



UNDERWRITTEN BY
WESTERN GENERAL
INSURANCE COMPANY

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Named Insured/Applicant			
Mailing Address			
City	State	Zip	
Garaging Address if different than Mailing			
Home Phone	Best time to call	Work Phone	Best time to call

Producer		
Agent ID#	Office Number	QC Initials
NO COVERAGE PRIOR TO DATE-TIME FAXED/TRANSMITTED/ACCEPTED		
Proposed Effective Date	Expiration Date	
12:01 AM		
Date-Time: Transmit or Fax (Pg. 1 only) to:		
Control #	Group Plan #	
Payment Plans:		Premium Finance
Direct Bill \$ _____	(Gross DP)	Paid in Full

OPERATOR INFORMATION: No coverage for any regular or resident driver unless named on policy. List below all residents and licensed operators														
DR	First	Driver Name		Last	Relation to Applicant	Date of Birth	Sex	Marital Status	License Number	Lic State	Yrs/Mo Licensed	SR22/SR1P	Auto Driven	PrOp/OcDry
1														
2														
3														
4														
5														
6														

DR	Occupation / Job Description	Employer's (or School) Name and Address (Including Zip Code)	Mature Driver Y/N	Good Student Y/N
1				
2				
3				
4				
5				
6				

Car No	Year	Make	Model	Body Type	Vehicle Identification Number	Cost New	Current Value	New or Used
1								
2								
3								
4								
5								
6								

Car No	Use Type WO-PL BU-AT	Days-Wk / Wks Month	Miles One-Way	Total Annual Miles	Current Odometer	Business Use (Y/N)	Multi-Car (Y/N)	Good Driver (Y/N)	Salvaged (Y/N)	ISO/ Perf	4WD (Y/N)	Car Type / Factor
1												
2												
3												
4												
5												
6												

Car No	Lienholder / Loss Payee	Car No	Lienholder / Loss Payee
1		4	
2		5	
3		6	

If there is a Co-Signer for this application, please handwritten their name below:	
Printed name of Co-Signer:	

COVERAGES	LIMITS OF LIABILITY								PREMIUMS							
									CAR 1	CAR 2	CAR 3	CAR 4	CAR 5	CAR 6		
BODILY INJURY LIABILITY	\$	EACH PERSON														
PROPERTY DAMAGE LIABILITY	\$	EACH ACCIDENT				\$	EACH ACCIDENT									
UNINSURED MOTORIST BODILY INJURY	\$	EACH PERSON				\$	EACH ACCIDENT									
UNINSURED MOTORIST PROPERTY DAMAGE (\$3,500 MAXIMUM)	COVERAGE	CAR 1	CAR 2	CAR 3	CAR 4	CAR 5	CAR 6									
COLLISION DEDUCTIBLE WAIVER	COVERAGE	CAR 1	CAR 2	CAR 3	CAR 4	CAR 5	CAR 6									
MEDICAL EXPENSE	\$	EACH PERSON <input type="checkbox"/> NO EXCESS, NO REIMBURSEMENT														
COMPREHENSIVE	DEDUCTIBLE	CAR 1	CAR 2	CAR 3	CAR 4	CAR 5	CAR 6									
COLLISION	DEDUCTIBLE	CAR 1	CAR 2	CAR 3	CAR 4	CAR 5	CAR 6									
RENTAL CAR BENEFIT (FOR COVERED LOSS)	\$	PER DAY				DAYS										
SOUND AND SPECIAL EQUIPMENT	TOTAL LIMIT PER CAR	CAR 1	CAR 2	CAR 3	CAR 4	CAR 5	CAR 6									
Describe below all sound equipment, if value in each vehicle exceeds \$1,000, including radios, tape or CD players, amplifiers, equalizers and speakers. DO NOT BIND IN EXCESS OF \$1,500.								PREMIUM PER CAR								
CAR #	DESCRIPTION OF EQUIPMENT						COST/VALUE									
									SR22/SR1P							\$
									FULLY EARNED POLICY FEE							\$
									CA FRAUD FEE							\$
Does any vehicle have: <input type="checkbox"/> 2 Way radio <input type="checkbox"/> Special Wheels <input type="checkbox"/> Special Paint <input type="checkbox"/> Telephone (Factory Installed only)																
IMPORTANT: The policy does not cover special equipment unless it is specifically described and a premium charged therefor. If none, so state.								Applicant Initials		TOTAL POLICY PREMIUM \$						

		YES	NO
1	Are all residents of your household 14 years and older and all regular drivers of the vehicles listed on the application either listed as drivers or excluded? If no, please explain.	<input type="checkbox"/>	<input type="checkbox"/>
2	Has any driver had any moving violations/accidents and/or claims in the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>
3	Are there any vehicles used for delivery, such as pizza or newspaper delivery, or for any other commercial purpose?	<input type="checkbox"/>	<input type="checkbox"/>
4	Have any vehicles been modified, customized, rebuilt, salvaged or have existing damage?	<input type="checkbox"/>	<input type="checkbox"/>
5	Do you own any other vehicle(s) not listed on this application?	<input type="checkbox"/>	<input type="checkbox"/>
6	Were any of the listed minor violations received while operating a motor vehicle for compensation in the course of employment?	<input type="checkbox"/>	<input type="checkbox"/>
If so, please complete the Commercial Conviction Waiver			
7	Are you self-employed?	<input type="checkbox"/>	<input type="checkbox"/>
	a) If yes, do you have any employees?	<input type="checkbox"/>	<input type="checkbox"/>
	b) If yes, do you use any of the vehicles listed on the policy in the course of your business?	<input type="checkbox"/>	<input type="checkbox"/>
If you use a vehicle for business that is not currently listed on the policy, please provide proof of insurance.			
8	Are <u>all</u> names currently showing on the registration of any listed vehicle either added to the policy or excluded from coverage? You are required to exclude or add by endorsement any driver listed on the registration. Answering no to question 8 indicates that this requirement has not been met. Please add or exclude all drivers on the registration, and re-answer question 8.	<input type="checkbox"/>	<input type="checkbox"/>
REF #			

POLICY #	
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DESIGNATED PERSONS AND SPOUSAL EXCLUSION

It is understood and agreed that coverage and our obligation to defend under this policy shall not apply nor accrue to the benefit of any insured or any third party claimant while any motor vehicle is being used or operated by any of the persons designated below. You agree to reimburse us for any payment made by us to loss payee because of loss arising from the use or operation of your insured car by a person listed below. This endorsement shall apply to any use or operation of a motor vehicle, regardless of whether such use is permissive or not, including without limitation the negligent or alleged negligent entrustment of a motor vehicle to any designated person.

Name(s)	Relation to Insured	Date of Birth and/or license #
1 _____	_____	_____
2 _____	_____	_____
3 _____	_____	_____
4 _____	_____	_____
5 _____	_____	_____
6 _____	_____	_____

The California Insurance Code requires an insurer to provide uninsured motorist coverage in each bodily injury liability policy it issues covering liability arising out of the ownership, maintenance, or use of a motor vehicle. Those provisions also permit the insurer and the applicant to delete such coverage completely or to delete such coverage when a motor vehicle is operated by a natural person or persons designated by name. Uninsured Motorist coverage insures the insured, his or her heirs, or legal representatives for all sums within the limits established by law, which the person or persons are legally entitled to recover as damages for bodily injury, including any resulting sickness, disease, or death, to the insured from the owner or operator of an uninsured motor vehicle not owned or operated by the insured or resident of the same household. An uninsured motor vehicle includes an underinsured motor vehicle as defined in subdivision (p) of Section 11580.0 of the California Insurance Code.

Pursuant to the authority of the California Insurance Code, the undersigned, a named insured in the policy, and the company providing the insurance agree to the deletion of all coverage and obligation to defend, and including specifically uninsured motorist coverage as described above. The undersigned further agrees to reimburse the company providing the insurance for any payment made to a loss payee because of a loss arising from the use of operation of any vehicle by any person designated by name above.

The deletion shall be binding upon every insured to whom such policy or endorsement provisions apply while such policy is in force, and shall continue to be so binding with respect to any continuation, renewal or replacement of such policy by the named insured, or with respect to reinstatement of such policy within 60 days of any lapse thereof.

DO NOT SIGN THIS AGREEMENT UNTIL YOU HAVE READ AND UNDERSTAND IT.

Signature of Applicant _____ Date: _____

COMMERCIAL, BUSINESS AND PROFESSIONAL USE EXCLUSION

I represent and warrant that vehicle(s) to be insured by _____ Insurance Company are NOT used commercially, or in a business or professional endeavor.

I fully understand and agree that the insurance to be extended on the policy applied for shall not benefit either the insured(s) or a third party claimant when the vehicle for which coverage is requested is used commercially, or in a business or professional endeavor.

I further understand and agree that there will be NO INSURANCE COVERAGE IN FORCE from _____ Insurance Company on the policy hereby applied for if I, or any person using vehicles for which coverage is requested, am (is) involved in an accident while using the vehicles in the course of any commercial, business or professional endeavor.

Signature of Applicant _____ Date _____

POLICY #	_____
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AGREEMENT TO DELETE UNINSURED MOTORIST COVERAGE

Uninsured Motorist Bodily Injury Coverage provides that if you suffer bodily injury or sickness, including death, resulting from an accident with a hit and run driver or a person who does not carry liability insurance, and if he is at fault, you make claim against your own insurance company for general damages and special damages rather than against the uninsured motorist.

The California Insurance Code requires an insurer to provide uninsured motorist coverage in each bodily injury liability policy it issues covering liability arising out of ownership, maintenance, or use of a motor vehicle. Such section also permits the insurer and the applicant to delete such coverage completely or to delete such coverage when a motor vehicle is operated by a natural person or persons designated by name, or agree to provide such coverage in an amount less than that required by subdivision (m) of Section 11580.2 of the Insurance Code, but not less than the financial responsibility requirements. Uninsured motorist coverage insures that the insured, his heirs, or legal representatives for all sums within the limits established by law, which such person or persons are legally entitled to recover as damages for bodily injury, including any resulting sickness, disease, or death, to him from the owner or operator of an uninsured motor vehicle not owned or operated by the insured or a resident of the same household. An uninsured motor vehicle includes an underinsured motor vehicle as defined in subdivision (p) Section 11580.2 of the Insurance Code.

I have read the above and agree to the deletion of Uninsured Motorist Bodily Injury Coverage.

Signature of Applicant _____ Date _____

UNINSURED MOTORIST PROPERTY DAMAGE WAIVER

Uninsured Motorist Property Damage Coverage provides coverage for damage to your vehicle caused by a person who does not carry liability insurance. The uninsured vehicle must be identified by its license number.

I have read the above and I agree to the deletion of Uninsured Motorist Property Damage Coverage.

Signature of Applicant _____ Date _____

DELETION OF COLLISION DEDUCTIBLE WAIVER

Uninsured Motorist Collision Deductible Waiver Coverage

Uninsured Motorist Collision Coverage provides that if your automobile is damaged as the result of direct physical contact with an uninsured motor vehicle that your deductible under the collision coverage will be waived.

DELETION OF COLLISION DEDUCTIBLE WAIVER

By my signature below, I agree with the company that the Uninsured Motorist Collision Deductible Waiver Coverage shall be deleted from the policy I am applying for; shall be deleted from any renewal of the policy ; and shall be deleted from any other policy which extends, changes, supersedes or replaces the policy issued to me by the company, or with respect to reinstatement of the policy within 30 days of any lapse thereof. My agreement to delete the Uninsured Motorist Collision Deductible Waiver from the policy shall be binding upon me and upon any person covered by the policy.

I have read the above and I agree to the deletion of Uninsured Motorist Collision Deductible

Signature of Applicant _____ Date _____

DECLARATIONS

1) A routine inquiry will be made regarding your character, general reputation, personal characteristics and mode of living. Upon your written request we will disclose the nature and scope of the inquiry. 2) I hereby waive section 1808.21 of the California Vehicle Code and authorize _____ Insurance Company to obtain my Motor Vehicle Record. 3) Semi-annual policies are subject to rate revisions every 6 months.

I declare that the statements on all pages of this application are true and request the company to issue the insurance applied for in reliance on these statements. I understand that any material misrepresentation will void coverage. I also understand and agree that:

- 1) This policy does not afford coverage for Towing and/or Rental Reimbursement unless requested and premium charged.
- 2) No coverage applies to any Non-Factory Equipment unless listed and premium charged.
- 3) No coverage applies if the vehicle is repaired before inspection by the Company.
- 4) Failure to disclose complete and accurate information will jeopardize my coverage and/or will result in additional charges or rejection of this application.
- 5) If my check for the down payment or full payment is returned by the bank unpaid for any reason, coverage will be null and void from inception.
- 6) I certify that all persons aged 14 or older who are members of my household and all regular operators of my vehicle(s) have been listed on the application.
- 7) No coverages (including Uninsured Motorists) apply while any covered auto is used or operated by any individual listed in the "Designated Persons and Spousal Exclusion" section of this application, regardless of where the person resides or whether the person is licensed to drive.
- 8) In the event of repossession of the insured vehicle(s) as a result of an accident caused by an excluded driver, I will be liable for any payment made by the company to a loss payee.
- 9) The above declarations shall be binding upon every applicant listed on this application.
- 10) No coverage applied until issuance of a policy by the Company.

I acknowledge that I have received a copy of my _____ Policy and this application.

Signature of Applicant _____ Date _____ Time _____ AM/PM

Signature of Producer _____ Date _____ Time _____ AM/PM

POLICY #



ANNUAL MILEAGE SELF-CERTIFICATION FORM

I represent and warrant under penalty of perjury, that the vehicle(s) listed below are going to be driven the approximate annual mile listed below.

Vehicle:

Year____ Make_____ Model _____ Annual miles _____ Odometer_____

Year____ Make_____ Model _____ Annual miles _____ Odometer_____

Year____ Make_____ Model _____ Annual miles _____ Odometer_____

Year____ Make_____ Model _____ Annual miles _____ Odometer_____

Year____ Make_____ Model _____ Annual miles _____ Odometer_____

Year____ Make_____ Model _____ Annual miles _____ Odometer_____

PLEASE READ THE FOLLOWING CAREFULLY:

It contains terms of our agreements.

The above individual(s) has made Western General Insurance Company (hereinafter called the Company) a written application attached hereto and incorporated by reference. Each and every statement of fact contained in the application is hereby warranted by the insured to be true. The application and the particulars and statements contained therein are hereby agreed to be the basis of this policy, and any renewals of this policy, and shall any of these statements not be true, this policy shall be declared void from its inception date by the Company. It is also understood that unless drivers residing with the named insured are named in the Declarations, coverage may not be afforded. If you desire coverage for drivers other than those shown, request your agent to have your coverage amended to list and include the additional drivers.

I have read, understand and agree with all terms as stated above: (POA not acceptable - insured must sign)

Signature of Applicant: _____ Date: _____

As witnessed by: (must be signed)

Signature of Broker: _____ Date: _____

REDUCED COVERAGE DISCLOSURES

THIS POLICY HAS REDUCED OR LIMITED COVERAGES AND IS NOT LIKE A STANDARD POLICY

IT IS VERY IMPORTANT YOU READ AND UNDERSTAND THE FOLLOWING

NAMED OPERATOR ONLY (no permissive use). The policy you have purchased contains limited coverage in that there is no coverage for damage for your car if any person other than the named insured on the declaration page drives your car. This means that if someone else is driving your car, with or without your permission, and there is an accident this insurance policy will not afford any coverage for damage to your car, and any claim made against the policy for such damage will be denied. For damage to your car, **this policy only covers the named insured on the car listed – all other people in the world are excluded drivers.** See Part IV for policy provisions. I understand that I was offered to remove this restriction for an additional premium and I elected not to purchase the coverage.

Initials



NAMED VEHICLE ONLY (listed vehicle(s) only). This policy does not give you coverage if you drive any vehicle not listed on the declaration page. In other words, if you drive another vehicle this policy will provide NO insurance of any kind relating to any liability created while driving that vehicle or coverage for that vehicle. I understand that I was offered to remove this restriction for an additional premium and I elected not to purchase the coverage. See Global Policy Exclusion.

Initials



TRIPLE DEDUCTIBLE DURING FIRST 60 DAYS AFTER POLICY INCEPTION OR REINSTATEMENT WITH LAPSE, REWRITE WITH LAPSE OR RENEWAL WITH LAPSE OR GAP IN COVERAGE. During the first 60 days after the inception date of this policy and the first 60 days after the effective date of an reinstatement, rewrite or renewal with a lapse or gap in coverage, the deductible listed on the Declarations is tripled. For example, this means if you have a \$600 deductible listed and you have a claim within 60 days of any of these events the deductible will be \$1,800. See Part IV for policy provisions.

Initials



NO CASH OUT PROVISION. This policy does not have cash out provision. This means that if you have a covered loss, the policy will cover repairs only and we will not send you a check for the damage amount. In other words, we will only make covered payments to a body shop for actual repairs to your vehicle. Only if your car is deemed a total loss by us will we make payments directly to you. See Part IV for policy provisions.

Initials



NO RENTAL CAR REIMBURSEMENT COVERAGE. This policy does not provide reimbursement for a rental car in any form for any reason.

Initials



NO PAYMENT FOR STORAGE. Except as required by law, this policy does not cover storage costs in the event of a covered loss. This means that you are responsible for any and all storage costs. See Part IV for policy provisions.

Initials



72 HOUR NOTICE REQUIREMENT FOR NEW OR REPLACEMENT VEHICLES. You must notify us to add any replacement or additional cars to the policy within 72 hours of the purchase by means of an endorsement and paying the premium. This means that if you purchase another car there will be no coverage after 72 hours unless you notify us to specifically endorse the car to the policy and you pay the premium for coverage.

Initials



Client's Signature: _____



Date: _____



I have read and understood the above.

Producer's Signature: _____



Date: _____



Revised 5/10



Insurance Services Underwriting

Applications: Submit signed application with supporting documents, i.e. FSC quote sheet, MVR, registration, photos (if writing physical damage coverage), proof of discounts, proof of no fault/no injury accidents.

Endorsements On line: Original documents must still be submitted.

Annual miles: When rating you should always rate the policy with the insured's actual mileage driven. Self-certification form required.

Vehicle Usage: While it may not affect the rate for some programs, you **MUST** still enter the correct usage:

- Usage: **C** Commute - insured is commuting to work or school;
- Usage: **P** Pleasure - insured is unemployed, housewife, retired, disabled, extra vehicles;
- Usage: **B** Business - private passenger vehicles used by sales or professional people during their course of work; or
- Usage: **F** Farm - "Farm use" means the vehicle is garaged on a farm or ranch and is customarily used in the occupation of farming or ranching.

Years of Driving experience: All years with 3 years of provable licensing. **Out of state experience acceptable** – must submit copy of OOS license and/or name of state and license number on the application.

International experience: Two requirements: 1) Any driver with an International or Foreign Drivers License must provide evidence of a valid U.S. or Canada driver license for at least 3 years unless they qualify for the Good Driver Discount and 2) must sign the *INTERNATIONAL LICENSE CERTIFICATION* form.

Accident Self-Certification: This form may be submitted when there is no other proof regarding an accident. If the driver was insured at the time of the accident and is contending that they were not at fault or there was no injury, we will accept the following:

- letter of Experience demonstrating date of loss and disposition;
- cancelled check from insurance company demonstrating Named Insured, claimant and date of loss; or
- police report – for purposes of No fault ONLY.

Proof of Marriage: if spouses have different last names on MVR, Insured may sign the *PROOF OF MARRIAGE CERTIFICATION* form to qualify for the discount.

Named Driver Exclusions: Any person may be excluded from coverage except for a named insured or their spouse. Exclusion of a spouse is only acceptable if the spouse is unlicensed or all other drivers on the policy qualify for Good Driver Discount.

(800) 396-1485 Customer Service - Underwriting



APPLICANT PREINSPECTION NOTICE

Dear Applicant:

California law says that your vehicle must be inspected before you can buy collision or comprehensive insurance for your vehicle. (Depending on the terms of your insurance contract, "collision" insurance pays for all or part of loss or damage to an automobile resulting from most collision losses. "Comprehensive" insurance pays for all or part of loss or damage to an automobile resulting from most causes other than collision.)

There are exceptions to the California Automobile Preinspection Law which exempt some vehicles from the preinspection requirement. Your insurance company, agent or broker is required to tell you if you qualify for any of these exceptions. If you do not qualify for an exception, your vehicle must be inspected before your collision and/or comprehensive coverage may be issued.

The California Automobile Preinspection Law also says your insurance company can, under certain circumstances, provide your comprehensive and/or collision insurance coverage and allow for a delay in the inspection for a limited period of time. But if you do not comply with the Law and have your vehicle inspected by the end of that grace period, the collision and/or comprehensive insurance on your vehicle may be severely restricted or suspended. Whenever automobile collision or comprehensive coverage, or both, is suspended or restricted for the failure to have an inspection report, the insurer shall immediately notify the insured that the collision or comprehensive coverage, or both, is restricted or suspended until the vehicle is inspected.

If the insurance company, agent, or broker does delay the inspection, ask your insurance company, agent or broker why there is a delay and when the inspection will be conducted.

If the insurance company fails to conduct an inspection within the limited time period, your collision and/or comprehensive coverage may not be suspended or cancelled or restricted in any way. If the insurance company fails to tell you that an inspection is required, or your vehicle is not inspected because your insurance company, agent or broker fails to inspect your vehicle, your collision and/or comprehensive coverage may not be suspended, cancelled or restricted in any way.

The insurance company, or someone it chooses, must conduct the inspection at no direct charge to you. The inspection must be done at a time and place reasonably convenient for you, except that the insurer is not required to send an agent to your home or place of business. Whoever inspects the vehicle will record, in writing, any visible damage to the vehicle. The inspector will also record, in writing, a description of your vehicle, including any accessories or equipment not factory installed.

Finally the inspector will take at least two clear color photographs of the vehicle or the inspector may choose to photograph your vehicle by other means such as videotape.

The point of the inspection is not to find out whether your vehicle is safe to drive, but only to check for preexisting damage, prior conditions, equipment and accessories not factory installed, and mileage of the vehicle. The insurance company must give you a copy of the photographs or videotape.

If you have questions about having your vehicle inspected before you buy insurance, ask your insurance agent, broker, or the insurance company. If you ever have a problem with an insurance company that you cannot resolve on your own, call the California Department of Insurance at 1-800-927-HELP (4357).



Stonewood Insurance Services
AUTOMATIC RECURRING CREDIT CARD MONTHLY PAYMENT
AUTHORIZATION

I authorize Stonewood Insurance Services, Inc. to initiate scheduled deductions from the credit card identified below for payment of premium on the insurance policy issued to me and any renewals thereof. I authorize the financial institution identified by the credit card number on the credit card below to accept the post entries to the account.

I represent that I am the owner and/or an authorized signer of the account. I understand that this authorization allows Stonewood Insurance Services, Inc. to adjust the scheduled deductions to reflect any premium changes to my policy. Stonewood Insurance Services, Inc. agrees that it shall notify me in writing at least ten days prior to making any deduction if there is a premium change or seven days if there is a due date change. Please note that although payment will typically be processed on the Recurring Credit Card Schedule dates, please allow several days for processing of the credit card payment from your account. Please note that Stonewood Insurance Services, Inc. may electronically charge your account. I understand that Stonewood Insurance Services, Inc. will not send me a bill before scheduled deductions are made and that it is my responsibility to ensure sufficient funds are available at the time of each scheduled deduction. I also understand that my policy may cancel or expire if the payment is declined, which could cancel this agreement and remove my policy from automatic recurring credit card processing. In addition to any fees charged by the credit card Company, Stonewood Insurance Services, Inc. will charge an NSF fee of up to \$25.00 if my payment is dishonored or returned for any reason. Additionally, I may be removed from the Recurring Credit Card Payment Authorization program. This authorization is to remain in full force and effect until Stonewood Insurance Services, Inc. receives a written request from me to cancel my recurring credit card payment or until Stonewood Insurance Services, Inc. elects to cancel this agreement.

PLEASE NOTE THAT IF YOUR DUE DATE FALLS ON A WEEKEND OR HOLIDAY WE WILL MAKE THE PAYMENT ON THE NEXT BUSINESS DAY FOLLOWING THE HOLIDAY/WEEKEND.

Please allow up to 7 days for changes or termination of electronic payment withdrawal to ensure changes are made prior to the withdrawal of your installment. If you have any questions or concerns about this transaction, you can email accounting@StonewoodInsurance.com or call Stonewood Insurance Services at (800)396-1485. You may also fax this form to: 916-503-4667.

All of the information requested below is required and very important for the accurate processing of your recurring credit card monthly payment plan. If any of the information is missing or inaccurate, please be aware that this may delay the processing.

Please note that your monthly recurring credit card payments are subject to change depending on any changes that cause an increase or decrease to your written premium which are made to the existing policy during the term.

Insured Name: _____ Policy #: _____

Account Holder: _____ Phone #: _____

Circle One: Visa / MasterCard

Credit Card #: _____ CVV2# (Refer to back of Card): _____

Expiration Date (MM/YY): ____ / ____

Mailing Address of Credit Card: _____ City _____ State _____ Zip Code _____

Signature: Date: _____ Date: _____



ACCIDENT CERTIFICATION FORM

I represent and warrant under penalty of perjury, that the accident on _____ was not at-fault and/or involved no bodily injury.

Name of Driver _____

Date of Accident _____ Location _____

Did you or the other party have insurance? Yes _____ No _____

Was there a police report? Yes ___ No ___ If Yes police report # _____

Was anyone, including yourself injured? Yes _____ No _____

Were you at least 51% responsible for the accident? Yes _____ No _____

Total amount of the damages to both vehicles and people: \$ _____

Briefly describe how the accident occurred: _____

PLEASE READ THE FOLLOWING CAREFULLY:

It contains terms of our agreements.

The above individual(s) has made Western General Insurance Company (hereinafter called the Company) a written application attached hereto and incorporated by reference. Each and every statement of fact contained in the application is hereby warranted by the insured to be true. The application and the particulars and statements contained therein are hereby agreed to be the basis of this policy, and any renewals of this policy, and shall any of these statements not be true, this policy shall be declared void from its inception date by the Company. It is also understood that unless drivers residing with the named insured are named in the Declarations, coverage may not be afforded. If you desire coverage for drivers other than those shown, request your agent to have your coverage amended to list and include the additional drivers.

I have read understand and agree with all terms as stated above: (POA not acceptable - insured must sign)

Signature of Applicant: _____ Date: _____

As witnessed by: (must be signed)

Signature of Broker: _____ Date: _____



SALVAGED VEHICLE DE-VALUATION DISCLOSURE

I understand and ac knowledge that because my vehicle has a “Salvaged” title, my Comprehensive and Collision carrier may de-value the settlement of any claim by 50%.In any event, I understand that claims are paid on the Act ual Cash Value (ACV) of my vehicle at the time of the loss, as determined by the Company Claims Adjuster, which may be less than the value used to rate my policy.

Purchase Date_____ Purchase Price _____

Insured's signature

Date

Producer's Signature

Date

Policy Number



SR22 – STATEMENT OF OWNED VEHICLES

In consideration of Y ^•c!} /Ö^} ^!æ issuing an SR22 filing on my behalf, I certify that I own ___ _____ motor vehicles, which are identified below. I agree that these vehicles will be insured for Bodily Injury and Property Damage Liability with Y ^•c!} /Ö^} ^!æ Insurance Company, unless coverage for any vehicle is specifically excluded. I further agree to immediately notify my agent and/or broker if I acquire any additional vehicle(s).

I have applied for insurance through Y ^•c!} /Ö^} ^!æ Insurance Company on the following vehicles:

Policy / binder number Year Make Model

Policy / binder number Year Make Model

Policy / binder number Year Make Model

Applicant's signature Date Producer's signature Date



INTERNATIONAL LICENSE CERTIFICATION FORM

I represent and warrant under penalty of perjury, that I, _____ was previously licensed in _____ from _____ to _____.
(Country)

I represent and warrant under penalty of perjury, that my driving record was as follows:

Ticket(s): Date _____ Violation _____
Date _____ Violation _____
Date _____ Violation _____

Accident(s): Date: _____ Date: _____

Was anyone, including yourself injured? Yes _____ No _____

Were you at least 51% responsible for the accident? Yes _____ No _____

Total amount of the damages to both vehicles and people: \$ _____

PLEASE READ THE FOLLOWING CAREFULLY:
It contains terms of our agreements.

The above individual(s) has made Western General Insurance Company (hereinafter called the Company) a written application attached hereto and incorporated by reference. Each and every statement of fact contained in the application is hereby warranted by the insured to be true. The application and the particulars and statements contained therein are hereby agreed to be the basis of this policy, and any renewals of this policy, and shall any of these statements not be true, this policy shall be declared void from its inception date by the Company. It is also understood that unless drivers residing with the named insured are named in the Declarations, coverage may not be afforded. If you desire coverage for drivers other than those shown, request your agent to have your coverage amended to list and include the additional drivers.

I have read, understand and agree with all terms as stated above: (POA not acceptable - insured must sign)

Signature of Applicant: _____ Date: _____

As witnessed by: (must be signed)

Signature of Broker: _____ Date: _____



COMMERCIAL CONVICTIONS WAIVER

I represent and warrant under penalty of perjury, that the minor moving violation(s) on:

Violation _____ Date _____

Violation _____ Date _____

Violation _____ Date _____

Occurred while I was operating a motor vehicle for compensation during the hours of employment.

Signature of Applicant _____ Date: _____



LOW MILEAGE STATEMENT

(For Vehicles Driven Less than 6,000 miles Annually)

I hereby represent and state that this vehicle listed on my application for insurance with Y ^•c;} /Ö^} ^!æ Insurance Company is **NOT DRIVEN** more than _____ miles annually.

I fully understand that the information in this statement is part of my application, that it is the basis of a request for a substantial premium discount, and that NO COVERAGE will be provided to me in the event of a loss if I have misrepresented the annual mileage the listed vehicle is driven.

Year _____ Make _____ Model _____

Current Odometer Reading (COR) _____

Prior Odometer Reading (POR) showing at least 90 days experience,
from attached copy of repair orders, service receipt, or sales contract _____

(Underwriting use only: $COR - POR / \# \text{ of days Exp. } \times 365 = \text{Annual Mileage}$ _____)

Attach proof of prior Odometer Reading to this form

Applicant's signature

Date

Producer's signature



GOOD STUDENT DISCOUNT VERIFICATION

Named Insured _____ Policy Number _____

Student Name _____ Date of Birth _____

High School/College _____

Street _____ City _____ State _____ Zip _____

- Student is currently enrolled in High School
- Student is currently enrolled in College in 12 or more units of study
- Student is currently enrolled in 8 or more units of a graduate program

I hereby certify that the above named student was on the "Honor Roll" or "Dean's List" or had a "B" or better average or was in the upper 20% of his/her class during the previous semester.

Signature of School Official

Date

Title

Phone Number



**STATE OF CALIFORNIA
COMMUNITY SERVICE STATEMENT**

Completion of this form is voluntary. The information you provide will only be used for purposes as set forth in "CIC" Section 2646.6.

I will / will not participate in this community service survey (please circle).

The California Insurance Commissioner has directed insurers to ask for certain information regarding applicants for insurance. All applicants are requested to voluntarily provide the following information. This form will be separated from the application before it is processed. None of this information will be used in the underwriting or rating of any applicant or policyholder.

Applicant's Name and Address (to be provided in order to refer back to the application.)

Provide the gender of the applicant or policyholder: Male Female

Check the Race or National Origin as it applies to the applicant or policyholder. Latino does not apply to persons of Brazilian or Portuguese origin.

African- American Latino

American Indian or Alaskan Native Middle Eastern

Asian (Oriental) Pacific Islander

Asian (Other) White

Information not provided by applicant Other



NATION SAFE DRIVERS TRAVEL CLUB

This Is Not An Automobile Liability Or Physical Damage Insurance Contract.

Dear Member,

Congratulations! You have taken a very important step in protecting yourself and your financial future with your Nation Safe Drivers Travel Club. Your benefits are accessible 24-hours a day should a circumstance occur where you would need them.

Every year, millions of people are caught unprepared for automobile-related accidents and hospitalization, leaving themselves with medical bills that can take a lifetime if ever to overcome. Your choice to protect yourself and your family with Nation Safe Drivers Travel Club helps to ensure your family will not suffer financial ruin in the event of an auto accident. Your benefits are paid directly to you - not the doctor, and not the hospital. You are free to spend the money any way you choose.

Though we sincerely hope no family member ever experiences a circumstance where they would need these benefits, the reality is millions of people do end up in situations where they could greatly benefit from the protection we offer. In the event you should need us, we look forward to being there.

Nation Safe Drivers

As a Member of Nation Safe Drivers, you receive these fantastic Travel Benefits:

TRAVEL: Please visit www.preferredmembers.com and click "Travel." You will be able to access online discounts for hotel, airfare and car rental reservations. Package Discounts are available.

We have partnered with hotels.com to guarantee our members the lowest pricing available for hotels by visiting:

www.preferredmembers.com

When on the road, traveling away from home, you can access your hotel discounts by visiting our website or calling: **800-916-1439**

CREDIT CARD PROTECTION: If your credit cards are lost or stolen, simply notify us and we will in turn notify all your credit card companies of your loss and request replacements.

RENT-A-CAR DISCOUNTS: You will be furnished with discount cards for automobile rentals honored at thousands of locations in the United States and abroad.

LOST LUGGAGE PROTECTION: If your baggage is lost by a transportation carrier, follow carefully the Lost Baggage Claim Procedure which is customary with the carrier involved. If you are not satisfied with the results, notify us in writing, supplying a copy of your claim check and claim form. We will endeavor to follow up on your claim to assure a fair settlement.

EMERGENCY CASH: In the event your credit cards or cash have been stolen and you are 250 miles or more from home, call and we will loan you cash to tide you over. Theft must be reported to police department and a police report must be presented prior to loan. Loan must be repaid to Nation Safe Drivers within 30 days of loss.

Benefit: \$75

HOSPITAL INDEMNITY BENEFITS: FOR AUTO ACCIDENT ONLY (This Plan does not provide coverage for loss caused by sickness, disease and/or illness.)

The following is a description of your benefits issued under the Nation Safe Drivers Travel Program. Your benefit amounts are shown below. Benefit applies only to the "named member." Benefit applies only while involved in an auto accident while driving or riding in a Private Passenger (Pleasure Use Only) Auto Only. Exclusions/Limitations will apply.

Benefits are not paid on a per person basis. All limits are aggregate limits.

1. **Benefit "A": Accidental Death and Dismemberment**

Benefit applies only to the "named member" while involved in an auto accident while driving or riding in a Private Passenger (Pleasure Use Only) Auto that is insured under the Western General Insurance Company policy. Benefit is the most we will pay for any one loss. Principal Sum: \$7,500.

The following table shows percentages paid of the Principal Sum:

- Loss of Life: 100%
- Loss of One Limb or One Eye: 50%
- Loss of Two or More Limbs: 100%
- Loss of Speech or Hearing: 50%
- Loss of Speech or Hearing (both ears or singular mouth): 100%
- Loss of Thumb and Index finger (same hand): 25%

2. **Benefit "B": Excess Accident Medical Expense**

Benefit applies only to the "named member" while involved in an auto accident while driving or riding in a Private Passenger (Pleasure Use Only) Auto insured under your Western General Insurance Company policy. Elected benefit is the most we will pay for any one loss.

- Medical Benefit: \$750.
The Medical Benefit is "excess" over any other valid and/or collectable coverage (i.e. primary auto, health, etc.). "Excess" means that no payments will be made under this plan for any amounts paid or payable by any other available coverage.
- Daily In-Hospital Confinement Benefit: \$75 per day. (Benefit stated is the most we will pay for any one loss.)
Benefit is not per person. Benefits are payable regardless of any other coverage in force (not on an excess basis).
 Other restrictions apply:
 Annual Aggregate: 365 days
 Minimum Confinement Period: One Day
 Recurrence period: none
 Benefits Start: Day One

The plan will pay the Daily In-Hospital Confinement Benefit amount for each day the "named member" is registered as an In-Patient in a hospital if:

- A. The "named member" is hospitalized as a result of an auto accident only; and
- B. The auto accident involved the automobile insured under the Western General Insurance Company policy; and
- C. The "named member" is under a medical doctor's care; and
- D. The "named member" is confined for at least the Minimum Confinement Period; and
- E. The hospital provides at least a full day's Room and Board; and
- F. The accident occurred while this contract was in effect.

For the purpose of this benefit, the term "hospital" means the institution that provides primary medical or surgical care to the "named member." Rehabilitation, convalescent, psychiatric, and/or nursing home facilities are specifically excluded from this definition.

3. **Specific Exclusions / Limitations:** There is no coverage for the following:
 - A. Loss due to suicide or attempted suicide while sane or insane; or
 - B. Intentional or self-inflicted injury; or
 - C. Loss which occurred while the "named member" was driving under the influence of intoxicating liquor(s), drink(s), beverage(s) and/or narcotic(s) and/or psychedelic drug(s); or
 - D. Loss that occurs while the "named member" is driving or riding as a passenger in the insured vehicle while being driven in any competition, race or speed contest; or while being tested in any race track or speedway; or
 - E. For any loss that occurs while "named member" is engaged in any illegal act; or
 - F. Any claim(s) that appears and/or is found to be false and/or fraudulent; or
 - G. Whose operator (including but not limited to the "named member") leaves the scene of an accident (i.e. hit and run) note: written police report will be required; or
 - H. Any accident occurring outside the USA; or
 - I. Any work-related accident which occurs while the "named member" is at work.
4. **Claims:** If a loss occurs, please contact: National Adjustment Bureau, 800 Yamato Road, Ste. 100, Boca Raton, FL 33431 and/or 800-338-2680.
5. **Notice of Claim:** Written notice of claim must be given to National Adjustment Bureau within 20 days after a loss occurs or begins. The notice must include your name, the name of the "named member," the date of loss, and the member number (which is the Western General Insurance Company policy number). It should be sent to National Adjustment Bureau, 800 Yamato Road, Ste. 100, Boca Raton, FL 33431.
6. **Claim Forms:** Once we receive notice of a claim, we will provide claim forms. You can also obtain claim forms at www.nsdclaims.com. The written proof of loss requirement will be met by you or the beneficiary by sending us written proof as described in section 7, below.
7. **Written Proof of Loss:** Proof of Loss must describe the incident, extent and type and date of loss. For death claims, proof of loss includes a certified copy of the death certificate, autopsy report (if performed), coroner, medical examiner and/or justice of the peace reports, police motor vehicle accident report, police incident report or fire department incident reports. Written proof of loss must be sent to us at the address shown above. If the claim is for a continuing loss for which we make periodic payments, the claimant must give us written proof of loss within 60 days after the end of each period that benefits are payable. For any other loss, written proof must be given to us within 60 days after the date of loss.
8. **Payment of Claims:** We will pay any benefits due within 30 days from the receipt of written proof of loss and any additional documents/paperwork requested/required. Benefits that provide for periodic payment will be paid monthly.
9. **Physical Examination:** We reserve the right to have you examined by a physician assigned by National Adjustment Bureau. This may be done as often as reasonable necessary while a claim is pending or while we are paying benefits.
10. **Autopsy:** We require an autopsy unless forbidden by law.
11. **Legal Action:** No legal action may be brought until there has been full compliance with the terms and conditions of this membership. In no case can any action be taken to recover on this membership within 60 days after written proof of loss has been given. No such action may be brought after one year from the time written proof of loss is required to be given.
12. **Beneficiary Designation and Change:** The beneficiary is the "named member's" spouse. In the event that the "named member" is not married, or the spouse cannot be located, payment of death benefits will be issued to the decedent's estate.
13. **Subrogation:** In the event of any payment made under this membership, Nation Safe Drivers shall be subrogated to all the member's rights of recovery therefore against any person(s) and/or organization(s). The member shall execute and deliver any and all instruments and papers and do whatever else is necessary to secure such rights. The member shall do nothing to prejudice such rights of Nation Safe Drivers, and benefits will be void if such rights are prejudiced.

"Named member" means the persons whose names appears on the Western General Insurance Company insurance application as a named driver on the policy. Excluded and unlisted permissive use drivers are not considered "named members."

This description of Hospital Indemnity Benefits is intended to describe the benefits issued to Nation Safe Drivers. Nation Safe Drivers maintains insurance coverage for these benefits. The benefits shown herein may be changed or cancelled in accordance with the

provisions of Nation Safe Drivers' insurance policy. This may be done as a result of (1) a change of eligibility of Nation Safe Drivers; or (2) amendment or termination of the policy. A COPY OF NATION SAFE DRIVERS' INSURANCE POLICY WILL BE MAILED TO THE "NAMED MEMBER" UPON RECEIPT OF WRITTEN REQUEST.

CANCELLATION: If your Western General policy is cancelled, and your NSD membership was in-force for any length of time during the monthly increment in which your policy cancelled, your NSD membership will remain in-force until the end of that monthly increment.

CUSTOMER SERVICE : 800.338.2680
Nation Motor Club, Inc, 800 Yamato Road, Suite 100, Boca Raton, FL 33431

Western General Insurance Company Privacy Notice

The Western General Insurance Company is giving you this notice to tell you how we may collect and share nonpublic personal information about you and the accounts you have with a company (or companies) in the Western General Insurance Company. This notice also advises you of your right to keep this information from being shared with affiliates of the Western General Insurance Company** or other business associates (non-affiliated companies we do business with to provide financial products and services) under certain circumstances and your right to limit marketing, in some cases.*

What Nonpublic Personal Information Do We Collect About You?

We collect non-public personal information about you from the following sources:

- Information we receive from you, such as information on applications or other forms, which may include your name, address, e-mail address, social security number and driving history.
- Information about your transactions with us, our affiliates, or others, such as your account balance and payment history.
- Information we receive from outside sources such as consumer reporting agencies, insurance agencies and state motor vehicle departments which may provide information on your credit history, credit score, driving and accident history, or prior insurance coverage in place.

How Do We Protect The Information That We Collect About You and Your Accounts?

To protect the privacy and security of nonpublic personal information we collect about you, we restrict access to the information to our employees, agents and subcontractors who need this information to provide products and services to you. We maintain physical, electronic, and procedural safeguards that comply with applicable federal and state laws and regulations to guard your non-public personal information. We strive to keep our information about you accurate. If you tell us of an error, we update our records promptly. If you wish to review or correct personal information on your account, please write to us at the address on your account statement or other account materials.

Do We Share The Information We Collect About You and Your Accounts?

Yes, to provide you with superior service, inform you of product and service opportunities that may be of interest to you, or for other business purposes, **we may share** all of the nonpublic personal information we collect about you and your accounts, as described above, as permitted by law. Our sharing of information about you is subject to Your Rights, detailed below.

What Types of Affiliates and Non-affiliated Third Parties Do We Share Information About You With?

Subject to Your Rights, detailed below, **we may share** nonpublic personal information about you with the following types of affiliates and non-affiliated third parties:

- Financial service providers, such as mortgage bankers, credit card issuers, insurance companies, and insurance agents.
- Non-financial companies, such as credit reporting agencies, manufacturers, motor vehicle dealers, and telecommunications companies.
- Companies that perform business or professional services such as printing, mailing services, data processing or analysis, or customer surveys, on our behalf.
- Other companies we do business with to provide financial products and services to you.
- **We may also share** nonpublic personal information about you with affiliates and non-affiliated third parties, as permitted by law.

Do We Share Information About Former Customers?

Yes, subject to Your Rights - detailed below, we may share all of the nonpublic personal information described above about our former customers with the same types of affiliates and non-affiliated third parties, as described above and as permitted by law.

Your Rights:

Information Sharing

- If you want a company in the Western General Insurance Company not to share nonpublic personal information about you with affiliates, other companies we do business with to provide financial products and services to you, or both, you may opt out of Information Sharing. That is, you may direct the company in the Western General Insurance Company not to share information (other than as permitted by law). Information Sharing permitted by law includes, for example, sharing with companies that work for a company in the Western General Insurance Company to provide the product or services you request.
- Your Information Sharing opt out direction will apply to nonpublic personal information, as described above, that the company in the Western General Insurance Company has collected about you and your existing account.

Affiliate Marketing

- Federal law gives you the right to limit some but not all marketing from the companies in the Western General Personal Lines Group and their affiliates. You may limit companies in the Western General Personal Lines Group and their affiliates from marketing their products or services to you based on nonpublic personal information about you that they receive from a company in the Western General Personal Lines Group. This information includes income, account information, credit history, and payment history.
- Your choice to limit Affiliate Marketing will apply to nonpublic personal information about you and your existing account.

How to Opt Out of Information Sharing or Limit Affiliate Marketing:

- If you wish to allow Information Sharing and Affiliate Marketing as described above, no further action is necessary.
- If you wish to opt out of Information Sharing with affiliates, or with non-affiliated third parties, or with both, or to limit Affiliate Marketing, other than as permitted by law, please complete the enclosed "Important Privacy Choices for Consumers".

Please Note: Completing and returning the Important Privacy Choices Form will opt you out of all Information Sharing and Affiliate Marketing as described above, other than as permitted by law.

- Return the completed form in the enclosed postage paid envelope to the following address:
Western General Insurance Company
5230 Las Virgenes Road Suite 100
Calabasas, CA 91302
- Each time you establish a new account with a company in the Western General, you will receive a privacy notice and an opportunity to opt out of Information Sharing and limit Affiliate Marketing for that account, as permitted by law.
- If you have a joint account with another person, either of you may opt out of Information Sharing or limit Affiliate Marketing (other than as permitted by law) for both of you.

Important Privacy Choices for Consumers

You have the right to control whether we share some of your personal information. Please read the following information carefully before you make your choices below.

Your Rights

You have the following rights to restrict the sharing of personal and financial information with our affiliates (companies we own or control, or that own or control us) and outside companies that we do business with. Nothing in this form prohibits the sharing of information necessary for us to follow the law, as permitted by law, or to give you the best service on your accounts with us. This includes sending you information about some other products or services.

Your Choice

Restrict Information Sharing With Companies We Own or Control, or That Own or Control Us (Affiliates): Unless you direct us not to, we may share personal and financial information about you with our affiliates (and those affiliates may use the information to market to you).

Restrict Information Sharing With Other Companies We Do Business With To Provide Financial Products and Services: Unless you direct us not to, we may share personal and financial information about you with outside companies we contract with to provide financial products and services to you.

No, please do not share personal and financial information about me with your affiliates or with outside companies you contract with to provide financial products and services.

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Time Sensitive Reply

You may make your choice at any time. Your choice marked here will remain unless you state otherwise. However, if we do not hear from you, we may share some of your information with affiliates and with other companies with whom we have contracts to provide products and services.

Named Insured: _____

Account(Policy) _____

Number: _____

Signature: _____

Date: _____

To exercise your choice, fill out, sign and send back this form to us using the envelope provided. (You may want to make a copy for your records.)

AUTOMOBILE INSPECTION REPORT

(Attach Photos Here)

NOTE: Area for explanation where lack of clarity of VIN number not located is at bottom of form.

INSURED INFORMATION

Name _____ Policy/Reference # _____
 (Last, First, Initial)

Address _____
 (Street)

_____ Insurer Y ESTERN GENERAL INSURANCE COMPANY
 (City, State, Zip)

VEHICLE INFORMATION

License Plate No. _____ State CA Year/Make _____ Model _____

Body Style 2D 4D St. W Van MiniVan Truck Convttl Htchbk Mtrcycl Other

Mileage _____ Vehicle ID No. _____ Color _____

RECORD ANY VISIBLE EXISTING DAMAGE TO ANY OF THE FOLLOWING AREAS OF THE AUTOMOBILE. CHECK THE BOX IF THERE IS DAMAGE OR RUST.

- | | | |
|----------------------------------|---------------------------------|-------------------------------|
| 1. <u>Front Bumper</u> () | 9. <u>RT Rear Qtr Panel</u> () | 17. <u>Lft Rear Glass</u> () |
| 2. <u>Grill</u> () | 10. <u>RT Rear Door</u> () | 18. <u>Rear Glass</u> () |
| 3. <u>Lft Front Fender</u> () | 11. <u>RT Front Door</u> () | 19. <u>Rt Rear Glass</u> () |
| 4. <u>Lft Rear Door</u> () | 12. <u>Rt Front Fender</u> () | 20. <u>Rt Front Glass</u> () |
| 5. <u>Lft Rear Door</u> () | 13. <u>Hood</u> () | 21. <u>Seats</u> () |
| 6. <u>Lft Rear Qtr Panel</u> () | 14. <u>Roof</u> () | 22. <u>Center Console</u> () |
| 7. <u>Rear Bumper</u> () | 15. <u>Windshield</u> () | 23. <u>Floor Covering</u> () |
| 8. <u>Trunk/Rear Door</u> () | 16. <u>Lft Front Glass</u> () | 24. <u>Dash Board</u> () |

THIS MUST BE FULLY COMPLETED FOR FACTORY OPTIONS & NON-FACTORY EQUIPMENT INDICATE THE PRESENCE OF ANY OF THE FOLLOWING EQUIPMENT OR ACCESSORIES:

- | | | |
|---------------------------------------|---|-------------------------------------|
| 1. <u>Air Conditioning</u> () () | 9. <u>Power Steering</u> () () | 17. <u>Air Bag(s)</u> () () |
| 2. <u>Tilt Wheel</u> () () | 10. <u>Power Brakes</u> () () | 18. <u>Automobile Trans</u> () () |
| 3. <u>Power Antenna</u> () () | 11. <u>Vinyl Top</u> () () | 19. <u>Manual Trans</u> () () |
| 4. <u>Power Trunk</u> () () | 12. <u>Mounted Brake Lights</u> () () | 20. <u>Rear Window Def</u> () () |
| 5. <u>Digital Instruments</u> () () | 13. <u>Cruise Control</u> () () | 21. <u>Rear Wiper</u> () () |
| 6. <u>Anti-Theft Systems</u> () () | 14. <u>Tape Deck</u> () () | 22. <u>Radar Detector</u> () () |
| 7. <u>Compact Disc Player</u> () () | 15. <u>CB Radio</u> () () | 23. <u>Telephone</u> () () |
| 8. <u>Radio/Stereo</u> () () | 16. <u>Custom Wheels/Tires</u> () () | 24. <u>Other</u> () () |

Enter Make and Model, Where Applicable _____

Describe Other Accessories _____

NOTE: The insured may, at his/her discretion, attach copies of receipts and/or other evidence showing the make and model of any accessories not factory installed.

THE ABOVE IS A TRUE STATEMENT RECORDING ANY AND ALL EXISTING DAMAGE, RUST AND/OR MISSING PARTS AS OF THE DATE OF THIS INSPECTION. THE UNDERSIGNED CERTIFIES, UNDER PENALTY OF PERJURY, THAT THIS INSPECTION REPORT IS TRUE AND COMPLETE TO THE BEST OF HIS/HER KNOWLEDGE.

Inspector Name _____ Date _____

Inspector Signature _____ Time _____ AM/PM

Location _____

Party Presenting Vehicle for Identification _____

Relationship to Insured _____ Date _____

I have received a copy of both this automobile inspection report.

Applicant's Signature _____ Time _____ AM/PM

Photo VIN Explanation _____

Note: Authority Insurance Code sections 400, 401, 402, 403, and 12926. Reference Insurance Code sections 400, 402 and 403.

UNDERWRITTEN BY WESTERN GENERAL INSURANCE COMPANY



AUTHORIZATION TO RELEASE VEHICLE(S)

POLICY NO:

This Authorization to Release Agreement is made effective
Vehicle(s) Covered by this Release:

Pursuant to your policy under **PART IV-CAR DAMAGE-COVERAGE D-CAR**

DAMAGE COVERAGE-POWER OF ATTORNEY.

I, _____, hereby grant the power, right and ability to Western General Insurance Company and its employees and assign the right to release, move and transfer the above listed vehicles on my behalf and without any additional communication from me.

I hereby release the body shop, service center or other service provider of any liability for such release.

Insured