

ACKNOWLEDGMENT OF REQUIREMENT FOR PRE-INSURANCE INSPECTION

(This is **not** a safety inspection)

Name and Address of Insured or Applicant:

EFFECTIVE DATE
OF COVERAGE:

DATE INSPECTION MUST BE
COMPLETED BY:

INSPECTION LOCATION:

POLICY NUMBER: _____
(If Applicable)

VEHICLE(S) TO BE INSPECTED:

| | YEAR | MAKE | MODEL |
|----|-------|-------|-------|
| 1. | _____ | _____ | _____ |
| 2. | _____ | _____ | _____ |
| 3. | _____ | _____ | _____ |

By my signature below I certify that I have been informed that my vehicle(s) which is (are) being insured for Fire and Theft/Comprehensive and/or Collision or Limited Collision Coverage must be inspected by a representative of the insurer. This inspection must be completed with ten (10) calendar days (not including legal holidays and Sundays) after the effective date of coverage, and in no event later than the date shown above to avoid a suspension in coverage.

I understand that failure to submit to the required inspection(s) will result in the suspension (losses will not be covered) of the physical damage coverage (Fire and Theft/Comprehensive, Collision, Limited Collision) as of 12:01 A.M. of the day following the date by which the inspection must be completed, as shown above.

I understand that if coverage is suspended it will be restored only after the inspection has been completed **and** the adjusted premium due for such coverage(s) has been paid.

SIGNATURE OF INSURED OR APPLICANT: _____

SIGNATURE OF PRODUCER OR INSURANCE
COMPANY REPRESENTATIVE: _____

PRODUCER CODE: _____

NAME, ADDRESS AND TELEPHONE NUMBER OF
PRODUCER OR INSURANCE COMPANY
REPRESENTATIVE COMPLETING THIS FORM: _____

INSURED/APPLICANT MUST RECEIVE A COMPLETED COPY OF THIS FORM