OKLAHOMA AUTOMOBILE INSURANCE PLAN POLICY CHANGE REQUEST

PRIVATE PASSENGER/COMMERCIAL

Complete all applicable sections and mail directly to assigned Company.

Name of Insurance Company	Policy No.
Name of Insured	

Producer	Telephone No. (incl. area code)	Tax ID or Social Security No.	Producer License No.
Street Address	City	State	Zip Code

1. VEHICLE DELETION ☐

Vehicle	Year	Make	Vehicle Identification No.
No. 1			
No. 2			

2. VEHICLE ADDITION

a. Private Passenger Type

Replacement Vehicle ☐

Or Added Vehicle ☐

Year	Make	Model Name & Body Style	Vehicle Identification Number

H.P./Cu. In./CC	Purchased Mo. Yr.	New ☐	Used ☐	Cost New	Damaged Yes ☐ No ☐	Altered Yes ☐ No ☐	Damaged Glass Yes ☐ No ☐	Garaged Yes No ??

Use and Classification	Pleasure ☐	Business ☐	Comm. ☐	Farm ☐	Principal Place of Garaging	Miles to Work or to Transportation	Estimated Annual Mileage	State of Registration

Address of Applicant as Appears on Registration	Territory	Rate Class	Penalty Points	Symbols Comp.	Symbols Coll.	Model Year/ Age Group	Custom Equipment ACV above $1,500

b. Commercial Type

Replacement Vehicle ☐

Or

Added Vehicle ☐

Year	Vehicle Identification No.	Load Capacity	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)	State of Registration	Rating Classification	Gross Comb. Weight (GCW) Trucks-Tractors only	Radius (2) (L-I-LD)	Tank Capacity	Loss Payee Address

Type (1)	Name of Registered Owner of Vehicle	Rating Territory	Orig. Cost New (3)	Comp. Symbol	Coll. Symbol	Size (L-M-H-EH)	Final Rating	Purpose of Use (P - B) (S-R-C)	Loss Payee City, State, Zip Code

Where vehicle is permitted to operate	List all cities through and in which vehicles operate

(1) Type - Truck=T, Truck-Tractor=TT, Trailer=TR, Semi-Trailer=ST
(2) For Public and Long Distance, list cities in which vehicles operate.
(3) Chassis & Body including Special Equipment

3. LOSS PAYEE

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

Name of Loss Payee	Street	City	State	Zip Code

4. COVERAGES

In Accordance with Plan Rules

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

Check Applicable Box ➔	Bodily Injury Liability	Property Damage Liability	Medical Payments Coverage	Uninsured Motorists Coverage*	Comprehensive and Collision
	☐	☐	☐	☐	☐
Limits/Ded.	$	$	$	$	$
Premium	$	$	$	$	$

Premium for Excess Custom Equipment Coverage: $________________________

Estimated Annual Premium $ ________________________ Deposit (40% 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.

5. OPERATOR INFORMATION

☐ Delete Operator: Name ______________________________

	Name	Relationship to Insured	% Use of Veh 1	% Use of Veh 2	Birth date Mo. Day Yr.	Sex M-F	Marital Status	Driver's License No. and State	Licensed 3 Yrs. Yes	Licensed 3 Yrs. No–Give Date Issued
Added Operator(s) ☐										

Has every driver eligible for DRIVER TRAINING CREDIT, qualified? ☐ Yes ☐ No If "Yes", submit school certificate.

5a. ACCIDENTS

Have additional operators been involved as owner or operator in any motor vehicle accident within the past thirty-six months?
☐ Yes ☐ No If "Yes", complete the following. (If necessary, use Remarks section.)

Name of Operator	Accident Date Mo./Day/Yr.	Place of Accident		Bodily Injury or Death	Property Damage (incl. your own) Amount
		Town	State		
				☐ Yes ☐ No	$
				☐ Yes ☐ No	$

5b. CONVICTIONS

Have additional operators 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 Mo./Day/Yr.	Did Conviction arise as a result of an accident?	Type of Violation	Place of Conviction	
				Town	State
		☐ Yes ☐ No			
		☐ Yes ☐ No			
		☐ Yes ☐ No			

6. CHANGE

☐ Name
☐ Address

New Name | Street | Apt. | City | State | Zip Code

7. POLICY CANCELLATION

☐ Cancel policy

Reason for cancellation:

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 Oklahoma 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)

APPLICANT'S STATEMENT

I declare and certify that: To the best of my knowledge and belief that all statements contained in this Policy Change Request are true.

______________________________ Date ______________ Hour ___________ ☐ A.M. ☐ P.M.
(Applicant's Signature)