# MINNESOTA AUTOMOBILE INSURANCE PLAN COMMERCIAL POLICY CHANGE REQUEST
## THIS POLICY CHANGE REQUEST FORM MUST BE PRINTED IN INK OR TYPED

| Name of Insured, Address and Legal Status (As shown on Policy Declarations) | | | |
|---|---|---|---|
| | | | |
| Policy No. | Policy Effective Date | | |
| | | | |
| Producer's Name and Address | License No. | Social Security No.<br>IRS No. | Telephone No. (incl. area code) |
| | | | |

**1. ☐ VEHICLE DELETION**

| Veh. No. | Year | Make | Vehicle Identification No. |
|---|---|---|---|
| | | | |

How was vehicle disposed? ☐ Sold ☐ Other (describe)

**2. ☐ REPLACEMENT VEHICLE OR ☐ ADDED VEHICLE**

| Veh. No. | | Year, Trade Name, Body Type-Truck, Truck-Tractor Trailer, Semi-Trailer, Model No. | Load Capacity | Type of Registration / Rating Classification | Gross Vehicle Weight (GVW) Trucks Only | Size (L-M-H-EH) | Radius (L-I-LD) | Seating Capacity |
|---|---|---|---|---|---|---|---|---|
| | a. | | | | | | | |
| | b. | Identification No. | State of Registration | Orig. Cost New (Chassis & Body Incl. Spec. Equip.) / Comp. Symbol / Coll. Symbol | Gross Comb. Weight (GCW) Truck-Trailers Only | Purpose Of Use (P or B) (S-R-C) | Spec. Ind. (M-T-FD-SD-WD-F-D-C-L-O | Tank Capacity |
| | c. | Garaging Location (Town, State) | | | | | | Final Rating |
| | d. | Name of Registered Owner of Vehicle | Rating Territory | | | | | |
| 1. | a. | | | | | | | |
| | b. | | | | | | | |
| | c. | | | | | | | |
| | d. | | | | | | | |

Territory(ies) in which, or through which, vehicles are customarily operated _____

Use of Vehicle _____

☐ Supplemental Commercial Vehicle Schedule attached.

**3. COVERAGES** In Accordance with Plan Rules

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

| Check Applicable Box ➔ | Bodily Injury Liability ☐ | Property Damage Liability ☐ | Personal Injury Protection ☐ | Uninsured Motorists Coverage ☐ | Underinsured Motorists Coverage ☐ | Other Than Collision Coverage ☐ | Collision Coverage ☐ |
|---|---|---|---|---|---|---|---|
| Limits/Ded. | $ | $ | $ | $ | $ | $ | $ |
| Premium | $ | $ | $ | $ | $ | $ | $ |

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 Insurance Company and mail directly to Insurance Company, not to Plan office.

**Note:** If MCS 90, ICC, Bus Regulatory Act, state or local filings are required of this risk, check may be a producer's check, certified check, cashier's check, or money order payable to Insurance Company. Make check payable to Insurance Company and mail directly to Insurance Company, not to Plan office.

**UNINSURED AND UNDERINSURED MOTORIST COVERAGE**

**Note**: The limits of liability, uninsured motorist coverage, and underinsured motorist coverage must be the same for all vehicles on the policy.

**Uninsured Motorist (UM)**

Basic Limits**:** ☐ $25/50,000 (required by Law)
Optional Limits: ☐ Limits equal to BI Liability limits up to $500,000
☐ Other _____ (as required by law)
☐ Optional higher limits rejected

**Underinsured Motorist (UIM)**

Basic Limits**:** ☐ $25/50,000 (required by Law)
Optional Limits: ☐ Limits equal to BI Liability limits up to $500,000
☐ Other _____ (as required by law) $100/300,000
☐ Optional higher limits rejected

**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 "not-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 if 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** Other than Collision: ☐ Coverage Rejected Collision: ☐ Coverage Rejected

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

**Insured's Signature** _____ **Date** _____

| DISCOUNTS/CREDITS | Accident Prevention Discount: * ☐ Insured ☐ Added Driver 1 ☐ Added Driver 2 ☐ Added Driver 3 * Must be operator AGE 55 OR OVER<br>Anti-theft Protection Device Discount: ☐ Vehicle 1 ☐ Vehicle 2 ☐ Vehicle 3 ☐ Vehicle 4 |
|---|---|

**4. LOSS PAYEE**

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

| Name of Loss Payee | Street | City | State | Zip Code |
|---|---|---|---|---|
| | | | | |

**5. OPERATOR INFORMATION**

☐ Delete Operator: Name _____

☐ Added Operators

| Name (Last, First, Middle Initial) | Date of Birth | License No. and State |
|---|---|---|
| 1. | | |
| 2. | | |

**5a. 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 a separate sheet.)

| Name of Operator | Accident Date Mo./Day/Yr. | Place of Accident | | B.I. or Death Amount | Property Damage Amount | Physical Damage Amount |
|---|---|---|---|---|---|---|
| | | City | State | | | |
| | | | | | | |
| | | | | | | |

**5b. CONVICTIONS**

Have additional operators 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.
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 Mo./Day/Yr. | Did Conviction arise as a result of an accident? | Nature of Conviction | Place of Conviction | | Penalty | Was License suspended or revoked? |
|---|---|---|---|---|---|---|---|
| | | | | City | State | | |
| | | ☐ Yes ☐ No | | | | | ☐ Yes ☐ No |
| | | ☐ Yes ☐ No | | | | | ☐ Yes ☐ No |
| | | ☐ Yes ☐ No | | | | | ☐ Yes ☐ No |

**6. CHANGE**

| | |
|---|---|
| ☐ Name/Ownership* | New Name |
| ☐ Address | New Address |
| ☐ Legal Status* | New Legal Status ☐ Individual ☐ Corporation ☐ Partnership ☐ Other _____ |

*Note: Name and/or Ownership Change Form must accompany this request.

**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 _____ ☐ U.S. 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 non-owned vehicles) ☐ Both
State where filing required _____ Case of File No. _____ Reason for filing _____
_____

**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)

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

By _____ Date _____ Hour _____ ☐ A.M. ☐ P.M.
(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 _____ ☐ A.M. ☐ P.M.
(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 Minnesota Automobile Insurance Plan.