CANAL

**MARYLAND**

# Canal Commercial Combination Insurance Application

**Entire Application Must Be Completed and Signed**

☐ **CANAL INSURANCE COMPANY**

☐ **CANAL INDEMNITY COMPANY**

Canal General Agent Use Only

Date and Time Coverage is Bound by Canal

Requested Effective Date _____

## 1. *GENERAL INFORMATION*

| | | | |
|---|---|---|---|
| Applicant Legal Name | | Form of Business<br>☐Individual ☐LLC ☐Partnership ☐Corporation ☐Joint Venture ☐Other | |
| Company Name (DBA) (if any) | | Principal or Majority Owner (please include all principals) | |
| DOT Number | Telephone Number | | Mobile Phone Number |
| *Tax Identification Number or Social Security Number | E-Mail Address | | Fax Number |
| Location of Business Premises or Physical Address | | | |
| City | State | Zip Code | County |
| Location Is ☐ Inside City Limits ☐ Outside City Limits | | | |
| Mailing Address (if different than above) | | | |
| City | State | Zip Code | County |

*If provided, certificates of insurance can be accessed from www.canal-ins.com 24 hours a day.

## 2. *GENERAL QUESTIONS*

**Policy Type**

☐ Scheduled Vehicle ☐ Gross Receipts (only available for 25 or more power units) ☐ Gross Mileage (only available for 25 or more power units)

**How long has this operation been in business?**

☐ Less than one year ☐ One to two years ☐ Two or more years

**Have you ever had insurance with Canal?**

☐ Yes ☐ No

If yes, please provide policy number or year(s) and name on policy.

**Business Class**

☐ For Hire Trucking (hauls goods for others) ☐ Private Carrier (hauls owned goods) ☐ Public Auto/Taxi ☐ Non Trucking ☐ Small Commercial

If applying for **Non-Trucking Coverage** list name and the motor carrier number of the lessee to whom you are permanently leased.

| Name of Motor Carrier | Motor Carrier Number |
|---|---|
| | |

If applying for **Small Commercial**, describe type of business and use of vehicle(s).

| Type of Business | Use of Vehicle(s) |
|---|---|
| | |

**Do you own any other businesses?**

☐ Yes ☐ No

If yes, please provide the name, address and details.

**Have there been any changes in the ownership, management or name of the operation in the past five years?**

☐ Yes ☐ No

If yes, please provide details.

**Indicate Policy Term and Payment Method**

☐ Short Term Policy***** Desired Expiration Date: _____ *****(No company payment plan available for short term policies.)

☐ Continuous Until Cancelled Policy (2 month escrow deposit and monthly billing)

☐ Annual Policy: ☐ Full Payment to Company ☐ Company Payment Plan ☐ Financed through outside Premium Finance Company with full payment to Canal (no double financing permitted – attach contract)

## 3. *MOTOR CARRIER FILINGS*

**Do you need an MCS-90? ☐Yes ☐No**

**Authority Type**

☐ **Common** ☐ **Contract** ☐ **Brokerage**

If brokerage, please provide the percentage of total revenue generated by brokerage operations and MC number

_____
Applicant's Initials

### *MOTOR CARRIER FILINGS continued*

| Filings Required | Motor Carrier # | Applicant's Name and Address Exactly As It Appears On Each Permit |
|---|---|---|
| ☐ Liability BMC 91X ☐ Cargo BMC 34 | MC | |
| ☐ Liability – Form E _____ State | | |
| ☐ Oversized/Overweight | | |
| ☐ Hazardous | | |
| ☐ Cargo – Form H _____ State | | |
| ☐ SR 22- If yes explain | | |

If an MCS-90 is issued, Canal will issue with the required limits as posted on the FMCSA website. Please note: 36 days notice of cancellation is mandatory on all policies that have an MCS-90 or filings. Canal requires all units to be scheduled when an MCS-90 or filings are issued.

## 4. *OPERATIONS*

**Please Identify Metropolitan Areas Traveled Through or Into**

| | | | | | |
|---|---|---|---|---|---|
| ☐ Atlanta | ☐ Cleveland | ☐ Jacksonville | ☐ Milwaukee | ☐ Philadelphia | ☐ San Diego |
| ☐ Baltimore/DC | ☐ Dallas/Ft. Worth | ☐ Kansas City | ☐ Mpls/ St. Paul | ☐ Phoenix | ☐ San Francisco |
| ☐ Boston | ☐ Denver | ☐ Little Rock | ☐ Nashville | ☐ Pittsburgh | ☐ Seattle |
| ☐ Buffalo | ☐ Detroit | ☐ Los Angeles | ☐ New Orleans | ☐ Portland | ☐ Tulsa |
| ☐ Charlotte | ☐ Hartford | ☐ Louisville | ☐ New York City | ☐ Richmond | ☐ _____ |
| ☐ Chicago | ☐ Houston | ☐ Memphis | ☐ Oklahoma City | ☐ St. Louis | ☐ _____ |
| ☐ Cincinnati | ☐ Indianapolis | ☐ Miami | ☐ Omaha | ☐ Salt Lake City | ☐ _____ |

☐ Yes ☐ No **Do you act as a freight forwarder, freight broker or arrange loads for others?**
☐ Yes ☐ No **Do you lease to others?**
☐ Yes ☐ No **Do you allow guest passengers?**
☐ Yes ☐ No **Do you haul double trailers?**
☐ Yes ☐ No **Do you haul triple trailers?**
☐ Yes ☐ No **Are any vehicles used to transport employees?**
☐ Yes ☐ No **Do you hire owner operators on a trip lease basis?**
☐ Yes ☐ No **Do you lend, lease or rent trucks, tractors or trailers to others without drivers?**

Please explain all "Yes" answers

## 5. *HISTORY*

**Have there been any losses in the current year or the past three years? ☐Yes ☐No If yes, please complete below.**
Please complete for all lines of business for the current year, as well as for the three years prior, or submit loss runs.

| Policy Term From Month | From Year | To Month | To Year | Company Name | Liability # Claims | Liability *Amount Incurred | Physical Damage # Claims | Physical Damage *Amount Incurred |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
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| | | | | | | | | |

Attach separate loss runs if space provided is not sufficient. *Amount incurred should include paid as well as reserved total.

| Policy Term From Month | From Year | To Month | To Year | Company Name | Cargo # Claims | Cargo *Amount Incurred | General Liability # Claims | General Liability *Amount Incurred |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |
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Attach separate loss runs if space provided is not sufficient. *Amount incurred should include paid as well as reserved total.

Please describe all claims over $10,000

_____
Applicant's Initials

## 6. *DRIVERS*

I declare the following list includes all drivers of vehicles requested to be covered under the policy including employees, leased employees, owner operators, mechanics, family members, and any other person allowed to drive an insured vehicle.

| Driver Name | Date of Birth | Driver License State | Driver License Number | No. of Moving Violations in Past 3 Years | No. of Accidents in Past 3 Years | Year Hired | Years of Experience |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
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**Have any drivers been convicted of any of the following?** ☐ Yes ☐ No

Negligent homicide, unlawful use of vehicle, speed contest or racing, reckless driving, leaving the scene of an accident or a hit and run, any felony conviction which involves a motor vehicle, speed twenty miles or more over the speed limit or driving while license is suspended or revoked in a commercial vehicle, DUI or DWI.

If yes, please provide driver name and details.

☐ Yes ☐ No **Do you agree to report all drivers to your agent prior to them driving an insured unit?**

☐ Yes ☐ No **Do you comply with all DOT regulations concerning driver employment, files and regulations?**

## 7. *VEHICLES*

**Description of Vehicles (trailers must be scheduled for liability coverage to apply while detached from a power unit)**

| Unit No. | Model Year | Make and Unit Type | Serial Number | Number of Axles | GVW | *Owner Type | **Is Garaging address same as physical? |
|---|---|---|---|---|---|---|---|
| 1 | | | | | | | ☐ Yes ☐ No |
| 2 | | | | | | | ☐ Yes ☐ No |
| 3 | | | | | | | ☐ Yes ☐ No |
| 4 | | | | | | | ☐ Yes ☐ No |
| 5 | | | | | | | ☐ Yes ☐ No |

*Please enter the owner type by entering the corresponding number. 1. Owned by Named Insured, 2. Owned by Leasing Company (long term lease without a driver), 3. Owned by Owner Operator (leased with driver), 4. Owned by Employee of Named Insured (officer)

**If a unit is not garaged at the physical address, it is necessary to complete the sections below for additional garaging addresses.

**Name and address of vehicle owners other than the named insured (owner types 2, 3 & 4 listed above)**

| Unit No. | Name of Owner | Mailing Address |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Please note that coverage for owners might not be afforded if this section is not completed.

****If a unit is not garaged at the physical address of the applicant, please complete the garaging addresses for each unit**

| Unit No. | Street Address | | | |
|---|---|---|---|---|
| City | | State | Zip Code | County |
| Unit No. | Street Address | | | |
| City | | State | Zip Code | County |

Applicant's Initials

### *VEHICLES (continued)*

**Are all owned and operated power units listed on this application?**

☐ Yes ☐ No

If no, please provide details.

**Do you have any mobile equipment subject to financial responsibility laws?**

☐ Yes ☐ No

If yes, please provide details of equipment.

## 8. *PRIMARY OPERATION*

**Please indicate the percentage of operations for each of the following:**

____ Dump ____ Flatbed ____ Log Hauling ____ Refrigeration ____ Tank ____ Dry Van

____ Auto Hauler ____ Mobile Home Toter ____ Driveaway ____ Double Trailer Hauler ____ Other _____

**Are any of the following commodities hauled?**

☐ Yes ☐ No Hazardous Materials Requiring 1,000,000 Liability Limits or Less
☐ Yes ☐ No Hazardous Materials Requiring 5,000,000 Liability Limits
☐ Yes ☐ No Refuse/Waste/Garbage
☐ Yes ☐ No Explosives

If yes, please provide details.

**Commodities Transported (Please be specific - general freight and miscellaneous is not acceptable)**

| % | Type | % | Type |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## 9. *COVERAGE SELECTION*

It is only necessary to complete sections for desired coverage. If a coverage section is left blank it will be understood that no coverage is desired.

### 9. *AUTO LIABILITY*

**Commercial Vehicles**

Combined Single Limit - each accident
$

**Taxicabs Only**

Bodily Injury - each person / Bodily Injury - each accident
$ / $

Property Damage - each accident
$

**Please indicate the desired radius restriction if less than an unlimited radius is desired.**

☐ **150** ☐ **300** ☐ **200 (FL and CT only)**

**For an unlimited radius please indicate the percentage of trips by radius from the physical address.**

| Percentage of Trips by Radius | | |
|---|---|---|
| **0-150** | **151-300** | **Over 300** |
| | | |

**Additional/Designated Insureds**

| Name | Mailing Address | *Type of Additional Insured |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

*Please enter each desired additional/designated insured by entering the corresponding number: 1. Designated Additional Insured, 2. Intermodal, 3. Additional Insured Waiver Rights Recovery, 4. Additional Insured Hired/Non-Owned

### 9. *AUTO PHYSICAL DAMAGE*

Please complete for all units that desire physical damage coverage.

| Unit No. | Physical Damage Limit | Name of Loss Payee | Loss Payee Complete Address |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

_____
Applicant's Initials

***AUTO PHYSICAL DAMAGE (continued)***

**Deductible Desired-** Please select one

☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000 (submit for approval)

**Coverage Desired**

☐ Collision and Specified Causes of Loss
☐ Collision and Comprehensive (not available in all states)

**Additional Coverages Desired**

☐ Additional Towing Limit $ _____ (in the event of a total loss to the described unit) $2,500 included

☐ Trailer Interchange Limit $ _____ Minus $1,000 Deductible (UIIA container haulers)

☐ Non-Owned Trailer Limit $ _____ Minus $1,000 Deductible (coverage applies only while attached to a scheduled power unit)

**Please list the name and address of owners of Non-Owned trailers**

| Name of Owner | Address of Owner |
|---|---|
| | |
| | |

**9. *MOTOR TRUCK CARGO***

Coverage for cargo in trailers applies ONLY while trailer is attached to a scheduled power unit.

**Limit Desired**

**Per Vehicle $** _____

Units that require specific limits other than above, please indicate below.

| Unit No. | Desired Limit | Unit No. | Desired Limit |
|---|---|---|---|
| | $ | | $ |

**Deductible Desired-** Please select one

☐ $500 (available only on limits up to $25,000) ☐ $1,000 ☐ $2,500 ☐ $5,000 (submit for approval)

**Additional Coverages Desired**

☐ Refrigeration Breakdown - $2,500 minimum deductible required

☐ Poultry Cages

☐ Water Damage - $2,500 minimum deductible required

☐ Earned Freight Increase to $ _____ $1,000 included

☐ Debris Removal Increase to $ _____ $10,000 included

**9. *TRUCKERS GENERAL LIABILITY***

This application is for General Liability Coverage on businesses solely involved in "for-hire" transportation of property.

**Desired Limits**

General Aggregate - please select one ☐ $1,000,000 ☐ $2,000,000

Each Occurrence $1,000,000 (included)

**Employers Liability (Stop Gap) Coverage**

Applicable only in ND, OH, WA and WY. Please select either yes or no.

☐ Yes ☐ No

| Limits | |
|---|---|
| $1,000,000 | Bodily Injury by Accident - each accident |
| $1,000,000 | Bodily Injury by Disease - each employee |
| $1,000,000 | Bodily Injury by Disease - each policy |

☐ Yes ☐ No Do you haul bulk fuel? If yes, a $1,000 deductible applies. If desired, please indicate an optional higher deductible $ _____

☐ Yes ☐ No Do you repair or service vehicles of others?

☐ Yes ☐ No Do you have dogs at premises? (see exclusion endorsement)

☐ Yes ☐ No Do you carry a firearm? (see exclusion endorsement)

☐ Yes ☐ No Do you generate income from other activities besides the operation of the trucks?

Please explain all "Yes" answers

Please list all mobile equipment owned by the applicant, if any (i.e. forklift, backhoe, mobile crane, etc.)

_____
Applicant's Initials

***TRUCKERS GENERAL LIABILITY (continued)***

Please list all premises owned or rented

| Street Address | | | |
|---|---|---|---|
| City | State | Zip Code | County |
| Street Address | | | |
| City | State | Zip Code | County |
| Street Address | | | |
| City | State | Zip Code | County |

**Additional/Designated Insureds**

| Name | Mailing Address | *Type of Additional Insured |
|---|---|---|
| | | |
| | | |
| | | |

*Please enter each desired additional/designated insured by entering the corresponding number: 1. Controlling Interest, 2. Designated Person or Organization, 3. Managers or Lessors of Premises, 4. Mortgagee, 5. Owners, Lessees or Contractors, 6. Co-Owner of Insured Premises, 7. Vicarious Liability for Owners, Lessees or Contractors

## 10. *CERTIFICATES OF INSURANCE*

| Name | Mailing Address |
|---|---|
| | |
| | |
| | |
| | |
| | |

## 11. *MVR AND CREDIT REPORT ACKNOWLEDGEMENT*

I authorize Canal Insurance Company to obtain a copy of any Motor Vehicle Report for rating/underwriting the insurance for which I have applied. I also understand that a routine inquiry may be made providing information concerning my character, general reputation, personal characteristics and mode of living. Upon written request, information as to the nature and scope of the report will be provided to me.

**Disclosure:** In connection with this application for commercial automobile insurance, we may review a credit report or obtain or use a credit-based insurance score based on the information contained in that credit report. We may use a third party in connection with the development of the insurance score. Your credit report/credit-based insurance score will not be used for any purpose other than the underwriting of the commercial automobile insurance policy for which you have applied.

**Under no circumstances can the credit-based insurance score, the lack thereof, or the refusal to authorize the obtaining of a credit report or a credit-based insurance score be a factor in determining your eligibility for commercial automobile insurance, including cancellation or nonrenewal, if a policy is ultimately issued.**

I authorize Canal Insurance Company to obtain a credit report, including but not limited to a credit-based insurance score based on personal information provided. This authorization is valid for future reports obtained for renewal policies with Canal Insurance Company.

_____ _____

Applicant's Signature Date

## 12. *ACKNOWLEDGEMENT AND SIGNATURE*

I hereby certify that the information contained in this application is true and agree that a misrepresentation of any of the facts by me will constitute reason for the company to void or cancel any policy issued on the basis of this application, and will hold the company harmless for the action taken. I also agree that if a policy is issued pursuant to this application, the application and any elections or rejections, which are included with the application and signed by me, may be relied upon by the company as accurate and shall become a part of the policy.

I recognize that all or parts of my operations are under the Department of Transportation oversight requiring me to adhere to their rules and regulations. I acknowledge that DOT rules and regulations are understood by me, and I will adhere to the rules and regulations including, but not limited to, driver hiring, vehicle inspection, maintenance and hours of service.

**NOTICE: CANAL'S ACCEPTANCE OF THIS APPLICATION IS CONTINGENT UPON THE CONSIDERATION OF THE APPLICANT'S CLAIMS HISTORY. IF ACCEPTED, YOUR CLAIMS HISTORY WILL ALSO BE CONSIDERED IN DETERMINING IF THE POLICY SHOULD BE CANCELED OR NON-RENEWED.**

## MARYLAND FRAUD WARNING

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

## MARYLAND NOTICE OF UNDERWRITING PERIOD
## ADVISORY NOTICE TO POLICYHOLDERS

We are notifying you that the policy you have just agreed to purchase is subject to a 45 day underwriting period beginning on the effective date of your coverage. Your coverage may be cancelled during the underwriting period if your risk does not meet our underwriting standards. If we decide to cancel the policy, we will send you a written Notice of Cancellation advising you of the reason(s) for the cancellation and the date on which your policy will be cancelled.

Signature of **APPLICANT** **X** _____

Type or Print Applicant Name _____

Title or Relationship to Applicant _____

Date Application Completed _____

Signature of **AGENT** of the Applicant **X** _____

Agency Name _____

Address of Agency _____

**Premium Calculations (agent use only)**

| Coverage | Premium |
|---|---|
| Auto Liability | |
| Auto Physical Damage | |
| Motor Truck Cargo | |
| Truckers General Liability | |
| **Total** | |

| Deposit or Down Payment | Number of Installments | Amount Enclosed |
|---|---|---|
| | | |

# CANAL

☐ INSURANCE COMPANY

☐ INDEMNITY COMPANY

**MARYLAND SUPPLEMENTAL APPLICATION**

**MUST be completed in conjunction with Form A-101 MD if Auto Liability Coverage is requested**

1. Applicant Name

2. DBA, if any

**NOTICE: CANAL'S ACCEPTANCE OF THIS APPLICATION IS CONTINGENT UPON THE CONSIDERATION OF THE APPLICANT'S CLAIMS HISTORY. IF ACCEPTED, YOUR CLAIMS HISTORY WILL ALSO BE CONSIDERED IN DETERMINING IF THE POLICY SHOULD BE CANCELED OR NON-RENEWED.**

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## UNINSURED MOTORISTS COVERAGE

Uninsured Motorists Coverage provides protection for persons who are legally entitled to recover damages because of bodily injury (including resulting death) or damage to property from an owner or operator of an uninsured motor vehicle or those whose liability limits are less than the limits of your Uninsured Motorists Coverage.

In accordance with Maryland law, your commercial automobile liability policy automatically includes Uninsured Motorists Coverage at the Financial Responsibility Limits of $55,000 bodily injury and property damage combined single limit (CSL); or $20,000 each person/ $40,000 each accident for bodily injury and $15,000 each accident for property damage unless you select higher limits of Uninsured Motorists Coverage. Higher limits of Uninsured Motorists Coverage may be purchased at an additional premium provided that the limits selected do not exceed the liability limits of the policy.

To be certain that the policy is issued with the Uninsured Motorists Coverage limits that you want, please indicate your desired coverage limits below and sign and date this form, where provided, as your indication of approval of the limits selected.

### I. DISCLOSURE OF UNINSURED MOTORISTS COVERAGE PREMIUMS

| Limits Offered | Annual Premium for Gasoline or Petroleum Haulers | Annual Premium for Other Commercial |
|---|---|---|
| 20/40/15* | 124 | 53 |
| 55 CSL | 156 | 89 |
| 75 CSL | 219 | 144 |
| 100 CSL | 285 | 215 |
| 200 CSL | 458 | 360 |
| 250 CSL | 656 | 430 |
| 300 CSL | 736 | 482 |
| 350 CSL | 810 | 530 |
| 400 CSL | 882 | 578 |
| 500 CSL | 1,024 | 670 |
| 600 CSL | 1,114 | 730 |
| 750 CSL | 1,210 | 790 |
| 800 CSL | 1,260 | 820 |
| 900 CSL | 1,320 | 850 |
| 1,000 CSL | 1,380 | 880 |

*Property Damage Uninsured Motorist Coverage is subject to a $250 per accident deductable.

Applicant's Initials

## II. OFFER OF UNINSURED MOTORISTS COVERAGE

I have had this coverage fully explained to me and I wish to purchase at Uninsured Motorists Coverage at the following limits, which do not exceed the Liability Coverage limits of my policy **(applicable item marked ☒):**

☐ Minimum Required by Law (select one below)

- ☐ BI - $20,000 per person/$40,000 per accident; PD - $15,000 per accident; or
- ☐ $55,000 combined single limit; or

☐ The following **HIGHER** limit of liability (not to exceed policy liability limits)

$ _____ combined single limit

## III. APPLICANT'S ACKNOWLEDGMENT

The undersigner(s) hereby acknowledge(s) they have read, or have had read to them and understand, the above explanations and offers of Uninsured Motorist Coverage. Selections have been made by checking the appropriate boxes in Section II. The signature appearing below is that of the named insured or authorization has been given to the signer of this Offer of Uninsured Motorist Coverage to select or reject coverage and limits on the behalf of the named insured.

**YOUR SELECTION OR REJECTION OF COVERAGE IS BINDING ON ALL PERSONS INSURED UNDER THIS POLICY.**

Applicant /Named Insured: _____ Date: _____

By: _____

Title: _____

Signature of Agent of Insured: _____ Date: _____

Address: _____

_____

## NOTICE CONCERNING THE WAVIER OF PERSONAL INJURY PROTECTION (PIP) COVERAGE IN MARYLAND

You have the choice of purchasing certain Personal Injury Protection (PIP) Coverages. Before deciding whether to purchase or waive this coverage, please read the following carefully.

**Full** PIP coverage provides the following protection, without regarding to fault:

1. It covers you and members of your family residing with you who are injured in **any** motor vehicle accident; anyone injured while **in** your vehicle; and pedestrians injured **by** your vehicle.

2. The **minimum** coverage is $2,500 and may be used to cover:
   a. All reasonable and necessary medical expenses incurred within 3 years of injury; and
   b. 85% of actually incurred lost wages; or
   c. If the injured person is not employed at the time of injury, any reasonable and necessary expenses to provide for essential services which that person would have provided for the care and maintenance of his or her family or household.

If you do **not** sign the waiver, you will automatically receive the full PIP protection described above. Your PIP premium will be $ _____ annually.

You may only waive PIP coverage for:

1. The named insured (you);
2. All listed drivers on the policy; and
3. Members of your family who are 16 years of age or older and reside with you in your household.

The waiver prevents the **named** insured (you) from collecting PIP benefits under **any** motor vehicle liability insurance policy issued in the State of Maryland or another form of security authorized to be used in place of a motor vehicle liability insurance policy.

The waiver prevents individuals described in category 2 or 3 above from collecting PIP benefits under your policy. In addition, the waiver prevents these individuals from collecting benefits under any other policy of motor vehicle liability insurance issued in the State of Maryland or another form of security authorized to be used in place of a motor vehicle liability insurance policy unless the individual:

- Is the first named insured under the other policy;
- Has not waived PIP benefits under the other policy; and
- Is not a named insured under any policy of motor vehicle liability insurance where a waiver of PIP benefits is in effect.

The waiver does not impair the rights of other individuals such as pedestrians or minor children from collecting PIP under your policy.

If you decide to sign the waiver, your PIP premium will be _____ % of the full PIP coverage. The total premium will be $ _____ annually.

If you decide **not** to sign the waiver, your insurance company may not refuse to write your insurance coverage.

## WAIVER OF PERSONAL INJURY PROTECTION (PIP) COVERAGE

**I hereby confirm that I have fully read and understood the attached notice, required by Section 19-506 of the Insurance Article, and I understand and agree that the Company indicated below, in reliance upon my signature as the first named insured/applicant, will NOT provide the Personal Injury Protection (PIP) coverage required by Section 19-505 and described in the attached notice provided to me with this waiver. This coverage is waived for any injury which may be sustained by:**

1. **Anyone listed as a named insured on the policy;**
2. **All drivers listed on the policy; and**
3. **All members of the named insured's family living in the insured's household who are 16 years of age or older.**

**I further understand and agree that the waiver of Personal Injury Protection (PIP) benefits under the policy being applied for waives coverage for PIP benefits for anyone described above under any other policy issued in the State of Maryland or another form of security authorized to be used in place of a motor vehicle liability insurance policy, unless the individual is:**

- **Is the first named insured under the other policy; and**
- **Has not waived PIP benefits under the other policy; and**
- **Is not a named insured under any policy of motor vehicle liability insurance where a waiver of PIP benefits is in effect.**

**I, the first named insured/applicant, have fully read and understood the above noted information and hereby:**
***(check one of the following)***

☐ **request full PIP coverage be applicable to the policy or binder of insurance described below, on all future renewals of the policy and on all replacement policies unless I notify the company in writing to the contrary, with the effective date of such change being no earlier than the receipt date by the company of my written notification.**

☐ **affirmatively waive the benefits required by Section 19-505 of the Insurance Article (PIP). I understand and agree that this waiver of coverage shall be applicable to the policy or binder of insurance described below, on all future renewals of the policy and on all replacement policies unless I notify the company in writing to the contrary, with the effective date of such change being no earlier than the receipt date by the company of my written notification.**

**Print Name:** _____
**First Named Applicant/Insured**

**Signature:** _____
**Signature of First Named Applicant/Insured**

**Date:** _____ **Policy/Binder #:** _____

**Insurer:** _____

**Producer Name:** _____ **Producer Code:** _____

**THIS IS NOT A BINDER THIS IS NOT A BINDER THIS IS NOT A BINDER THIS IS NOT A BINDER**