



AGENCY CUSTOMER ID: _____

WASHINGTON GARAGE AND DEALERS COVERAGES / LIMITS SECTION

DATE (MM/DD/YYYY)

AGENCY		NAMED INSURED(S)		
POLICY NUMBER	EFFECTIVE DATE	CARRIER	NAIC CODE	

COVERAGES / LIMITS		Applies to:	AUTOMOBILE	PREMISES OPERATIONS			
COVERAGES	COVERED AUTO SYMBOLS	LIMITS OF LIABILITY		COVERAGES	COVERED AUTO SYMBOLS	LIMITS OF LIABILITY	
LIABILITY	21	GARAGE OPERATIONS		MEDICAL PAYMENTS	21	\$	
	22	AUTO ONLY OTHER THAN AUTO ONLY			22		
	23	EA ACC \$	\$		23		
	24	AGGREGATE	\$		24		
		DEALERS ONLY:	LIMITED	UNLIMITED			
PERSONAL INJURY PROTECTION	25	MEDICAL EXPENSE \$	SERVICE LOSS \$				
	27	INCOME CONTIN \$	FUNERAL EXPENSE \$				
ADD'L PERSONAL INJURY PROTECTION	25			UNDERINSURED MOTORIST	22	CSL	BI EA PER \$
	27	\$			23	BI EACH ACCIDENT \$	
					24	PROPERTY DAMAGE \$	\$

PHYSICAL DAMAGE				LOC #	ENTER THE LIMIT FOR EACH LOCATION	DEDUCTIBLE PER AUTO	MAXIMUM DED PER LOSS
COMP / OTC SPECIFIED PERILS	22	27		\$		\$	\$
	23	28		\$		\$	\$
	24	31		\$		\$	\$
COLLISION	22	27		\$		\$	
	23	28		\$		\$	
	24	31		\$		\$	
AUTO LOAN	22	24	28	\$			
23	27						
OTHER				\$		\$	

GARAGE KEEPERS				LOC #	ENTER THE LIMIT FOR EACH LOCATION	# OF AUTOS	DEDUCTIBLE PER AUTO	MAXIMUM DED PER LOSS
LEGAL LIABILITY	COMP / OTC SPECIFIED PERILS			30	\$		\$	\$
					\$		\$	\$
					\$		\$	\$
DIRECT BASIS	COLLISION			30	\$		\$	
					\$		\$	
					\$		\$	
OTHER				\$		\$		

PHYSICAL DAMAGE REPORTING PERIOD	<input type="checkbox"/> NON-REPORTING	# DEALER / REPAIRER PLATES	# TRANSPORTATION PLATES	TEMPORARY LOCATION LIMIT	TRANSIT LIMIT
				\$	\$

COVERED AUTO SYMBOLS

(21) ANY AUTO	(25) OWNED AUTOS SUBJECT TO NO-FAULT	(29) NON-OWNED AUTOS USED IN YOUR AUTO DEALERSHIP
(22) OWNED AUTOS ONLY	(26) OWNED AUTOS SUBJECT TO A COMPULSORY UNINSURED MOTORISTS LAW	(30) AUTOS LEFT WITH YOU FOR SERVICE, REPAIR, STORAGE OR SAFEKEEPING
(23) OWNED PRIVATE PASSENGER AUTOS ONLY	(27) SPECIFICALLY DESCRIBED AUTOS	(31) AUTO DEALERS' AUTOS (PHYSICAL DAMAGE COVERAGES)
(24) OWNED AUTOS OTHER THAN PRIVATE PASSENGER AUTOS ONLY	(28) HIRED AUTOS ONLY	

ENDORSEMENTS / REMARKS (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

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SIGNATURE

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.

UNDERINSURED MOTORISTS COVERAGE STATEMENT: I HAVE BEEN OFFERED UNDERINSURED MOTORISTS COVERAGE (UIM) UP TO THE LIMITS OF MY BODILY INJURY LIABILITY (BI) AND PROPERTY DAMAGE LIABILITY (PD) COVERAGE.

- 1. I HAVE SELECTED UIM LIMITS EQUAL TO MY BI AND PD COVERAGE _____ (INITIALS)
- 2. I HAVE SELECTED UIM BI LIMITS EQUAL TO MY BI COVERAGE, BUT UIM PD LIMITS LOWER THAN MY PD COVERAGE _____ (INITIALS)
- 3. I HAVE SELECTED UIM BI LIMITS LOWER THAN MY BI COVERAGE, BUT UIM PD LIMITS EQUAL TO MY PD COVERAGE _____ (INITIALS)
- 4. I HAVE SELECTED UIM BI LIMITS AND UIM PD LIMITS LOWER THAN MY BI AND PD COVERAGE _____ (INITIALS)
- 5. I HAVE REJECTED UIM BI COVERAGE _____ (INITIALS)
- 6. I HAVE REJECTED UIM PD COVERAGE _____ (INITIALS)

IN ORDER TO PROVIDE FOR AN INFORMED DECISION OF THE POTENTIAL CONSEQUENCES OF REJECTING UNDERINSURED MOTORIST COVERAGE; THE UNDERSIGNED ACKNOWLEDGES THAT BY REJECTING UNDERINSURED MOTORIST COVERAGE THERE IS EXPOSURE TO THE RISK OF NOT BEING SUFFICIENTLY INSURED FOR INJURY AND/OR DAMAGES WHEN INVOLVED IN AN ACCIDENT WITH A DRIVER OF AN UNDERINSURED VEHICLE.

I 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	PRODUCER'S SIGNATURE	NATIONAL PRODUCER NUMBER
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**MANDATORY OFFER OF
PERSONAL INJURY PROTECTION COVERAGE**

Washington insurance law requires that we offer you Personal Injury Protection Coverage with certain minimum limits, unless you reject this coverage. We are also required to offer you the right to purchase higher limits.

Please indicate your choices by initialing next to the appropriate item(s) below.

Minimum Coverages:

_____ Health and Hospital Benefits: \$10,000 per each insured, covering expenses incurred within 3 years of the auto accident.

_____ Funeral Benefits: \$2,000 per each insured for funeral expenses.

_____ Income Continuation: Up to \$10,000 per each insured to cover income losses incurred within one year after the date of the insured's injury, subject to the lesser of \$200 per week or 85% of the insured's weekly income. The combined weekly payment receivable by an insured under any workers compensation or other disability insurance benefit, and other income continuation benefit and this insurance, may not exceed 85% of the insured's weekly income.

_____ Loss of Services Benefit: Up to \$ _____ per each insured, subject to a limit of \$ _____ per day, not to exceed \$ _____ per week.

All payments under Personal Injury Protection Coverage are limited to the amount of actual loss or expense incurred.

Optional Coverages:

_____ Health and Hospital Benefits: \$35,000 per each insured instead of \$10,000.

_____ Income Continuation: Up to \$35,000 per each insured instead of \$10,000, subject to the lesser of \$700 per week (instead of \$200 per week) or 85% of the insured's weekly income. The combined weekly payment receivable by the insured under any workers compensation or other disability insurance benefit, and any other income continuation benefit and this insurance, may not exceed 85% of the insured's weekly income.

_____ Loss of Services Benefit: Up to \$ _____ per each insured, subject to a limit of \$ _____ per day, not to exceed \$ _____ per week.

Rejection of Coverage:

_____ I reject Personal Injury Protection Coverage in its entirety.

Coverage is generally described here. Only the policy provides a complete description of the coverages and their limitations.

I understand these coverage selections will apply to all future renewals, continuations and changes in my policy unless I notify you otherwise in writing.

Applicant's Signature _____ Date _____