MAIL OR FAX APPLICATION TO:
DMI INSURANCE SERVICES, INC.
P. O. Box 248 Morgan Hill, CA 95038
Phone (800)877-2525 Fax(408)778-0298
"Automotive Program Specialists"

COLORADO
Garage Insurance
State Specific Application

Unsigned & incomplete applications will be refused and no coverage will have been bound.

Named Insured: _____ **Quote #** _____

DBA: _____ **EFFECTIVE DATE:** _____

EFFECTIVE TIME: _____

COLORADO SPECIFIC COVERAGES / LIMITS SELECTION:

GARAGE LIABILITY ☒ **Limited Liability For Customers.**

UNINSURED MOTORISTS COVERAGE REJECTION OR SELECTION OF HIGHER LIMIT OF BODILY INJURY LIABILITY

Colorado law permits you, the insured named in the policy, to reject the Uninsured Motorists Coverage for bodily injury or to select a limit for such coverage higher than the required minimum financial responsibility limit, of $50,000 limit each accident up to the limit for Bodily Injury Coverage in the policy, but not more than $300,000. Uninsured Motorists Coverage for bodily injury provides insurance for the protection of persons insured under the policy who are legally entitled to recover damages from the owners or operators of uninsured motor vehicles because of bodily injury, sickness or disease, including death resulting therefrom.

If you reject Uninsured Motorists Coverage or wish to increase the limits applying to Uninsured Motorists Coverage, such should be indicated below by marking the appropriate ballot box.

The undersigned insured (and each of them) –
(Applicable item marked X)

☐ agrees that the Uninsured Motorists Coverage afforded in the policy is hereby rejected in its entirety.

☐ agrees that UM Bodily Injury coverage at the Basic Limit of $50,000 each accident applies unless another limit is selected here: $ _____

MEDICAL PAYMENTS

Colorado law requires that Medical Payments Coverage be offered in an amount of at least $5,000. 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.

The undersigned insured (and each of them).

☐ agrees that the Medical Payments Coverage afforded in the policy is hereby deleted.

☐ agrees to a limit of $ 5,000.

A credit report or other investigate report about you may be requested in connection with this application for insurance and subsequent renewalS. Credit scoring information may be used to determine either your eligibility for insurance, or the premium you will be charged. Any information which we have or may obtain about you or other individuals listed as policyholders on your policy will be treated confidentially. However, this information, as well as other personal or privileged information subsequently collected, may, under certain circumstances, be disclosed without prior authorization to non-affiliated third parties. We may also share such information with affiliated companies for such purposes as claims handling, servicing, underwriting and insurance marketing. You have the right to see personal information collected about you, and you have the right to correct any information which may be wrong. If you are interested in obtaining a description of our information practices, and your rights regarding information we collect, ask your agent, or, if you have been issued a policy, please write to us at the address provided with your policy.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

I understand that the coverage selection and limit choices indicated here or in any state supplement will apply to all future policy renewals, continuations and changes unless I notify you otherwise in writing.

INSURED'S SIGNATURE OF ACCEPTANCE _____ **DATE:** _____

PRODUCER'S SIGNATURE OF COMPLETION _____ **DATE:** _____