



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 <input type="checkbox"/> Individual <input type="checkbox"/> LLC <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Joint Venture <input type="checkbox"/> 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 <input type="checkbox"/> Inside City Limits <input type="checkbox"/> 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
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If applying for **Small Commercial**, describe type of business and use of vehicle(s).

Type of Business	Use of Vehicle(s)
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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
<input type="checkbox"/> Liability BMC 91X <input type="checkbox"/> Cargo BMC 34	MC	
<input type="checkbox"/> Liability – Form E _____ State		
<input type="checkbox"/> Oversized/Overweight		
<input type="checkbox"/> Hazardous		
<input type="checkbox"/> Cargo – Form H _____ State		
<input type="checkbox"/> 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

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

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

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

Policy Term				Company Name	Cargo		General Liability	
From		To			# Claims	*Amount Incurred	# Claims	*Amount Incurred
Month	Year	Month	Year					

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



CANAL Canal Commercial Combination Insurance Application

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

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							<input type="checkbox"/> Yes <input type="checkbox"/> No
2							<input type="checkbox"/> Yes <input type="checkbox"/> No
3							<input type="checkbox"/> Yes <input type="checkbox"/> No
4							<input type="checkbox"/> Yes <input type="checkbox"/> No
5							<input type="checkbox"/> Yes <input type="checkbox"/> 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

Taxicabs Only

Combined Single Limit - each accident

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

Table with 2 columns: 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.

Table with 4 columns: 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.

WEST VIRGINIA FRAUD WARNING

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

Signature of **APPLICANT** X

Type or Print Applicant Name _____ Signature of **AGENT** of the Applicant X

Title or Relationship to Applicant _____ Agency Name _____

Date Application Completed _____ Address of Agency _____

Premium Calculations (agent use only)

Coverage	Premium			
Auto Liability				
Auto Physical Damage				
Motor Truck Cargo				
Truckers General Liability		Deposit or Down Payment	Number of Installments	Amount Enclosed
Total				

CANAL

WEST VIRGINIA SUPPLEMENTAL APPLICATION

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

INSURANCE COMPANY

INDEMNITY COMPANY

1. Applicant Name

2. DBA, if any

WEST VIRGINIA FRAUD WARNING

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

UNINSURED/UNDERINSURED MOTORIST COVERAGE - The laws of the State of West Virginia require that we make available optional limits of uninsured and underinsured motorist coverage. Please complete the Uninsured & Underinsured Motorists Coverages form and submit it with this application.

UNINSURED & UNDERINSURED MOTORISTS COVERAGES

Split Limits - Form A

Combined Single Limits - Form B

Complete and Return Through Your Insurance Agent

IMPORTANT NOTICE

OFFER VOID AFTER THIRTY (30) DAYS

TO: PROPOSED POLICYHOLDERS (APPLICANT):

IF YOU DO NOT RETURN THIS FORM TO YOUR INSURER WITHIN THIRTY (30) DAYS IT MEANS YOU HAVE DECIDED NOT TO BUY OPTIONAL UNDERINSURED COVERAGES OR OPTIONAL LIMITS OF UNINSURED MOTORIST COVERAGE ABOVE THAT REQUIRED BY LAW.

OR

PRESENT POLICYHOLDERS:

IF YOU DO NOT RETURN THIS FORM TO YOUR INSURER WITHIN THIRTY (30) DAYS IT MEANS YOUR COVERAGE WILL STAY THE SAME AS IT IS NOW. THIS IS AN OPPORTUNITY TO CHANGE THE COVERAGE YOU PRESENTLY HAVE.

UNINSURED MOTOR VEHICLE COVERAGE

The State of West Virginia requires that you purchase **Uninsured** motor vehicle coverage with limits not less of \$20,000 per person, \$40,000 per accident for uninsured bodily injury losses, and \$10,000 for uninsured property losses. The law also requires that you be given the opportunity to purchase higher limits. (See the charts on pages 2 and 3 or pages 4 and 5 for coverages available to you.)

Uninsured Motor Vehicle Coverage will protect you and passengers in your car if you are injured in an accident that was caused by an uninsured driver who was at-fault, or an unidentified driver who was at-fault.

UNDERINSURED MOTOR VEHICLE COVERAGE

The State of West Virginia **does not require** you to purchase **UNDERinsured** motor vehicle coverage. However, the law does state that you must be given the opportunity to purchase this coverage at limits as high as your liability coverage.

If you and passengers in your car are involved in an accident in which the other driver is legally at fault, the at-fault driver's insurance policy has the obligation to pay for your damages. It is not uncommon that the at-fault driver will not have enough liability insurance to pay for all the damages you have suffered. In order for you to protect yourself and others in your car, **UNDERinsured motor vehicle coverage** is available to you. This type of coverage will pay for the remainder of your damages up to your policy limits.

EXAMPLE:

You have purchased **UNDERinsured** motor vehicle coverage with limits of \$50,000 per person with a maximum of \$100,000 for any accident. You are in an accident where the other driver is at fault. The at-fault driver's liability policy limits are \$20,000 per person. You suffered damages of \$30,000. You receive \$20,000 from the at-fault driver's insurance. Since you still have outstanding losses of \$10,000, you can receive \$10,000 from your **UNDERinsured** motor vehicle coverage.

If you do not have **UNDERinsured motor vehicle coverage**, you may have found yourself in a situation where you did not have enough coverage to meet all of the losses you sustained in the accident.

UNINSURED MOTORISTS COVERAGE OFFER

Below are different limits and the _____ month premium available to you.

COMPANY MUST COMPLETE THE BLANK SPACES BELOW TO CREATE AN EFFECTIVE OFFER IN ORDER FOR THE CONSUMER TO EXERCISE A KNOWING AND INTELLIGENT SELECTION.

UNINSURED MOTORISTS COVERAGE (MANDATORY)

AGENT _____

Number of vehicles subject to premiums below _____.

POLICY/BINDER NUMBER _____

Rates include do not include multi-car discount.

Bodily Injury Per Person	Bodily Injury Per Accident	Property Damage	Premium	SELECT (Check One)
MANDATORY LIMITS				
\$ 20,000	\$ 40,000	\$ 10,000	[A] \$ _____	[A] <input type="checkbox"/>
OPTIONAL LIMITS				
\$ 25,000	\$ 50,000	\$ 10,000	[B] \$ _____	[B] <input type="checkbox"/>
\$ 50,000	\$ 100,000	\$ 10,000	[C] \$ _____	[C] <input type="checkbox"/>
\$ 100,000	\$ 300,000	\$ 10,000	[D] \$ _____	[D] <input type="checkbox"/>
\$ 100,000	\$ 300,000	\$ 50,000	[E] \$ _____	[E] <input type="checkbox"/>
\$ _____	\$ _____	\$ _____	[F] \$ _____	[F] <input type="checkbox"/>
\$ _____	\$ _____	\$ _____	[G] \$ _____	[G] <input type="checkbox"/>

You may select limits up to the liability limits of your policy.

A named insured or applicant must complete this part of the form in his or her own handwriting.

I have read the IMPORTANT NOTICE, attached, on UNinsured motor vehicle coverage and understand how this coverage works.

I have been given the opportunity to select the optional limits of UNinsured motor vehicle coverage listed above and have selected the coverage that matches the box I have checked.

X

SIGNATURE OF A NAMED INSURED OR APPLICANT

DATE

This selection of coverage is binding on all persons covered under the policy. These limits apply until a change in the limits is requested.

UNDERINSURED MOTORISTS COVERAGE OFFER

Below are different limits and the _____ month premium available to you.

COMPANY MUST COMPLETE THE BLANK SPACES BELOW TO CREATE AN EFFECTIVE OFFER IN ORDER FOR THE CONSUMER TO EXERCISE A KNOWING AND INTELLIGENT SELECTION OR REJECTION.

UNDERINSURED MOTORISTS COVERAGE (OPTIONAL)

AGENT _____

Number of vehicles subject to premiums below _____.

POLICY/BINDER NUMBER _____

Rates include do not include multi-car discount.

<u>Bodily Injury Per Person</u>	<u>Bodily Injury Per Accident</u>	<u>Property Damage</u>	<u>Premium</u>	<u>I SELECT (Check One)</u>
<u>\$ 20,000</u>	<u>\$ 40,000</u>	<u>\$ 10,000</u>	<u>[A] \$ _____</u>	<u>[A] <input type="checkbox"/></u>
<u>\$ 25,000</u>	<u>\$ 50,000</u>	<u>\$ 10,000</u>	<u>[B] \$ _____</u>	<u>[B] <input type="checkbox"/></u>
<u>\$ 50,000</u>	<u>\$ 100,000</u>	<u>\$ 10,000</u>	<u>[C] \$ _____</u>	<u>[C] <input type="checkbox"/></u>
<u>\$ 100,000</u>	<u>\$ 300,000</u>	<u>\$ 10,000</u>	<u>[D] \$ _____</u>	<u>[D] <input type="checkbox"/></u>
<u>\$ 100,000</u>	<u>\$ 300,000</u>	<u>\$ 50,000</u>	<u>[E] \$ _____</u>	<u>[E] <input type="checkbox"/></u>
<u>\$ _____</u>	<u>\$ _____</u>	<u>\$ _____</u>	<u>[F] \$ _____</u>	<u>[F] <input type="checkbox"/></u>
<u>\$ _____</u>	<u>\$ _____</u>	<u>\$ _____</u>	<u>[G] \$ _____</u>	<u>[G] <input type="checkbox"/></u>
<u>REJECT</u>	<u>REJECT</u>	<u>REJECT</u>	<u>REJECT</u>	<u><input type="checkbox"/> I REJECT</u>

You may not select limits up to the liability limits of your policy.

A named insured or applicant must complete this part of the form in his or her own handwriting.

I have read the **IMPORTANT NOTICE**, attached, on **UNDERinsured** motor vehicle coverage and understand how this coverage works.

I have been given the opportunity to select or reject limits of **UNDERinsured** motor vehicle coverage listed above and have selected the coverage that matches the box I have checked.

X

SIGNATURE OF A NAMED INSURED OR APPLICANT

DATE

This selection of coverage is binding on all persons covered under the policy. These limits apply until a change in the limits is requested.

UNINSURED MOTORISTS COVERAGE OFFER

Below are different limits and the 12 month premium available to you.

COMPANY MUST COMPLETE THE BLANK SPACES BELOW TO CREATE AN EFFECTIVE OFFER IN ORDER FOR THE CONSUMER TO EXERCISE A KNOWING AND INTELLIGENT SELECTION.

UNINSURED MOTORISTS COVERAGE (MANDATORY)

AGENT _____

Number of vehicles subject to premiums below _____.

POLICY/BINDER NUMBER _____

Rates **include** **do not include** multi-car discount.

Single Limits

Premium

MANDATORY LIMITS

1st unit / each add'l unit

**I SELECT
(Check One)**

- \$50,000
- \$100,000
- \$200,000
- \$300,000
- \$350,000
- \$500,000
- \$1,000,000

OPTIONAL LIMITS

- [A] \$ \$64 / \$58
- [B] \$ \$110 / \$99
- [C] \$ \$180 / \$162
- [D] \$ \$241 / \$217
- [E] \$ \$288 / \$259
- [F] \$ \$335 / \$302
- [G] \$ \$440 / \$396

- [A] _____
- [B] _____
- [C] _____
- [D] _____
- [E] _____
- [F] _____
- [G] _____

You may select limits up to the liability limits of your policy.

A named insured or applicant must complete this part of the form in his or her own handwriting.

I have read the **IMPORTANT NOTICE**, attached, on **Uninsured** motor vehicle coverage and understand how this coverage works.

I have been given the opportunity to select the optional limits of **Uninsured** motor vehicle coverage listed above and have selected the coverage that matches the box I have checked.

X

SIGNATURE OF A NAMED INSURED OR APPLICANT

DATE

This selection of coverage is binding on all persons covered under the policy. These limits apply until a change in the limits is requested.

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

UNDERINSURED MOTORISTS COVERAGE OFFER

Below are different limits and the 12 month premium available to you.

COMPANY MUST COMPLETE THE BLANK SPACES BELOW TO CREATE AN EFFECTIVE OFFER IN ORDER FOR THE CONSUMER TO EXERCISE A KNOWING AND INTELLIGENT SELECTION OR REJECTION.

UNDERINSURED MOTORISTS COVERAGE (OPTIONAL)

AGENT _____

Number of vehicles subject to premiums below _____.

POLICY/BINDER NUMBER _____

Rates include do not include multi-car discount.

Single Limits

Premium

OPTIONAL LIMITS

- \$50,000
- \$100,000
- \$200,000
- \$300,000
- \$350,000
- \$500,000
- \$1,000,000

[A] \$ _____

[B] \$ _____

[C] \$ _____

[D] \$ _____

[E] \$ _____

[F] \$ _____

[G] \$ _____

REJECT _____

REJECT _____

I SELECT (Check One)

[A] _____

[B] _____

[C] _____

[D] _____

[E] _____

[F] _____

[G] _____

I REJECT _____

You may select limits up to the liability limits of your policy.

A named insured or applicant must complete this part of the form in his or her own handwriting.

I have read the **IMPORTANT NOTICE**, attached, on **UNDERinsured** motor vehicle coverage and understand how this coverage works.

I have been given the opportunity to select or reject the optional limits of **UNDERinsured** motor vehicle coverage listed above and have selected the coverage that matches the box I have checked.

X

SIGNATURE OF A NAMED INSURED OR APPLICANT

DATE

This selection of coverage is binding on all persons covered under the policy. These limits apply until a change in the limits is requested.

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