

KENTUCKY AUTOMOBILE INSURANCE PLAN

P.O. Box 6530, Providence, RI 02940-6530

Email: kyaip@aipso.com

POLICY CHANGE REQUEST AUTOMOBILE INSURANCE PLAN	Name of Insurance Company	Policy No.
	Name of Insured (Last Name, First Name, M.I.)	

Producer	Telephone No. (Incl. area code) ()	Producer's License No.	Producer's IRS or Social Security No.
Street Address		City	State Zip Code

1. VEHICLE INFORMATION <input type="checkbox"/> DELETE VEHICLE	Year	Make	Vehicle Identification No.	
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<input type="checkbox"/> REPLACEMENT VEHICLE or <input type="checkbox"/> ADDED VEHICLE	Year	Make	Model Name & Body Style	Vehicle Identification No.	Cyls.
	H.P./Cub. In./CC	Purchased: Mo. _____ Yr. _____		<input type="checkbox"/> New	<input type="checkbox"/> Used

Use and Classification	Pleasure <input type="checkbox"/>	Business <input type="checkbox"/>	Comm. <input type="checkbox"/>	Farm <input type="checkbox"/>	Principal Place of Garaging	Miles to Work or to Transportation	Est Annual Mileage	State Registered in
	Address of Applicant as Appears on Registration					Territory	Rate Class	Penalty Points

2. COVERAGES In Accordance with Plan Rules	Add <input type="checkbox"/>	Change <input type="checkbox"/>	No Change <input type="checkbox"/>	Delete <input type="checkbox"/>	Applicable Year Make To Vehicle:	Vehicle Identification No.
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Check Applicable Box →	Bodily Injury Liability <input type="checkbox"/>	Property Damage Liability <input type="checkbox"/>	<input type="checkbox"/> Basic Personal Injury Protection Coverage <input type="checkbox"/> Added Reparations Benefits (\$10,000) <input type="checkbox"/> I Reject No-Fault/Tort Limitations <input type="checkbox"/> PIP Buyback <input type="checkbox"/> Guest Personal Injury Protection <input type="checkbox"/> Motorcycle PIP (Optional) <input type="checkbox"/> Pedestrian PIP (Optional if Motorcycle PIP is not selected.)	Medical Payments Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No	Uninsured Motorists Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No	Underinsured Motorist Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No
	Deductibles <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000					
	Limits	\$	\$		\$	\$
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. Does Municipal Tax apply? Yes No

3. DRIVER INFORMATION	<input type="checkbox"/> Delete Driver Name
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<input type="checkbox"/> Added Driver	Name	Relationship To Insured	% Use of Veh. 1 Veh. 2	Date of Birth Mo. Day Yr.	Sex M-F	Marital Status	Driver's License No. and State

3a. ACCIDENTS Have additional drivers been involved 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.)

Accident Date	Place of Accident		Personal Injury Protection Claim	Bodily Injury or Death	Property Damage Amount	Chargeable
	Town	State	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No

Give Reason(s) if the Above Accident(s) Not Chargeable Under the Rules of the Plan.

3b. CONVICTIONS Have additional Drivers been convicted or forfeited bail at any time during the immediately preceding thirty-six months? Yes No
 If "Yes", complete the following. (If necessary, use a separate sheet.) Note: A paid ticket or fine constitutes a conviction.

Date of Conviction	Did conviction arise as a result of an accident?	Nature of Violation	Place of Accident	
	<input type="checkbox"/> Yes <input type="checkbox"/> No		Town	State
	<input type="checkbox"/> Yes <input type="checkbox"/> No			

4. CHANGE	<input type="checkbox"/> Name	New Name	Street	Apt.	City	State	Zip Code
	<input type="checkbox"/> Address						

5. POLICY CANCELLATION

Cancel policy
Reason for cancellation: _____

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 _____ **IN NO EVENT SHALL ADDITIONAL COVERAGE BE EFFECTIVE PRIOR TO THE DATE AND HOUR OF COMPLETION OF THIS REQUEST FORM.**
 A.M. P.M. Month Day Year Hour

Producer's Signature _____ Date _____ Hour _____ A.M. P.M.

APPLICANT'S STATEMENT

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

WARNING

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 commits a fraudulent insurance act, which is a crime.

Applicant's Signature _____ Date _____ Hour _____ A.M. P.M.

Mail to:
Kentucky Auto Insurance Plan
P.O. Box 6530
Providence, RI 02940-6530

Email: kyaip@aipso.com

Questions? Please Call 1-800-555-0513