

SELECTION OF UNINSURED MOTORISTS COVERAGE AND MEDICAL PAYMENTS COVERAGE NEVADA

The Nevada Insurance Code (Section 687B.145) requires that Uninsured Motorists Coverage be offered at a limit equal to the Bodily Injury Limit of Liability in your policy unless you, the insured named in the policy, select a lower limit, but not less than the minimum financial responsibility limits, or reject the Uninsured Motorists Coverage entirely. Uninsured Motorists Coverage includes underinsured motorists coverage and provides insurance for the protection of persons insured under the policy if they sustain bodily injury in an accident for which the owner or operator of a motor vehicle is legally liable and does not have insurance (uninsured) or does not have enough insurance (underinsured). The named insured has the right to reject this coverage in writing.

So that we may be certain that your policy is properly issued, it is necessary that you indicate below your choice of Uninsured Motorists Coverage. In the event the policy names more than one Named Insured, all such Named Insureds must sign.

INDICATE BY "X"

– The undersigned hereby rejects Uninsured Motorists Coverage entirely.

The undersigned understands and agrees that the provisions of Uninsured Motorists Coverage will not be included in the policy issued.

– OR –

Uninsured Motorists Coverage to be written with limits of liability equal to Bodily Injury Liability limits being provided.

– OR –

Uninsured Motorists Coverage to be written with limits of liability lower than Bodily Injury Liability limits being provided, but not less than the minimum financial responsibility limits, as indicated below:

Bodily Injury

\$ _____ each person

\$ _____ each accident

Combined Single Limit (BI)

\$ _____ each accident

Section 687B.145 further requires that Medical Payments Coverage be offered in an amount of at least \$1,000 or at a higher amount if the minimum limit offered by an insurer is greater than \$1,000. You may accept or reject this offer. Medical Payments Coverage provides protection without regard to legal liability for reasonable and necessary medical expenses resulting from accidental bodily injury while operating or occupying an insured vehicle or being struck as a pedestrian by a motor vehicle or trailer.

So that we may be certain that your policy is properly issued, it is necessary that you indicate below your choice of Medical Payments Coverage. In the event the policy names more than one Named Insured, all such Named Insureds must sign.

INDICATE BY "X"

– The undersigned hereby rejects Medical Payments Coverage entirely.

The undersigned understands and agrees that the provisions of Medical Payments Coverage will not be included in the policy issued.

– OR –

Medical Payments Coverage to be written at the minimum limit of \$1,000.

– OR –

Medical Payments Coverage to be written at limit of \$ _____ .

Signature of Named Insured

Date

Signature of Named Insured

Date

(Until you advise us otherwise in writing, your choice as indicated above, will continue regardless of any addition or change in Auto coverage on your current policy or addition of any scheduled Autos and will be carried forward on all future renewal policies without additional notice.)

SIGNATURE IS ALSO REQUIRED ON LAST PAGE OF APPLICATION

MUST BE SIGNED BY THE APPLICANT PERSONALLY

No coverage is bound until the Company advises the Applicant or its representative that a policy will be issued and then only as of the policy effective date and in accordance with all policy terms. The Applicant acknowledges that the **Applicant's Representative named below is acting as Applicant's agent and not on behalf of the Company. The Applicant's Representative has no authority to bind coverage, may not accept any funds for the Company, and may not modify or interpret the terms of the policy.**

The Applicant agrees that the foregoing statements and answers are true and correct. The Applicant requests the Company to rely on its statements and answers in issuing any policy or subsequent renewal. The Applicant agrees that if its statements and answers are materially false, the Company may rescind any policy or subsequent renewal it may issue.

If any jurisdiction in which the Applicant intends to operate or the FHWA requires a special endorsement to be attached to the policy which increases the Company's liability, the Applicant agrees to reimburse the Company in accordance with the terms of that endorsement.

The Applicant agrees that any inspection of autos, vehicles, equipment, premises, operations, or inspection of any other matter relating to insurance that may be provided by the Company, is made for the use and benefit of the Company only, and is not to be relied upon by the Applicant or any other party in any respect.

The Applicant understands that an inquiry may be made into the character, finances, driving records, and other personal and business background information the Company deems necessary in determining whether to bind or maintain coverage. Upon written request, additional information will be provided to the Applicant regarding any investigation.

The Applicant represents that she/he has completed all relevant sections of this Application prior to execution and that the Applicant has personally signed below (or if Applicant is a Corporation, a corporate officer has signed below).

Will premium be financed? Yes No If yes, with whom _____

Witness

Applicant's Signature

Date

TO BE COMPLETED BY APPLICANT'S REPRESENTATIVE

Is this direct business to your office? _____ If not, explain _____

Is this new business to your office? _____ If not, how long have you had the account? _____

How long have you known applicant? _____

REQUEST TO COMPANY GENERAL AGENT:

Please quote Please bind at earliest possible date and issue policy

Please issue policy effective _____ Coverage was bound by _____
(Time and Date Bound by General Agent) (Name of Person in Company General Agency's Office Binding Coverage)

Applicant's Representative's Name and Address

Phone No.