox"/> New <input type="checkbox"/> Used	Cost New	Damaged* <input type="checkbox"/> Yes <input type="checkbox"/> No	Altered* <input type="checkbox"/> Yes <input type="checkbox"/> No	Damaged Glass* <input type="checkbox"/> Yes <input type="checkbox"/> No	* If yes, detail in Remarks Section		Garaged <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Loss Payee <input type="checkbox"/> Lessor	Name		Street Address		City		State	Zip Code		
<input type="checkbox"/> Pleasure <input type="checkbox"/> To Work/School <input type="checkbox"/> Business <input type="checkbox"/> Farm		Principal Address of Garaging			Miles one way to work, school or transportation		Est. Annual Mileage			
If vehicle is a pick-up truck, is it equipped for attaching a snowplow blade? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", is any snow plowing done other than at the applicant's resident premises? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", describe usage in Remarks section.										
Applicant address as it appears on registration, if different from Section 3.			State Registered In	License Plate No.	Territory	Rate Class	Symbols Comp. Coll.		Penalty Points	Percent

SECTION 6. COVERAGES (As provided by the Rules of the Plan.)	Premiums for Vehicles or Non-owner Applicant			
Liability Coverage	Vehicle or Non-Owner No.1	Vehicle No.2	Vehicle No.3	Vehicle No.4
The limits of Liability, UM, UIM coverages must be the same for all vehicles on the policy. Check appropriate box for coverage. For Non-Owner applicant, also complete Section 12.				
<b>Bodily Injury Liability</b> <input type="checkbox"/> \$30/60,000 <input type="checkbox"/> \$50/100,000 <input type="checkbox"/> \$100/300,000 <input type="checkbox"/> Other _____ (as required by law)				
<b>Property Damage Liability</b> <input type="checkbox"/> \$10,000 (Available only with \$30/60,000 BI Limits) <input type="checkbox"/> \$25,000 (Available only with \$50/100,000 BI Limits) <input type="checkbox"/> \$50,000 (Available only with \$100/300,000 BI Limits)				
<b>Uninsured Motorist (UM)</b> Basic Limits: <input type="checkbox"/> \$25/50,000 (required by law) Optional Limits: <input type="checkbox"/> Limits equal to BI Liability limits				
<b>Underinsured Motorist (UIM)</b> Basic Limits: <input type="checkbox"/> \$25/50,000 (required by Law) Optional Limits: <input type="checkbox"/> Limits equal to BI Liability limits				
<b>Personal Injury Protection (PIP) Coverage</b>				
<b>Personal Injury Protection (PIP) Coverage (Also, select option below to "Stack" or "Not-stack" and, if applicable, complete Work Loss Benefit section.)</b> Basic Limits: <input type="checkbox"/> \$20,000 Medical and \$20,000 Non-medical  <b>Stacking Option:</b> The undersigned understands that the option to "stack" or to "non-stack" PIP is available. Selection to "stack" could increase the amount of insurance available to cover injuries in a covered motor vehicle accident, by adding together the limits of coverage on two or more vehicles. However, the total amounts available under this coverage would not exceed the actual amount of the loss. There is an additional charge for "stacking". It is acknowledged and agreed that the undersigned has been informed of the option and has made the decision to: <input type="checkbox"/> Not-Stack <input type="checkbox"/> Stack PIP coverage, and that this selection is applicable to the policy of insurance now being applied for and to all future renewals of the policy until a specific request is made in writing to select a different option. <b>Work Loss Benefit:</b> The undersigned understands that the option to reject Work Loss Benefits coverage is available if the applicant is age 65 or older, or is age 60 or older if retired and receiving a pension. <input type="checkbox"/> I accept Work Loss Benefits I reject Work Loss Benefits for (Check one box) <input type="checkbox"/> the applicant age 65 or older, or age 60 or older if retired and receiving a pension. <input type="checkbox"/> the applicant and any family member age 65 or older, or age 60 or older if retired and receiving a pension.				
<b>Physical Damage</b>				
<b>Veh 1</b> Comprehensive: Deductibles: <input type="checkbox"/> \$100 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> Coverage Rejected				
Collision: Deductibles: <input type="checkbox"/> \$100 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> Coverage Rejected				
<b>Veh 2</b> Comprehensive: Deductibles: <input type="checkbox"/> \$100 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> Coverage Rejected				
Collision: Deductibles: <input type="checkbox"/> \$100 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> Coverage Rejected				
<b>Veh 3</b> Comprehensive: Deductibles: <input type="checkbox"/> \$100 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> Coverage Rejected				
Collision: Deductibles: <input type="checkbox"/> \$100 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> Coverage Rejected				
<b>Veh 4</b> Comprehensive: Deductibles: <input type="checkbox"/> \$100 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> Coverage Rejected				
Collision: Deductibles: <input type="checkbox"/> \$100 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> Coverage Rejected				
<b>Customized Equipment Buy Back Stated Amount - Indicate Value:</b> Veh 1 \$_____ Veh 2 \$_____ Veh 3 \$_____ Veh 4 \$_____				
<b>Extended Nonowned Auto (Complete Section 13.)</b>				
<b>Full Safety Glass Coverage:</b> Veh 1 <input type="checkbox"/> Veh 2 <input type="checkbox"/> Veh 3 <input type="checkbox"/> Veh 4 <input type="checkbox"/>				
<b>Sub-total Estimated Premium per vehicle/non-owner:</b>	\$	\$	\$	\$
<b>Certificate of Insurance Fee: (Complete Section 7.)</b>	\$			
<b>Total Estimated Premium:</b>	\$			
The undersigned has selected the Limits, Coverages and Deductibles indicated by the boxes marked above.				
Applicant's Signature: _____ Date: _____				

**SECTION 6a. DISCOUNTS/CREDITS**

Accident Prevention Course Discount:  Applicant  Operator 2  Operator 3  Operator 4 (Must be operator age 55 and older who has successfully completed an approved Accident Prevention Course or Refresher Course.)

Antitheft Protection Device Discount:  Vehicle 1  Vehicle 2  Vehicle 3  Vehicle 4

**SECTION 7. CERTIFICATE OF INSURANCE** (Complete if applicant or other eligible operator is required to file certificate of insurance.)

1. Last Name	First Name	Case or File No.	State where Filing required	Reason for Filing
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Relationship to Applicant	Resides with Applicant <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you own any other vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes", give name of insurance company	Policy No.
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Type of Filing:  Owner's (operation of owned vehicles)  Operator's (operation of non-owned vehicles)  Both

2. Last Name	First Name	Case or File No.	State where Filing required	Reason for Filing
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Relationship to Applicant	Resides with Applicant <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you own any other vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes", give name of insurance company	Policy No.
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Type of Filing:  Owner's (operation of owned vehicles)  Operator's (operation of non-owned vehicles)  Both

**SECTION 8. PAYMENT PLANS**

<input type="checkbox"/> Option 1 - Full Annual Premium <input type="checkbox"/> Option 2 - 30% Premium Deposit. Balance due within 30 days of the date of premium notice. <input type="checkbox"/> Option 3 - Installment Premium Payment. 40% Deposit. Balance due in 5 monthly installments beginning 60 days from effective date of policy. (Not Available on Premium Financed Policies.) <input type="checkbox"/> Premium to be Financed – Name of Premium Finance Company*	Payment by: <input type="checkbox"/> Check No. _____
	<input type="checkbox"/> Money Order No. _____
	Total Estimated Premium \$ _____
	Amount Submitted with Application \$ _____

\* Attach a copy of Premium Finance contract

**SECTION 9. INSURANCE RECORD**

Has applicant had insurance in the past 3 years?  No  Yes If "Yes", complete the following.

Name of applicant's latest carrier	Policy No.	Termination date
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Mailing address of latest carrier:	City	State	Zip
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Was coverage through Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was 3 year assignment completed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "No", give reason terminated.
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Are any other vehicles owned by any member of household? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes", give name of insurer.	Policy No.
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**SECTION 10. 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 <input type="checkbox"/> Yes <input type="checkbox"/> No	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	\$	

If the answer to any of the following is Yes, check "Yes" box and give date of accident.

1. Applicant reimbursed by or on behalf of person responsible for the accident or has such judgment against such person.	<input type="checkbox"/> Yes	Date(s) of Accident(s) _____ _____ _____
2. Other person involved in accident was convicted. Applicant or operator was not convicted.	<input type="checkbox"/> Yes	
3. Damaged by "Hit-and-Run" driver and accident reported to police within 24 hours from time of accident.	<input type="checkbox"/> Yes	
4. Other type of accident – non-chargeable under provisions of the Plan. If "Yes", describe in Remarks Section.	<input type="checkbox"/> Yes	

**SECTION 11. CONVICTIONS**

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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of Violation	Place of Conviction		Penalty Points	Was License Suspended or Revoked? <input type="checkbox"/> Yes <input type="checkbox"/> No
				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 12. NON-OWNER** (Complete if application is for a non-owner policy.)

1. Type of vehicle applicant will operate:  Private Passenger  Commercial  Taxi/Bus  Other (describe) \_\_\_\_\_

2. Will vehicle be operated in applicant's occupation or business?  Yes  No

3. Is vehicle owned by a member of applicant's household?  Yes  No

4. If answer to 2 or 3 is "Yes", give name of Insurance Company providing liability coverage. \_\_\_\_\_

5. Is applicant excluded?  Yes  No

**SECTION 13. EXTENDED NONOWNED AUTO**

The policy may be endorsed to provide this coverage to the individual named in the policy, the spouse (if resident in the same household), or a resident *relative* who is furnished an auto for regular use.

1. Name of individual(s) to be covered: \_\_\_\_\_
2. Is primary liability insurance in effect for the auto furnished for regular use?  Yes  No

**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.

**EVIDENCE OF INSURANCE AND EFFECTIVE DATE OF COVERAGE**

This application shall be evidence of temporary insurance, for the coverages and limits specified in this application, effective at the date and time shown below, subject to the following conditions:

1. The application must be fully completed and duly executed (signed and dated by the applicant and signed and dated by the producer).
2. 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 law and the provisions of the Minnesota Automobile Insurance Plan.
3. **The application must be received by the Plan with a deposit of NO LESS THAN the 30% or 40% required (see "Payment Options"). The deposit must be in the form of a certified check, cashier's check, money order, or producer's check (an applicant's check is not acceptable).**
4. A premium charge will be made if the policy, when and as issued, is not accepted by the insured.
5. The insurance provided hereunder shall be subject to all the terms and conditions of the policy forms prescribed for use in accordance with the provisions of the Minnesota Automobile Insurance Plan.
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 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 is a metered mail stamp (without USPS postmark), coverage will become effective no earlier than 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 is a metered mail stamp (without a USPS postmark), coverage will become effective no earlier than 12:01 A.M. on the date of receipt of the application by the Plan. If the envelope accompanying the application has a USPS postmark, coverage shall be effective at 12:01 A.M. on the day following the date of mailing of the application.

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

Example: 09/01/2014 11:30 AM

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

**PRODUCER OF RECORD STATEMENT:** I do hereby certify that I am licensed as an insurance agent by the Commerce Department of the State of Minnesota. I am familiar with the Minnesota Automobile Insurance Plan, have explained to the applicant all provisions pertinent to their insurance, have asked the applicant for all of the information for all of the questions in this application, and have included in this application all of the information given to me by the applicant. If Physical Damage coverage(s) is (are) being applied for, I have seen the vehicle and it has no existing damage to the vehicle or to any window glass except as described in the Remarks section at the end of this application. In the event of cancellation or a policy change resulting in a reduction of premium, I agree to return any compensation that has been paid which is in excess of the compensation on the earned premium received by the company. I understand that the alternate procedure for private passenger application submission contained in the Appendix of the Minnesota Automobile Insurance Plan may only be used when authorized 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 Minnesota Automobile Insurance Plan.

\_\_\_\_\_  
(Producer's Signature) Date: \_\_\_\_\_ Hour: \_\_\_\_\_  A.M.  P.M.

**APPLICANT'S STATEMENT**

I, the Applicant, declare and certify that:

1. I have tried and failed to obtain automobile insurance in Minnesota within the preceding 60 days.
2. To the best of my knowledge and belief all statements contained in this application are true, and these statements are offered to the company to which this application is assigned as an inducement to issue the policy for which I am applying.
3. **I understand that any misleading information or failure to disclose all the information requested in this application will be considered to not be in good faith on my part, will prejudice my application for insurance, and could cause the insurance to be cancelled.**
4. I hereby agree to pay all premiums when due.
5. I hereby certify that I do not owe any insurance company for any previous automobile insurance.
6. With respect to any past due premium I may owe for coverage through the Minnesota Automobile Insurance Plan, I understand that any premium currently paid may be applied against any such past due premium, and if so, I will be billed for additional premium to place or maintain my currently applied for coverage in effect.
7. I designate as Producer of Record for this insurance the producer or firm named in this application, and I understand he is not acting as an agent of any company or the Plan for the purposes of this insurance.
8. **By signing this application I understand that I must pay 40% of the annual premium as a deposit with this application (or 30% if the balance of the annual premiums is to be paid within 30 days); and I also understand that the premium shown on this application is an estimated premium, and that the company to which this application is assigned has the right to adjust the premium to the correct figure either prior to or after the issuance of the policy, whenever applicable. I also understand that: 1) If the company to which this application is assigned does correct the premium to a higher total than that shown on this application, I have the right to cancel the policy if I do not want the policy at the higher premium; 2) My request to cancel must be made in writing within 20 days of my receipt of the corrected premium; 3) My signed request to cancel must specify the date of cancellation, which date can not be more than 20 days after my request to cancel; and 4) Such cancellation will be on the basis of charging me for the period of time that this coverage is in effect pro rata (that is, on the basis of) the premium shown on this application.**
9. **THE INSURER MAY ELECT TO CANCEL COVERAGE AT ANY TIME DURING THE FIRST 59 DAYS FOLLOWING ISSUANCE OF THE COVERAGE FOR ANY REASON THAT IS NOT SPECIFICALLY PROHIBITED BY STATUTE.**
10. I understand and agree that the assigned insurer may obtain an investigative consumer report in support of my application for insurance. If the insurer obtains such report, I may submit a written request to the insurer asking that they provide me with written disclosure of the nature and scope of the investigation.

\_\_\_\_\_  
(Applicant's Signature) Date: \_\_\_\_\_ Hour: \_\_\_\_\_  A.M.  P.M.

**NOTICE TO APPLICANT AND PRODUCER**

In the event acknowledgement of coverage is not received within 45 days, notify the Minnesota Automobile Insurance Plan, 302 Central Avenue, Johnston, RI 02919 or phone (888) 706-6100.

**NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN INSOLVENCY UNDER THE MINNESOTA INSURANCE GUARANTY ASSOCIATION LAW**

The financial strength of your insurer is one of the most important things for you to consider when determining from whom to purchase a property or liability insurance policy. It is your best assurance that you will receive the protection for which you purchased the policy. If your insurer becomes insolvent, you may have protection from the Minnesota Insurance Guaranty Association as described below but to the extent that your policy is not protected by the Minnesota Insurance Guaranty Association or if it exceeds the Guaranty Association's limits, you will only have the assets, if any, of the insolvent insurer to satisfy your claim.

Residents of Minnesota who purchase property and casualty or liability insurance from insurance companies licensed to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer becomes insolvent. This protection is provided by the Minnesota Insurance Guaranty Association.

**Paul Steffan, Executive Director**  
**Minnesota Insurance Guaranty Association**  
**7600 Parklawn Ave. Suite 460**  
**Edina, MN 55435**

**Phone: 952-831-1908**  
**Fax: 952-831-1973**

The maximum amount that the Minnesota Insurance Guaranty Association will pay in regard to a claim under all policies issued by the same insurer is limited to \$300,000. This limit does not apply to worker's compensation insurance. Protection by the Guaranty Association is subject to other substantial limitations and exclusions. If your claim exceeds the Guaranty Association's limits, you may still recover a part or all of that amount from the proceeds of the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The Guaranty Association assesses insurers licensed to sell property and casualty or liability insurance in Minnesota after the insolvency occurs. Claims are paid from the assessment.

THE PROTECTION PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY OR POLICY, YOU SHOULD NOT RELY ON PROTECTION BY THE GUARANTY ASSOCIATION.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF PROPERTY AND CASUALTY INSURANCE POLICIES OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES INSOLVENT. THIS NOTICE NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL PROPERTY AND CASUALTY INSURANCE POLICIES ARE REQUIRED TO PROVIDE THIS NOTICE.

**REMARKS**