RHODE ISLAND AUTOMOBILE INSURANCE PLAN
PO Box 6530
Providence, RI 02940-6530
Fax # (401) 528-1409

PERSONAL AUTOMOBILE POLICY CHANGE REQUEST

Name of Insurance Company	Policy No.
Producer Name	Policy Expiration Date
Address	Producer License No.
City, State, Zip Code	Producer No.
Telephone No. (Inc. area code)	Producer Social Security No.

Name of Insured (☐ Check box if this a correction)

1 CHANGE
☐ Please print new address and check box
☐ Phone Number (if changed)
☐ Mailing Address if different than garaging address.

2. VEHICLE DELETION
☐ Delete Veh. No. _____
Year | Make | Vehicle Identification No.

3. VEHICLE ADDITION
☐ Added Vehicle
Year | Make | Model Name & Body Style | Vehicle Identification No.
H.P./Cubic In./CC | Purchased Mo. Yr. New ☐ Used ☐ | Cost New | ACV (for camper bodies and trailers) | ☐ Antique ☐ Acc. Prev. Discount ☐ Classic ☐ Anti-Theft (Attach necessary documentation)

USE AND CLASSIFICATION
Pleasure ☐ Business ☐ Work ☐ Farm ☐ School ☐ | Principal Place of Garaging | Miles to Work/School or to Transportation | State of Registration | Cust. Equipment Above $1,500 ACV (Attach List)

Address of Applicant as Appears on registration | Territory | Rate Class | Penalty Points | Symbols: Comp. | Coll.

4. LOSS PAYEE
Add ☐ Change To ☐ Delete ☐ Applicable To Vehicle: Year Make Vehicle Identification No.
Name of Loss Payee Street City State Zip Code

4a. LESSOR
Add ☐ Change To ☐ Delete ☐ Applicable To Vehicle: Year Make Vehicle Identification No.
Name of Lessor Street City State Zip Code

5. COVERAGES
In Accordance with RI 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 ☐ BI***	Uninsured Motorists ☐ PD**	Other Than Collision (Comprehensive) ☐	Collision ☐
Limits/Ded.	$	$	$	$	$	$ Ded.	$ Ded.
Premium	$	$	$	$	$	$	$

Premium for Excess Custom Equipment Coverage: $_____

* ☐ 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 ☐ Other – Named Non-Owner

_____
APPLICANT'S SIGNATURE

*** I Reject the limits of UMBI which would have been equal to the limits of BI and select the following:
☐ 25,000/50,000 ☐ 50,000/100,000 ☐ 100,000/300,000 ☐ 250,000/500,000

_____ Applicant's Signature
_____ Applicant's/ Other Named Insured's Signature

Estimated Annual Premium $ _____
Deposit (30% of Estimated Annual Premium or Pro Rata Premium for the remainder of policy period whichever is less) $ _____

Payment can be made electronically, or by check or money order, in accordance with Plan rules.

6. DRIVER INFORMATION
☐ Delete Driver: Name Reason

☐ Added Drivers	Name	Relationship To Insured	Driver Use of Each Vehicle* Veh 1	Veh 2	Veh 3	Veh 4	Birth Date Mo. Day Yr.	Sex	**MS	Drivers License No.	State	Date Licensed Mo. Yr.	***Drivers Training
													☐ Yes ☐ No
													☐ Yes ☐ No

* Driver Use of each Vehicle: P-Principal, O-Occasional, NR-Not Rated
**MS Marital Status: S-Single, M-Married, W-Widowed, D-Divorced, P-Separate, CU Civil Union
***If Yes, Attach 6 Hour Behind Wheel Certificate

EMPLOYMENT INFORMATION (For each operator listed above)

Occupation	Employer's Name	Address	Nature of Business	Business Telephone No.
1.				
2.				

6a. ACCIDENTS Have additional drivers been involved as owner or operator in any motor vehicle accident with the past thirty-six months?

☐ No
☐ Yes
Complete the Following

Accident Date	Place of Accident: Town	Place of Accident: State	Personal Injury Protection Claim	Bodily Injury Or Death	Property Damage Amount (including your own)	Chargeable
			☐ Yes ☐ No	☐ Yes ☐ No	$	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No	$	☐ Yes ☐ No

Give Reasons(s) if the above Accident(s) Not Chargeable Under the Rules of the Plan.

6b. CONVICTIONS Have additional drivers 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.**

☐ No
☐ Yes
Complete the Following

Date of Conviction (Not Arrest)	Did Conviction arise as a result of an accident?	Nature of Violation	Place of Conviction: Town	Place of Conviction: State
	☐ Yes ☐ No			
	☐ Yes ☐ No			

7. FINANCIAL RESPONSIBILITY **If an additional operator is required to file evidence of financial responsibility, complete the following.**

Driver Name _____ **State where filing is required** _____ **Resides with applicant? ☐ Yes ☐ No**

Explain in detail reason for filing (☐ Check box if minor filing is required) _____

_____

_____

8. NON-OWNER Complete if changing from an owner policy to a non-owner policy

Applicant elects coverage for vehicles furnished or available for regular use. ☐ Yes ☐ No

Operator 1	Type of vehicle that will be operated. ☐ Priv Pass ☐ Comm ☐ Taxi/Bus ☐ Other (describe**)**_____
	Will vehicle be operated in applicant's occupation of business? ☐ Yes ☐ No If yes, name of Insurance Company providing liability coverage. _____
	Is vehicle owned by applicant or member of household? ☐ Yes ☐ No If yes, name of Insurance Company providing liability coverage. _____
	Is applicant excluded? ☐ Yes ☐ No
Operator 2	Type of vehicle that will be operated. ☐ Priv Pass ☐ Comm ☐ Taxi/Bus ☐ Other (describe**)**_____
	Will vehicle be operated in applicant's occupation of business? ☐ Yes ☐ No If yes, name of Insurance Company providing liability coverage. _____
	Is vehicle owned by applicant or member of household? ☐ Yes ☐ No If yes, name of Insurance Company providing liability coverage. _____
	Is applicant excluded? ☐ Yes ☐ No

9. POLICY CANCELLATION

☐ Cancel policy
Reason for cancellation:

10. 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 Rhode Island Automobile Insurance Plan.

Effective Date and Time _____ ☐ A.M. ☐ P.M.
Month Day Year Time

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)

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

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

NOTICE TO INSURED

The requested comprehensive and/or collision coverage for your auto will not be effective unless the vehicle is properly registered to you at the time of loss, as required by the provisions of the Rhode Island Automobile Insurance Plan, and the policy contract.