FOREMOST INSURANCE COMPANY
GRAND RAPIDS, MICHIGAN

RHODE ISLAND MOTORCYCLE INSURANCE APPLICATION

AGENCY CODE		
AGENCY NAME		
STREET ADDRESS		
CITY	STATE	ZIP CODE

REFERENCE OR POLICY NUMBER	EFFECTIVE DATE	TERM	PHONE NUMBER	FAX NUMBER
		12 MO		

NAMED INSURED MUST BE THE TITLED OWNER OF THE VEHICLE AND AT LEAST 18 YEARS OLD

FIRST NAME	MI	LAST	OCCUPATION

DATE OF BIRTH	GENDER	MARITAL STATUS	SOCIAL SECURITY NUMBER	PHONE NUMBER
	❑ M ❑ F	❑ S ❑ M		

MAILING ADDRESS	CITY	STATE	ZIP CODE

IS THE NAMED INSURED'S PRIMARY RESIDENCE OWNED OR RENTED? ❑ OWNED ❑ RENTED

IS THERE AN ADDITIONAL TITLED OWNER? IF YES:	FIRST NAME	MI	LAST	IS THE JOINT OWNERSHIP ENDORSEMENT NEEDED? ❑ Y ❑ N

DOES ANY OPERATOR BELONG TO AN APPROVED AFFINITY GROUP OR ALLIANCE? ❑ Y ❑ N (AGENT: VERIFY AND RETAIN PROOF OF CURRENT MEMBERSHIP)

Which operator: _____ Which organization: _____ MEMBERSHIP NUMBER

GARAGING COMPLETE IF ANY VEHICLE IS GARAGED AT A LOCATION DIFFERENT FROM OWNER'S MAILING ADDRESS

VEH #	GARAGING ADDRESS	CITY	STATE	ZIP CODE

OPERATOR LIST ALL RESIDENT OPERATORS

NAME	GENDER	DATE OF BIRTH	MARITAL STATUS	MOTORCYCLE SAFETY COURSE DATE	MOTORCYCLE SAFETY COURSE INSTRUCTOR DATE	TOTAL YEARS LICENSED	ACCIDENT PREVENTION COURSE DATE	DRIVER'S LICENSE NUMBER	ISSUING STATE	MC LICENSE OR ENDT	YEARS MC EXPERIENCE
1 Named Insured	-	-----	---							❑ Y ❑ N	
2										❑ Y ❑ N	
3										❑ Y ❑ N	
4										❑ Y ❑ N	
5										❑ Y ❑ N	

ACCIDENTS OR VIOLATIONS

HAS ANY OPERATOR BEEN CONVICTED OF A MOVING VIOLATION OR HAD AN ACCIDENT (REGARDLESS OF FAULT OR TYPE OF VEHICLE DRIVEN) WITHIN THE PAST 3 YEARS? ❑ Y ❑ N
IF YES, PROVIDE DETAILS BELOW OR IN "REMARKS".

OPERATOR #	ACCIDENT/VIOLATION		ACCIDENT			PLACE (CITY-STATE)	DESCRIPTION
	(SPECIFY)	DATE	AT-FAULT	BODILY INJURY	AMOUNT OF PROPERTY DAMAGE		
	❑ ACC ❑ VIOL		❑ Y ❑ N	❑ Y ❑ N	$		
	❑ ACC ❑ VIOL		❑ Y ❑ N	❑ Y ❑ N	$		
	❑ ACC ❑ VIOL		❑ Y ❑ N	❑ Y ❑ N	$		
	❑ ACC ❑ VIOL		❑ Y ❑ N	❑ Y ❑ N	$		

VEHICLE INFORMATION

VEH	MAKE AND MODEL	MODEL YEAR	CC SIZE	TURBOCHARGED OR SUPERCHARGED	CURRENT MARKET VALUE	USE P=PERSONAL B=BUSINESS	ESTIMATED ANNUAL MILEAGE	STORED IN FULLY-ENCLOSED LOCKED GARAGE OR SIMILAR STRUCTURE*
1				❑ Y ❑ N	$			❑ Y ❑ N ❑ M
2				❑ Y ❑ N	$			❑ Y ❑ N ❑ M
3				❑ Y ❑ N	$			❑ Y ❑ N ❑ M
4				❑ Y ❑ N	$			❑ Y ❑ N ❑ M
5				❑ Y ❑ N	$			❑ Y ❑ N ❑ M

***CHECK "M" IF APPLICANT IS A SERVICEMEMBER WHO LIVES *ON* A MILITARY BASE AND GARAGES THE VEHICLE(S) *ON* THE BASE.**

VEH	VEHICLE IDENTIFICATION NUMBER	NUMBER OF WHEELS	CONVERTED FROM 2 WHEELS	SPECIFY TRIKE CONVERSION KIT MANUFACTURER	ABS	AIRBAG
1			❑ Y ❑ N		❑ Y ❑ N	❑ Y ❑ N
2			❑ Y ❑ N		❑ Y ❑ N	❑ Y ❑ N
3			❑ Y ❑ N		❑ Y ❑ N	❑ Y ❑ N
4			❑ Y ❑ N		❑ Y ❑ N	❑ Y ❑ N
5			❑ Y ❑ N		❑ Y ❑ N	❑ Y ❑ N

LOSS PAYEE or LEASING COMPANY

VEH #	LEASE OR LOAN NUMBER	NAME OF LIENHOLDER	STREET ADDRESS	CITY	STATE	ZIP CODE

RATING QUESTIONS

DOES THE APPLICANT HAVE ANOTHER IN-FORCE PERSONAL LINES POLICY OR *QUALIFIED** LIFE POLICY WITH FOREMOST, FARMERS, ZURICH OR BRISTOL-WEST? ❑ Y ❑ N
*REFER TO PROGRAM GUIDE FOR QUALIFICATIONS.

HAS APPLICANT HAD INSURANCE ON THIS TYPE OF VEHICLE FOR THE PAST 6 MONTHS? ❑ Y ❑ N

COVERAGE

POLICY COVERAGE

BODILY INJURY (Includes Passenger Liability)
❑ 25/50 ❑ 50/100 ❑ 100/300 ❑ 250/500

PROPERTY DAMAGE
❑ 25,000 ❑ 50,000 ❑ 100,000 ❑ 250,000

BODILY INJURY/PROPERTY DAMAGE CSL (Includes Passenger Liability)
❑ 300,000 ❑ 500,000

MEDICAL PAYMENTS
❑ 2,500 ❑ 5,000 ❑ 10,000

UNINSURED MOTORISTS BODILY INJURY
❑ 25/50 ❑ 50/100 ❑ 100/300 ❑ 250/500
❑ 300/300 ❑ 500/500

VEHICLE COVERAGE

INDICATE SELECTION FOR EACH VEHICLE	VEH 1	VEH 2	VEH 3	VEH 4	VEH 5
UNINSURED MOTORISTS PROPERTY DAMAGE $200 DED 25,000 50,000 100,000 250,000 300,000 500,000	$	$	$	$	$
OTHER THAN COLLISION *Specify Deductible:*	DED $	DED $	DED $	DED $	DED $
COLLISION *Specify Deductible:*	DED $	DED $	DED $	DED $	DED $
TOWING, ROADSIDE ASSISTANCE and TRIP INTERRUPTION COVERAGE	❑ Y ❑ N	❑ Y ❑ N	❑ Y ❑ N	❑ Y ❑ N	❑ Y ❑ N

OPTIONAL EQUIPMENT (Does not apply to vehicles written as Classic or Custom)

1. COLLISION and/or OTHER THAN COLLISION include(s) a minimum amount of coverage for optional equipment at no additional charge (see state Program Guide for the amount included at no additional charge).
2. The total amount of optional equipment coverage may not exceed $15,000. Vehicles with more than $15,000 optional equipment must be placed in the Custom program.

Indicate how much *additional* coverage is needed for each vehicle (do not include trike conversion kit in optional equipment amount)	$	$	$	$	$

TRANSPORT TRAILER COVERAGE
Indicate how much coverage is needed and complete the Transport Trailer section below. $

TOTAL WRITTEN PREMIUM $

TRANSPORT TRAILER

MODEL YEAR	MAKE AND MODEL	SERIAL NUMBER	VALUE
			$

Remarks:

REQUIRED APPLICANT INFORMATION APPLICANT MUST COMPLETE, SIGN AND DATE THIS APPLICATION.

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

In connection with this application for insurance, we may review your credit report or obtain or use a credit-based insurance score based on information contained in that credit report. We may use a third party in connection with the development of your insurance score.

1. I agree that the insurer may investigate and secure consumer reports, including motor vehicle records or credit report information as described above, for persons listed in the application. I further agree that the insurer may investigate and secure new consumer reports in evaluating this policy for each future renewal or replacement policy.
2. I declare that the information contained in this application is true to the best of my knowledge and belief. I understand that the insurer will rely on this information in determining my eligibility and premium.
3. I declare that the selections indicated in this application accurately reflect the limits, coverages and deductibles I chose.
4. I agree that the Company and its affiliates may use any telephone number I provide now or in the future to contact me by way of live calls or by use of any automatic dialing system or artificial or prerecorded voice.

APPLICANT SIGNATURE DATE TIME ❑ AM ❑ PM

REQUIRED AGENT INFORMATION

By signing this application, I certify that I am both licensed by the state and appointed by Foremost to write this specific line of business.

AGENT SIGNATURE DATE TIME ❑ AM ❑ PM

AGENT NAME (Print) AGENT LICENSE NO. COVERAGE BOUND? ❑ YES ❑ NO

PAYMENT PLANS COLLECT FULL PAYMENT OR DOWN PAYMENT BEFORE CALLING TO REQUEST COVERAGE

❑ FULL PAYMENT ❑ 3 PAY ❑ 6 PAY ❑ _____	DOWN PAYMENT $	BALANCE DUE $

MEDICAL PAYMENTS REJECTION FORM - RHODE ISLAND

Medical Payments Coverage provides coverage for medical bills incurred by you, your family members and passengers for injuries resulting from a motor vehicle accident. You have the right to reject this coverage in writing if desired.

❑ I do not want Medical Payments Coverage on my policy and reject this coverage entirely.

SIGNATURE OF APPLICANT OR NAMED INSURED _____ DATE _____

APPLICANT OR NAMED INSURED (Please print) _____ POLICY NUMBER _____

732080 12/08

UNINSURED MOTORISTS BODILY INJURY COVERAGE SELECTION/REJECTION FORM - RHODE ISLAND

Uninsured Motorists Bodily Injury Coverage is being offered to you at limits equal to your Bodily Injury Liability limits. You have the option of selecting lower limits, but the limits you select may not exceed your Bodily Injury Liability limits. You also have the option of rejecting this coverage. If you do not make a selection, Uninsured Motorists Bodily Injury Coverage will be added to your policy at your Bodily Injury Liability limits.

If you want Uninsured Motorists Bodily Injury coverage on your policy, please make your selection here:

❑ 25,000/50,000 ❑ 50,000/100,000 ❑ 100,000/300,000
❑ 250,000/500,000 ❑ 300,000/300,000 ❑ 500,000/500,000

SIGNATURE OF APPLICANT OR NAMED INSURED _____ DATE _____

APPLICANT OR NAMED INSURED (Please print) _____ POLICY NUMBER _____

If you want to reject Uninsured Motorists Bodily Injury coverage, please read and complete the following:

UNINSURED MOTORISTS BODILY INJURY COVERAGE
REJECTION NOTICE AND WARNING

THE LAW REQUIRES YOU TO READ THIS NOTICE FOR YOUR INFORMATION

In order to make sure that you are aware of the risks of going without uninsured/underinsured motorists bodily injury coverage, the State of Rhode Island **requires** your insurance agent or insurance company to obtain your signature showing that you have read this document and understand this warning, **before** they are allowed to sell you motorcycle insurance without uninsured/underinsured motorists bodily injury coverage. **IF YOU CHOOSE NOT TO BUY UNINSURED/UNDERINSURED MOTORISTS BODILY INJURY COVERAGE YOU MIGHT HAVE NO MOTORCYCLE INSURANCE COVERAGE FOR YOUR OWN INJURIES IF YOU ARE HIT BY AN UNINSURED MOTORIST.** Many motorists will ignore mandatory motorcycle insurance laws, and many motorists passing through from another state will not have insurance. Most uninsured/underinsured motorists do not have assets or money to pay you for your injuries, even if you win a lawsuit against them. Uninsured/underinsured motorists bodily injury (UMBI) coverage may be your only protection.

The Department of Business Regulation of the State of Rhode Island STRONGLY RECOMMENDS that most motorists obtain uninsured/underinsured motorists bodily injury coverage as part of their motorcycle insurance package.

❑ I have read and I understand this, and I choose not to buy Uninsured/Underinsured Motorists Coverage.

***UNINSURED/UNDERINSURED MOTORISTS COVERAGE MAY BE REJECTED ONLY IF MINIMUM BODILY INJURY LIABILITY LIMITS ARE REQUESTED. (25/50)**

SIGNATURE OF APPLICANT OR NAMED INSURED _____ DATE _____

WITNESS SIGNATURE _____ DATE _____

APPLICANT OR NAMED INSURED (Please print) _____ POLICY NUMBER _____

732066 12/08

PROPERTY DAMAGE UNINSURED MOTORISTS COVERAGE REJECTION FORM - RHODE ISLAND

Property Damage Uninsured Motorists Coverage shall be provided, unless rejected, under every liability policy to which **Collision Coverage is not selected.** This coverage is subject to a $200 deductible. You have the option of selecting limits lower than your Property Damage limits or may reject this coverage entirely.

I have reviewed my coverages and reject Property Damage Uninsured Motorists Coverage for:

❑ Vehicle 1 ❑ Vehicle 2 ❑ Vehicle 3 ❑ Vehicle 4 ❑ Vehicle 5

SIGNATURE OF APPLICANT OR NAMED INSURED _____ DATE _____

APPLICANT OR NAMED INSURED (Please print) _____ POLICY NUMBER _____

732073 12/08