# SOUTH CAROLINA COMMERCIAL AUTOMOBILE INSURANCE PLAN POLICY CHANGE REQUEST

**THIS POLICY CHANGE REQUEST FORM MUST BE PRINTED IN INK OR TYPED**

| Name of Servicing Carrier | | | |
|---|---|---|---|
| Name and Address of Insured (As shown on Policy Declarations) | | | |
| Policy Number | | Policy Effective Date | |
| Producer's Name and Address | License No. | Tax ID or Social Security No. | Tel. No. (Incl. Area Code) |

☐ **POLICY CANCELLATION—Please cancel policy per insured's request. Insured's signature required.**
*If deceased, please submit a copy of the death certificate. *If due to other insurance, please submit proof of coverage.

_____ _____

Signature Date

| 1. VEHICLE DELETION ☐ | VEHICLE NO. | YEAR | MAKE | VEHICLE IDENTIFICATION NO. |
|---|---|---|---|---|
| | | | | |
| | How was vehicle disposed? ☐ Sold ☐ Other (describe) | | | |

| 2. REPLACEMENT VEHICLE ☐ OR ADDED VEHICLE ☐ | Year | Vehicle Identification No. | Load Capacity | Type of Registration | | Gross Vehicle Weight (GVW) Trucks only | | Spec. Industry (T-FD-SD-WD-F-D-C-O) | Seating Capacity | Loss Payee Name |
|---|---|---|---|---|---|---|---|---|---|---|
| | Trade Name/ Model No. | Garage Location (Town/State) | State of Registration | Rating Classification | | Gross Comb. Weight (GCW) Truck-Tractors Only | | For Size Bus. Rad. (L-I-LD) | Tank Capacity | Loss Payee Address |
| | Type (1) | Name of Registered Owner of Vehicle | Rating Territory (2) | Orig. Cost New (3) | Comp Sym | Coll Sym | Size (L-M-H-EH) | Final Rating | How veh is licensed | Loss Payee City, State, Zip Code |
| | Where vehicle is permitted to operate | | | For public and long distance, list all cities through and in which vehicles operate. | | | | | | |
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| | | | | | | | | | | |

| 3. COVERAGES In Accordance with Plan | Add ☐ | Change ☐ | Delete ☐ | Applicable To Vehicle | Year | Make/Model | Vehicle Identification No. |
|---|---|---|---|---|---|---|---|

| Check Applicable Box | Liability Limit (Combined Single Limit) ☐ | Uninsured Motorists Coverage ☐ | Underinsured Motorists Coverage ☐ |
|---|---|---|---|
| Limits | $ | $ | $ |
| Premium | $ | $ | $ |

**Estimated Annual Premium** $_____

**period, whichever is less).** $_____

**Deposit (40% of estimated annual premium or pro rata premium for the remainder of Policy**

**Payment must be in the form of a cashier's check or premium finance company check.**

**Make check payable to the Servicing Carrier and mail check and this form directly to Servicing Carrier, not to Plan.**

| 4. OPERATOR INFORMATION Added Operators ☐ | ☐ Delete Operator: Name _____ | | |
|---|---|---|---|
| | Name (Last, First, Middle Initial) | Date of Birth | License No. and State |
| | 1. | | |
| | 2. | | |

5. a. ACCIDENTS—Have additional operators 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 separate sheet).

| Name of Operator | Accident Date | Place of Accident | Bodily Injury or Death Amount | Property Damage Amount | Physical Damage Amount |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

5. b. CONVICTIONS—Have additional operators been convicted or forfeited bail during the past thirty-six months?
Note: A paid ticket or fine is an admission of guilt and therefore constitutes a conviction.

Convicted: ☐ Yes ☐ No Forfeited Bail: ☐ Yes ☐ No If "Yes", for either item, complete the following: (If necessary, use a separate sheet.)

| Name of Operator | Date of Conviction or Forfeiture of Bail | Did Conviction Arise as a Result of an Accident? (Yes/No) | Nature of Conviction | Place of Conviction | Penalty | Was License Suspended or Revoked? |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |

6. CHANGE

| | |
|---|---|
| ☐ Name | New Name |
| ☐ Address | New Address |

7. FILING OR CERTIFICATES

Is filing or specific limits of liability needed to comply with:

☐ Motor Carrier Act of 1980 Type ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Bus. Regulatory Act of 1982 ☐ ICC Regulation—Docket No. _____

☐ Local Ordinance (attach copy) ☐ Other_____ ☐ US DOT No._____ ☐ State Regulation

If block(s) checked, list state(s)/province(s) and cities requiring filings or limits of liability required by law_____

_____

Is applicant required to file evidence of financial responsibility? ☐ Yes ☐ No If "Yes", complete below.

Name _____ Social Security No _____

☐ Owner's (To allow for operation of owned vehicles) ☐ Operator's (To allow for operation of nonowned vehicles) ☐ Both

State where filing required_____ Case or File No._____ Reason for filing_____

_____

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 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 _____ ☐ AM ☐ PM
(Producer's Signature)

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

By _____ Date _____ Hour _____ ☐ AM ☐ PM
(Applicant's Signature)

If additional named insureds are to be added under this Policy Change Request form, authorized signatures for each such additional named insured shall be provided below. Such additional named insureds agree to be bound by the statements made by the Applicant in this form.

_____ _____ Date _____ Hour_____ ☐ AM ☐ PM
(Person authorized to sign for additional named insured) (Title)

**This form is not, in and of itself, a binding commitment to provide the coverages requested herein. Such coverages are to be provided only as required by the rules of the South Carolina Commercial Automobile Insurance Plan (SC CAIP).**

**THIS IS NOT A BINDER**