DMI INSURANCE SERVICES, INC.
Automotive Program Specialists
www.dmi-insurance.com

PENNSYLVANIA
State Specific Application

NAMED INSURED: _____ **CONTROL #:** _____

DBA: _____ **EFFECTIVE DATE:** _____

Pennsylvania law permits you to make certain decisions regarding Uninsured/Underinsured Motorists Coverage. This document describes this coverage and the options available.

You should read this document carefully and contact us or your agent if you have any questions regarding Uninsured/Underinsured Motorists Coverage and your options with respect to this coverage.

This document includes general descriptions of coverage. However, no coverage is provided by this document. You should read your policy and review your Declarations page(s) and/or Schedule(s) for complete information on the coverages you are provided.

UNINSURED MOTORISTS COVERAGE

Uninsured Motorists Coverage provides insurance protection to an insured for compensatory damages which the insured is legally entitled to recover from the owner or operator of an uninsured motor vehicle because of bodily injury caused by an automobile accident. Also included are damages due to bodily injury that results from an automobile accident with a hit-and-run vehicle whose owner or operator cannot be identified.

Selection Of Uninsured Motorist Bodily Injury Protection

I / We select the following Uninsured Motorists Bodily Injury Coverage Option:

☐ Combined single limit of $35,000.

☐ Combined single limit equal to Bodily Injury Liability Limit.

☐ Combined single limit of $_____.

Signature of First Named Insured _____ Date _____

Rejection Of Stacked Uninsured Motorist Protection

By signing this waiver, I am rejecting stacked limits of uninsured motorist coverage under this policy that could stack on top of the coverage that may be available under a separate 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 limit selected above. I knowingly and voluntarily reject the stacked limits of coverage. I understand that my premiums will be reduced if I reject this coverage.

Signature of First Named Insured _____ Date _____

Rejection Of Uninsured Motorist Protection

By signing this waiver, I am rejecting uninsured motorist coverage under this policy, for myself and all relatives residing in my household. Uninsured Motorists coverage protects me and relatives living in my household for damages suffered if injury is caused by the negligence of a driver who does not have any insurance to pay for losses and damages. I knowingly and voluntarily reject this coverage.

Signature of First Named Insured _____ Date _____

UNDERINSURED MOTORISTS COVERAGE

Underinsured Motorists Coverage provides insurance protection to an insured for compensatory damages which the insured is legally entitled to recover from the owner or operator of an underinsured motor vehicle because of bodily injury caused by an automobile accident.

Selection Of Underinsured Motorist Bodily Injury Protection

I / We select the following Underinsured Motorists Bodily Injury Coverage Option:

☐ Combined single limit of $35,000.

☐ Combined single limit equal to Bodily Injury Liability Limit.

☐ Combined single limit of $_____.

Signature of First Named Insured _____ Date _____

Rejection Of Stacked Underinsured Motorist Protection

By signing this waiver, I am rejecting stacked limits of underinsured motorist coverage under this policy that could stack on top of the coverage that may be available under a separate 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 limit selected above. I knowingly and voluntarily reject the stacked limits of coverage. I understand that my premiums will be reduced if I reject this coverage.

Signature of First Named Insured _____ Date _____

Rejection Of Underinsured Motorist Protection

By signing this waiver, I am rejecting underinsured motorist coverage under this policy, for myself and all relatives residing in my household. Underinsured Motorists coverage protects me and relatives living in my household for losses and damages suffered if injury is caused by the negligence of a driver who does not have enough insurance to pay for all losses and damages. I knowingly and voluntarily reject this coverage.

Signature of First Named Insured _____ Date _____

FIRST PARTY BENEFITS NOTICE

Insurance companies operating in the Commonwealth of Pennsylvania are required by law to make available for purchase the following benefits for you, your spouse, or other relatives or minors in your custody or in the custody of your relatives residing in your household, occupants of your motor vehicle, or persons struck by your motor vehicle:

(1) Medical benefits up to at least $100,000.

(2) Extraordinary medical benefits from $100,000 to $1,000,000 that may be offered in increments of $100,000.

(3) Income loss benefits up to at least $2,500 per month up to a maximum benefit of at least $50,000.

(4) Accidental death benefits up to at least $25,000.

(5) Funeral benefits of $2,500.

(6) As an alternative to the coverage options outlined in paragraphs (1) through (5) above, a combination benefit of up to at least $177,500 is available. This benefit is subject to either the aggregate limit or benefits payable for up to three years from the date of the accident, whichever occurs first and is subject to a limit on the accidental death benefit of up to $25,000 and a limit on the funeral benefit of $2,500, provided that nothing contained in this subsection shall be construed to limit, reduce, modify, or change the provisions of section 1715(d) (relating to availability of adequate limits).

Additionally, insurers may offer higher benefit levels than those enumerated above as well as additional benefits. However, an insured may elect to purchase lower benefit levels than those enumerated above. Your signature on this notice or your payment of any renewal premium evidences your actual knowledge and understanding of the availability of these benefits and limits as well as the benefits and limits you have selected.

If you have any questions or you do not understand all of the various options available to you, contact your agent or company.

If you do not understand any of the provisions contained in this notice, contact your agent or company before you sign.

Basic First Party Benefit Coverage

"Basic First Party Benefits" are provided with your policy. The maximum limit for medical expenses provided for Basic First Party Benefits is $5,000 for any one person injured in any one accident.

Added First Party Benefit Coverage

"Added First Party Benefits" are also available for an additional premium. If you would like to purchase these optional First Party Benefits, make your selection(s) below by checking the corresponding boxes.

Increased Medical Expenses Benefit

☐ $10,000
☐ $25,000
☐ $50,000
☐ $100,000

Income Loss Benefits

☐ $1,000/month, $5,000 Maximum
☐ $1,000/month, $10,000 Maximum
☐ $1,000/month, $15,000 Maximum
☐ $1,500/month, $25,000 Maximum
☐ $2,500/month, $50,000 Maximum

Funeral Expenses Benefit

☐ $1,500 ☐ $2,500

Accidental Death Benefit

☐ $5,000 ☐ $10,000 ☐ $25,000

Combination First Party Benefits

☐ $50,000 ☐ $100,000 ☐ $177,500

Extraordinary Medical Benefit

☐ $100,000 ☐ $300,000 ☐ $1,000,000

Fraud Notice: Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete, or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and the payment of a fine up to $15,000.

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

APPLICANT'S SIGNATURE _____ DATE _____

APPLICANT'S NAME _____ TITLE _____