☐ **National Casualty Company**
Home Office: Madison, Wisconsin
Adm Office: 8877 Gainey Center Dr.
Scottsdale, Arizona 85258

☐ **Scottsdale Insurance Company**
Home Office: One Nationwide Plaza
Columbus, Ohio 43215
Adm. Office: 8877 North Gainey Center Drive
Scottsdale, Arizona 85258

☐ **Scottsdale Indemnity Company**
Home Office: One Nationwide Plaza
Columbus, Ohio 43215
Adm. Office: 8877 North Gainey Center Drive
Scottsdale, Arizona 85258

☐ **Scottsdale Surplus Lines Insurance Company**
Adm. Office: 8877 North Gainey Center Drive
Scottsdale, Arizona 85258

1-800-423-7675 • Fax (480) 483-6752

COMMERCIAL AUTOMOBILE/TRUCKERS APPLICATION

Name of Applicant: ____________
D/B/A: ____________
Street Address: ____________
____
P.O. Mailing Address: ____________
____
Phone Number: (___) ____________
FEIN/Social Security/Soundex No. ____________
Web site: ____________

Agent Name: ____________
____
Address: ____________
____
Agent No.: ____________

PROPOSED EFFECTIVE DATE:

From ____________ **To** ____________

12:01 A.M., Standard Time, at the address of the Applicant.

PLEASE ANSWER ALL QUESTIONS

DESCRIPTION OF OPERATIONS

1. **Applicant is:** ☐ Individual ☐ Partnership ☐ Corporation ☐ Joint Venture ☐ LLC ☐ Other: ____________
2. **Description of operations:** ____________
   ____
   Attach appropriate supplemental application as needed.
3. **How long has this operation been in business?** ____________
4. **How many years of experience does your management have in the truck/transportation business?** ____________
   Provide an explanation of their experience: ____________
5. **Have you had any insurance canceled, declined or non-renewed in the last three years** (Not applicable in Missouri)? ☐ Yes ☐ No
   If yes, explain: ____________
   ____
6. **Has there been any change in the nature of operations, ownership, management or the name of the operation during the last five years?** ☐ Yes ☐ No
   If yes, provide details: ____________
7. **Is the applicant a subsidiary of another entity or does the applicant have any subsidiaries or has the applicant operated under a different name?** ☐ Yes ☐ No
   If yes, provide details: ____________

8. **Is there a formal safety program?** .... ☐ Yes ☐ No
   If yes, provide details or a copy: ____________________
   ____

9. **List commodities transported:** ____________________

10. **Any exposure to flammables, explosives, chemicals or hazardous materials (including medical or contaminated waste)?** .... ☐ Yes ☐ No
    If yes, provide specific details: ____________________

11. **Radius of operations:** ☐ Intrastate only ☐ Interstate
    0-100 miles ________%, 101-300 miles ________%, 301-500 miles ________%, Over 500 miles _______%

12. **List all states in which vehicles operate:** ____________________
    a. For all states, list largest cities entered: ____________________
    b. For all states, list farthest city entered from garaging location: ____________________

13. **Is your operation subject to time constraints when delivering the commodity?** .... ☐ Yes ☐ No

14. **Do you haul for others?** .... ☐ Yes ☐ No
    If yes, indicate percentage and for whom: ____________________

15. **Do you back haul?** .... ☐ Yes ☐ No
    If yes, advise for whom and commodities transported? ____________________
    ____

16. **Do you have a signed trailer interchange agreement?** .... ☐ Yes ☐ No
    If yes, provide a copy of the signed agreement, cover letter and provider list.

17. **Do you operate under a UIIA (Uniform Intermodal Interchange Association) contract?** .... ☐ Yes ☐ No
    If yes, provide a copy of the signed contract, cover letter and provider list.

18. **Do any units have special equipment, customizations or alterations?** .... ☐ Yes ☐ No
    a. If yes, describe: ____________________
    b. If a boom, how far does the collapsed length of the boom extend beyond the front or rear bumper? ____________

19. **Are any vehicles used by family members?** .... ☐ Yes ☐ No
    If yes, list and provide MVRs: ____________________

20. **Is there personal use of vehicles?** .... ☐ Yes ☐ No
    If yes, explain: ____________________

21. **Do you allow passengers?** .... ☐ Yes ☐ No
    If yes, explain: ____________________

22. **Are any vehicles or equipment loaned, rented, or leased to others?** .... ☐ Yes ☐ No
    If yes, explain: ____________________
    ____

23. **Are all drivers covered by Workers' Compensation insurance?** .... ☐ Yes ☐ No

DRIVER INFORMATION

24. **Is there a formal driver hiring procedure?** .... ☐ Yes ☐ No
    If yes, provide a copy.

25. Is there a formal driver training program? .... ☐ Yes ☐ No

If yes, provide a copy.

26. Do you:

Perform employee drug & alcohol screening/testing? .... ☐ Yes ☐ No

Perform criminal background checks? .... ☐ Yes ☐ No

Have a "Good Driver" incentive program .... ☐ Yes ☐ No

Order MVRs prior to allowing employees to drive? .... ☐ Yes ☐ No

27. Criteria for hiring drivers: minimum age: ________ **years of experience:** ________

Describe MVR standards: ____________________

____

28. Average driver turnover per year: .... ________%

Number of drivers hired in the past twelve (12) months: .... ________

29. Is there an accident review procedure? .... ☐ Yes ☐ No

If yes, please describe: ____________________

____

30. Are all drivers employees? .... ☐ Yes ☐ No

If no, provide copy of contract.

31. How are your drivers paid? ☐ Per load ☐ Per hour ☐ Other: ____________________

32. Do you agree to screen and report all potential operators immediately upon hiring? .... ☐ Yes ☐ No

33. Maximum number of hours driver will operate a vehicle in a 24-hour period: ____________________

34. Are driver teams used? .... ☐ Yes ☐ No

35. Are drivers assigned to specific units? .... ☐ Yes ☐ No

36. List below all drivers, owners/officers, partners currently employed as of the proposed effective date. If a Non-Owned auto is to be considered, you must list information for all employees currently employed by you.

Driver's Name	D/C*	Date of Birth	Driver's License No.	State	Class of License	No. of Years Driving Similar Vehicle	Length of Employment	List Past Three Years of Accidents & Traffic Violations

*Designation Code: O—Owner/Officer, P—Partner, E—Employee

VEHICLE INFORMATION

37. Number of vehicles owned: ________ Light ________ Medium ________ Heavy ________ Extra Heavy

________ Tractors ________ Trailers ________ Private Passenger Types

38. **Number of vehicles leased:** ________ Light ________ Medium ________ Heavy ________ Extra Heavy
________ Tractors ________ Trailers ________ Private Passenger Types

39. **Do you use double or triple trailers?** .... ☐ Yes ☐ No
If yes, what percentage of trips involves the use of multiple trailers?.......... ________%

40. **Do all trailers havē DOT-required reflective tape?** .... ☐ Yes ☐ No

41. **Provide details on your vehicle maintenance program:** ____

____

____

42. **Are any vehicles owned, operated or leased that are not included in the vehicle schedule?**.......... ☐ Yes ☐ No
If yes, provide details: ____

PRIOR CARRIER AND LOSS EXPERIENCE SUMMARY

Include a minimum of four years currently valued company loss runs for all accounts.

The following Prior Carrier and Loss Experience Section must be completed:

Policy Period	Prior Carrier	Policy No.	Past Deductible Amount	Liability Premium	Physical Damage Premium	No. Of Losses	Liability Losses Paid/ Open*	Physical Damage Losses Paid/ Open*

OPERATION HISTORY

Year	Gross Receipts	Mileage	Number of Power Units
Current Year			
Projected for Coming Year			

FILING INFORMATION

43. **Do you hold an ICC/FHWA permit or UCRA/DOT registration?** .... ☐ Yes ☐ No
If yes, provide: US DOT No. ________________, MC No. ________________, Base State ________

44. **State filings required?** .... ☐ Yes ☐ No
If yes, list states and provide necessary state motor carrier number, if applicable: ________________________

____

45. **Provide exact name and address as shown on application for filings, permits, certificates, etc.:** ____________

____

____

____

46. **Are there any special requirements needed for City permits, Certificates of Insurance, oversize and/or over weight permits?** ☐ Yes ☐ No

If yes, provide details: ____

____

HIRED AUTO INFORMATION—Coverage Subject to Audit

47. **Why is hired auto coverage being requested?** ______________________________

48. **Do you lease, hire, rent or borrow any vehicles from others?** ☐ Yes ☐ No

What is the average term of the lease? ______________________________

Is there a written agreement? ☐ Yes ☐ No

Does it include a Hold Harmless agreement and/or Additional Insured clause? ☐ Yes ☐ No

Provide a copy of the agreement.

49. **Do you hire independent contractors?** ☐ Yes ☐ No

If yes, do you require certificates of insurance? ☐ Yes ☐ No

Provide a copy of the contract.

50. **If owner/operators are leased, will they be scheduled on your policy?** ☐ Yes ☐ No

If yes, provide a copy of the agreement you use.

51. **Do you use sub-haulers?** ☐ Yes ☐ No

If yes, provide cost of hire. $____________

Provide a copy of the contract.

52. **Do you lease, hire, rent, or borrow any vehicles from others without drivers?** ☐ Yes ☐ No

Will they be scheduled on the policy? ☐ Yes ☐ No

What is the average term of the lease? ______________________________

53. **What is your cost to lease, hire, rent or borrow vehicles?** With drivers $__________ Without drivers $__________

Estimated cost of hired autos: This year: $____________ Last year: $____________

54. **Is Hired Auto Physical Damage coverage desired?** ☐ Yes ☐ No

If yes, average value of auto hired? $____________

55. **How many autos are hired on average within a twelve (12) month period?** ____________

56. **How many hired autos are in the insured's possession at any one time?** ____________

57. **What type of vehicles do you lease, hire, rent or borrow?** Truck-Tractors ________% Trailers ________%

Heavy & Extra Trucks ________% Pickup trucks or Vans ________% Private Passenger Cars ________%

58. **At any time will your employees, subcontractors, or owner/operators lease vehicles in your name?** ☐ Yes ☐ No

If yes, explain: ____

59. **Do you arrange or dispatch loads for others, not including your own hired truckers?** ☐ Yes ☐ No

Explain: ____

Are you named on the Bills of Lading? ☐ Yes ☐ No

Annual number of Truckers: ____________ Loads: ____________

60. Do you have motor carrier brokerage authority? ☐ Yes ☐ No

If yes, is the brokerage authority held under the same name and motor carrier number as your trucking operation? ☐ Yes ☐ No

What is your motor carrier brokerage number? ______

Whose name appears on the bill of lading as the carrier? ______

What is your brokerage revenue for the most recent twelve (12) months? ______

Estimated next twelve (12) months? ______

61. Do you understand that we may audit your records for Hired auto exposure, which might result in an additional premium? ☐ Yes ☐ No

NON-OWNED AUTO INFORMATION—Coverage Subject to Audit

62. Why is non-ownership liability coverage being requested? ______

63. What types of non-owned autos will be used in your business? ______

Total number of non-owned autos used: ______ How will they be used? ______

64. How often are non-owned autos used in your business? ☐ Daily ☐ Weekly ☐ Monthly ☐ Other: ______

Estimate the number of hours per month: ______

Estimated annual mileage for use of all non-owned autos: ______

65. Do any employees use their autos in your business? ☐ Yes ☐ No

If yes, what limit of liability insurance are they required to maintain? ______

Do you require evidence of insurance? ☐ Yes ☐ No

66. Will you use non-owned autos other than those owned by employees? ☐ Yes ☐ No

If yes, describe the relationship: ______

67. Total number of employees: ______ **Total number of officers and partners:** ______

68. If a social service operation, do you use the autos of volunteers? ☐ Yes ☐ No

Maximum number of volunteers at any one time: ______

How will they use their vehicles? ______

______

69. Are volunteers required to have their own insurance? ☐ Yes ☐ No

Minimum limits required: ______

70. Do you obtain motor vehicle records for all employees and volunteers? ☐ Yes ☐ No

71. Do you understand that we may audit your records for Non-Owned auto exposure, which might result in an additional premium? ☐ Yes ☐ No

LIMIT AND COVERAGE INFORMATION

72. Liability: Combined Single Limits $______

Split Limit: B.I. Per Person: $______ B.I. Per Accident $______ Property Damage: $______

Liability Deductible: ☐ $1,000 ☐ Over $1,000 +______ **Submit to company—financials may be required**

73. Hired Auto: Cost of Hire: $______

Hired auto coverage is subject to audit.

74. Non-owned Auto: Number of: Partners:______ Employees: ______ Volunteers: ______

Non-owned auto coverage is subject to audit.

75. Uninsured Motorist: ☐ Rejected ☐ Limits Accepted ______

76. **Underinsured Motorist:** ☐ Rejected ☐ Limits Accepted ________________

(Complete appropriate UM/UIM Selection/Rejection Form for Questions **75.** and **76.**)

77. **Optional no-fault state:** PIP rejected? .... ☐ Yes ☐ No

78. **Mandatory no-fault state:** PIP basic limits accepted? .... ☐ Yes ☐ No

(Complete appropriate Personal Injury Protection Selection/Rejection Form for Questions **77.** and **78.**)

79. **Medical Payments:** ☐ Rejected ☐ Limits accepted: ________________

80. **Trailer Interchange:** Limit $ ________________ Number of Trailers: ________________

Deductibles: ☐ **Comp $**____________ ☐ **SCOL $**____________ ☐ **Coll $**____________

81. **Do you understand that we may audit your records, which might result in an additional premium?** .... ☐ Yes ☐ No

82. **Are any Lessors or other entities to be added as additional insureds?** .... ☐ Yes ☐ No

If yes, list:

NAME	VEHICLE	ADDRESS	RELATIONSHIP/INTEREST

VEHICLE SCHEDULE

(Attach copies of the vehicle registration for all vehicles and explain if registration name is different from applicant's name.)

Vehicle No.:	**Year:**	**V.I.N.:**
Make/model/type of vehicle:		
☐ ACV ☐ ST AMT: $ ________________	Value of perm. attached equip.: $____________	
Mfg. seating capacity:	Radius:	Farthest city:
City, state, zip where garaged:		
License state:	License plate No.:	
GVW/GCW:	Class.:	
Deductibles ☐ COMP ____________	☐ SCOL ____________	☐ COLL ____________
☐ Commercial ☐ Retail ☐ Service Leased Vehicle? .... ☐ Yes ☐ No		
Loss payee/additional insured/lessor:		
If limousine, name of coach builder:	Length:	

Vehicle No.:	**Year:**	**V.I.N.:**
Make/model/type of vehicle:		
☐ ACV ☐ ST AMT: $________		Value of perm. attached equip.: $________
Mfg. seating capacity:	Radius:	Farthest city:
City, state, zip where garaged:		
License state:		License plate No.:
GVW/GCW:		Class.:
Deductibles ☐ COMP ________	☐ SCOL ________	☐ COLL ________
☐ Commercial ☐ Retail ☐ Service Leased Vehicle? .... ☐ Yes ☐ No		
Loss payee/additional insured/lessor:		
If limousine, name of coach builder:		Length:

Vehicle No.:	**Year:**	**V.I.N.:**
Make/model/type of vehicle:		
☐ ACV ☐ ST AMT: $________		Value of perm. attached equip.: $________
Mfg. seating capacity:	Radius:	Farthest city:
City, state, zip where garaged:		
License state:		License plate No.:
GVW/GCW:		Class.:
Deductibles ☐ COMP ________	☐ SCOL ________	☐ COLL ________
☐ Commercial ☐ Retail ☐ Service Leased Vehicle? .... ☐ Yes ☐ No		
Loss payee/additional insured/lessor:		
If limousine, name of coach builder:		Length:

Vehicle No.:	**Year:**	**V.I.N.:**
Make/model/type of vehicle:		
☐ ACV ☐ ST AMT: $________		Value of perm. attached equip.: $________
Mfg. seating capacity:	Radius:	Farthest city:
City, state, zip where garaged:		
License state:		License plate No.:
GVW/GCW:		Class.:
Deductibles ☐ COMP ________	☐ SCOL ________	☐ COLL ________
☐ Commercial ☐ Retail ☐ Service Leased Vehicle? .... ☐ Yes ☐ No		
Loss payee/additional insured/lessor:		
If limousine, name of coach builder:		Length:

Vehicle No.:	**Year:**	**V.I.N.:**
Make/model/type of vehicle:		
☐ ACV ☐ ST AMT: $______		Value of perm. attached equip.: $______
Mfg. seating capacity:	Radius:	Farthest city:
City, state, zip where garaged:		
License state:		License plate No.:
GVW/GCW:		Class.:
Deductibles ☐ COMP ______	☐ SCOL ______	☐ COLL ______
☐ Commercial ☐ Retail ☐ Service Leased Vehicle? .... ☐ Yes ☐ No		
Loss payee/additional insured/lessor:		
If limousine, name of coach builder:		Length:

This application does not bind YOU or US to complete the insurance, but it is agreed that the information contained herein shall be the basis of the contract should a policy be issued.

FRAUD WARNING:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

FRAUD WARNING (APPLICABLE IN FLORIDA):

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

FRAUD WARNING (APPLICABLE IN MAINE):

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

FRAUD WARNING (APPLICABLE IN TENNESSEE AND WASHINGTON):

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

FRAUD WARNING APPLICABLE IN THE STATE OF NEW YORK:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the value of the subject motor vehicle or stated claim for each violation.

APPLICANT'S NAME AND TITLE: ______________________________

APPLICANT'S SIGNATURE: ______________________________ DATE: ____________

(Must be signed by an active owner, partner or executive officer.)

PRODUCER'S SIGNATURE: ______________________________ DATE: ____________

AGENT NAME: ______________________ AGENT LICENSE NUMBER: ____________

(Applicable in Florida Agents Only)

IMPORTANT NOTICE

As part of the underwriting procedure, a routine inquiry may be made which will provide applicable information concerning character, general reputation, personal characteristics and mode of living. Upon written request, additional information as to the nature and scope of the report, if one is made, will be provided.

SCOTTSDALE INSURANCE COMPANY®

National Casualty Company

Scottsdale Indemnity Company

FIRST PARTY BENEFITS COVERAGE—PENNSYLVANIA

A. Medical Expense Benefit: Coverage to reimburse you for reasonable and necessary medical treatment and services incurred.

B. Income Loss Benefit: Coverage to replace a portion of lost income and reimburse you for expenses in securing replacement services.

C. Accidental Death Benefit: A death benefit paid in the event of the death of an injured person due to a covered auto accident.

D. Funeral Benefit: Coverage to pay for direct funeral, burial and other related expenses incurred as a result of the death of an insured person due to a covered accident.

According to Pa. C. S. Title 75 Chapter 17, you are required to purchase a minimum of $5,000, Medical Expenses. All other options listed below (including a higher limit of Medical Payments) are choices for you to make. Indicate your choice of options shown below for each coverage. Then date and sign this form and return to your Agent.

BENEFIT LEVEL OPTIONS: (Include your choice by marking the box with a "X" for each coverage or for your choice of Combination Benefits option).

A. MEDICAL EXPENSES: Per Person, Per Accident with minimum and maximum benefits as shown:
❑ $5,000 $______ ❑ $10,000 $______ ❑ $25,000 $______ ❑ $50,000 $______ ❑ $100,000 $______

B. INCOME LOSS: Per Month, Per Person, Per Accident with minimum and maximum benefits as shown:
❑ None-Rejected ❑ $1,000/$ 5,000 $______ ❑ $1,000/$15,000 $______ ❑ $1,500/$25,000 $______
❑ $2,500/$50,000 $______

C. ACCIDENTAL DEATH: Per Person, Per Accident with minimum and maximum benefits as shown:
❑ None-Rejected ❑ $ 5,000 $______ ❑ $10,000 $______ ❑ $25,000 $______

D. FUNERAL EXPENSE: Per Person, Per Accident with minimum and maximum benefits as shown:
❑ None-Rejected ❑ $1,500 $______ ❑ $2,500 $______

OR

COMBINATION BENEFITS: This coverage is a combination of benefits. Do not complete this section if you have elected to purchase any of the above options.

❑ $ 50,000 ($2,500 Funeral and $10,000 Accidental Death Benefits) $______

❑ $100,000 ($2,500 Funeral and $10,000 Accidental Death Benefits) $______

❑ $177,500 ($2,500 Funeral and $25,000 Accidental Death Benefits) $______

❑ $277,500 ($2,500 Funeral and $25,000 Accidental Death Benefits) $______

AND

EXTRAORDINARY MEDICAL BENEFIT (EMB): Extraordinary Medical Benefits Coverage is an optional coverage. It pays the medical expenses of eligible persons for accidents covered under your policy. Payments under this coverage begin only when covered medical expenses exceed $100,000 and capped at the lifetime limit of $1,000,000.
The first $100,000 of medical expenses are not covered by this coverage. If you select the Extraordinary Medical Benefits Coverage and your First Party Medical Benefits limit is less than $100,000, you will be responsible for the difference.
❑ Do not include; ❑ $100,000 ❑ $300,000 ❑ $500,000 ❑ $1,000,000.

____
Named Insured

____
Policy Number

____
First Named Insured

____
Position

____
Signature of First Named Insured

____
Date

National Casualty Company

Scottsdale Indemnity Company

UNINSURED MOTORIST (UM) COVERAGE LIMITS OFFER—PENNSYLVANIA

Named Insured: ______________________________

Policy Number: ______________________________

Uninsured motorist coverage provides protection for damages incurred as a result of an accident with an uninsured motor vehicle. Pennsylvania law requires Uninsured Motorist protection be offered, but the purchase is optional. There is an additional premium for this coverage. Coverage can be rejected by the signing of a separate form.

If you have decided to purchase Uninsured Motorist (UM) protection, the law allows you to select a limit no less than $35,000 or no more than the Combined Bodily Injury and Property Damage Coverage Limit this policy presently provides. We have provided several options for the Uninsured Motorist (UM) limit.

Please check the box indicating the limit for either a combined coverage limit or split limit with or without stacked limits. Stacking means you can claim a total of the amounts of uninsured motorist coverage assigned to each vehicle in your policy. If you reject stacked limits, each vehicle insured under the policy will have its own limits of uninsured motorist coverage. There is an additional premium for this coverage. Stacked coverage can be rejected by the signing of a separate form.

Please indicate your choice(s) below:

Uninsured Motorist (UM)

Non-stacked		Stacked	
Combined Limits	Split Limits	Combined Limits	Split Limits
❑ $ 35,000	❑ $ 15,000/$ 30,000	❑ $ 35,000	❑ $ 15,000/$ 30,000
❑ $ 50,000	❑ $ 50,000/$ 100,000	❑ $ 50,000	❑ $ 50,000/$ 100,000
❑ $ 100,000	❑ $100,000/$ 300,000	❑ $ 100,000	❑ $100,000/$ 300,000
❑ $ 250,000	❑ $250,000/$ 500,000	❑ $ 250,000	❑ $250,000/$ 500,000
❑ $ 500,000	❑ $500,000/$ 1,000,000	❑ $ 500,000	❑ $500,000/$ 1,000,000
❑ $ 750,000		❑ $ 750,000	
❑ $1,000,000		❑ $1,000,000	

By signing and dating this limits offer, I am selecting the above limits for Uninsured Motorists (UM). I act on full authority of all insureds under this policy. I realize these limits will remain unchanged on future policies unless I notify the insurance company in writing.

______________________________ ______________________________
First Named Insured Position

______________________________ ______________________________
Signature of First Named Insured Date

SCOTTSDALE INSURANCE COMPANY®

National Casualty Company

Scottsdale Indemnity Company

REJECTION OF STACKED UNINSURED MOTORIST COVERAGE LIMITS—PENNSYLVANIA

By signing this waiver, I am rejecting **stacked** limits of uninsured motorist under the policy for myself and members of my household under which the limits of coverage available would be the sum of limits for each motor vehicle insured under the policy. Instead, the limits of coverage that I am purchasing shall be reduced to the limits stated in the policy. I knowingly and voluntarily reject the stacked limits of coverage. I understand that my premiums will be reduced if I reject this coverage.

____

Named Insured

____

Policy Number

__________________________	________________________
First Named Insured	Position
__________________________	________________________
Signature of First Named Insured	Date

National Casualty Company

Scottsdale Indemnity Company

UNDERINSURED MOTORIST (UIM) COVERAGE LIMITS OFFER—PENNSYLVANIA

Named Insured: ______________________________

Policy Number: ______________________________

Underinsured motorist coverage provides protection for damages incurred as a result of an accident with an underinsured motor vehicle. Pennsylvania law requires Underinsured Motorist protection be offered, but the purchase is optional. There is an additional premium for this coverage. Coverage can be rejected by the signing of a separate form.

If you have decided to purchase Underinsured Motorist (UIM) protection, the law allows you to select a limit no less than $35,000 or no more than the Combined Bodily Injury and Property Damage Coverage Limit this policy presently provides. We have provided several options for the Underinsured Motorist (UIM) limit.

Please check the box indicating the limit for either a combined coverage limit or split limit with or without stacked limits. Stacking means you can claim a total of the amounts of underinsured motorist coverage assigned to each vehicle in your policy. If you reject stacked limits, each vehicle insured under the policy will have its own limits of uninsured motorist coverage. There is an additional premium for this coverage. Stacked coverage can be rejected by the signing of a separate form.

Please indicate your choice(s) below:

Underinsured Motorist (UIM)

Non-stacked		Stacked	
Combined Limits	Split Limits	Combined Limits	Split Limits
❑ $ 35,000	❑ $ 15,000/$ 30,000	❑ $ 35,000	❑ $ 15,000/$ 30,000
❑ $ 50,000	❑ $ 50,000/$ 100,000	❑ $ 50,000	❑ $ 50,000/$ 100,000
❑ $ 100,000	❑ $100,000/$ 300,000	❑ $ 100,000	❑ $100,000/$ 300,000
❑ $ 250,000	❑ $250,000/$ 500,000	❑ $ 250,000	❑ $250,000/$ 500,000
❑ $ 500,000	❑ $500,000/$ 1,000,000	❑ $ 500,000	❑ $500,000/$ 1,000,000
❑ $ 750,000		❑ $ 750,000	
❑ $1,000,000		❑ $1,000,000	

By signing and dating this limits offer, I am selecting the above limits for Underinsured Motorists (UIM). I act on full authority of all insureds under this policy. I realize these limits will remain unchanged on future policies unless I notify the insurance company in writing.

______________________________ ______________________________

First Named Insured Position

______________________________ ______________________________

Signature of First Named Insured Date

SCOTTSDALE INSURANCE COMPANY®

National Casualty Company

Scottsdale Indemnity Company

REJECTION OF STACKED UNDERINSURED MOTORIST COVERAGE LIMITS—PENNSYLVANIA

By signing this waiver, I am rejecting **stacked** limits of underinsured motorist coverage under the policy for myself and members of my household under which the limits of coverage available would be the sum of limits for each motor vehicle insured under the policy. Instead, the limits of coverage that I am purchasing shall be reduced to the limits stated on the policy. I knowingly and voluntarily reject the stacked limits of coverage. I understand that my premiums will be reduced if I reject this coverage.

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Named Insured

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Policy Number

______________________ ______________________
First Named Insured Position

______________________ ______________________
Signature of First Named Insured Date