PRIVATE PASSENGER POLICY CHANGE REQUEST MINNESOTA AUTOMOBILE INSURANCE PLAN

Name of Insurance Company

Policy No.

Complete all applicable sections and Mail to Insurance Company.

Name of Insured (Last Name, First Name, M.I.)

Producer	Telephone (Incl. Area Code)	Producer's License No.	Producer's IRS or Social Security No.

Street City State Zip Code

1. VEHICLE DELETION ☐

Vehicle No.1 Year Make Vehicle Identification No.

No.2

2. VEHICLE ADDITION

☐ a. Private Passenger Replacement Vehicle or ☐ b. Added Vehicle

Year	Make	Model Name & Body Style	Vehicle Identification No.	Cyls.

H.P./Cub.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

If vehicle is a pickup truck, is it equipped for attaching a snowplow blade? ☐ Yes ☐ No
If "Yes," is any snow plowing done other than at the applicant's resident premises? ☐ Yes ☐ No
If "Yes," describe usage in Remark's section.

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 ☐	Personal Injury Protection ☐
Limits/Ded.	$	$	$
Premium	$	$	$

Check Applicable Box ➔	Uninsured Motorists Coverage ☐	Underinsured Motorist Coverage ☐	Comprehensive Coverage ☐	Collision Coverage ☐	Certificate of Insurance Fee ☐
Limits/Ded.	$	$	$	$	
Premium	$	$	$	$	

Does vehicle contain Customized Equipment? ☐ Yes ☐ No
If "Yes,"Stated Amount Premium for Customized Equipment Coverage: $_____

Personal Injury Protection (PIP) Coverage

Also, select option below to "Stack" or "Not-Stack" and, if applicable, complete Work Loss Benefit Section.

Basic Limits: ☐ $20,000 Medical and $20,000 Non-medical

Stacking Option: 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:

☐ **Not-Stack** ☐ **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.

Work Loss Benefit: 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.

☐ I accept Work Loss Benefits

I reject Work Loss Benefits for (Check one box)

☐ The applicant age 65 or older, or age 60 or older is retired and receiving a pension.

☐ The applicant and any family member age 65 or older, or age 60 or older if retired and receiving a pension

Physical Damage Coverage

Comprehensive Coverage: ☐ Coverage rejected

Collision Coverage: ☐ Coverage rejected

The undersigned has selected the Limits, Coverages, and Deductibles indicated by the boxes marked above.

Insured's Signature _____ Date _____

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 the Insurance Company and mail directly to the Insurance Company, not to the Plan Office.

5. DISCOUNTS AND CREDITS

Accident Prevention Course Discount: ☐ Insured ☐ Driver 1 ☐ Driver 2 ☐ Driver 3
(Must be principle operator age 55 or over)

Anti-theft Protection Device Discount: ☐ Vehicle 1 ☐ Vehicle 2 ☐ Vehicle 3 ☐ Vehicle 4

6. DRIVER INFORMATION ☐ Delete Driver: Name: _____Reason for Deletion: _____

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

*MS Marital Status: S-Single, M-Married, W-Widowed, P-Separated

6a.ACCIDENTS HAVE ADDITIONAL DRIVERS BEEN INVOLVED AS OWNER OR OPERATOR IN ANY MOTOR VEHICLE ACCIDENT WITHIN 36 MONTHS?

☐ No
☐ Yes
Complete the following

Accident Date	Place of Accident Town	Place of Accident State	Bodily Injury Or Death Yes	Bodily Injury Or Death No	Property Damage Amount	Chargeable Yes	Chargeable No
			☐	☐	$	☐	☐
			☐	☐	$	☐	☐

Explain under "Remarks" 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 36 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	Did Conviction Arise as a Result of Accident Yes	Did Conviction Arise as a Result of Accident No	Nature of Violation	Place of Conviction Town	Place of Conviction State
	☐	☐			
	☐	☐			

7. CHANGE
☐ Name
☐ Address

New Name Street Apt. City State Zip Code

Reason for Name Change: ☐ Marriage ☐ Divorce ☐ Legal Name Change

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 to 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.
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 all statements contained in the Policy Change Request are true.

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

ATTACHMENTS

Include the following attachments, if applicable:

1. Check/Money Order
2. Copy of Foreign Driver's License
3. Proof of Purchase of
   - Custom Auto Equipment
   - Anti-theft Equipment
4. Copy of Accident Prevention Course Certificate