MICHIGAN PERSONAL AUTOMOBILE APPLICATION

Auto-Owners Insurance
Life Home Car Business
The No Problem People®

☐ Auto-Owners Insurance Company
☒ Home-Owners Insurance Company
☒ Group Name MATURE GROUP, AARP
Group # 2

APPLICANT/AGENCY INFORMATION

Policy Number: **Pending**	☒ New ☐ Rewrite	☐ Annual ☒ Semi-annual	Effective Date: **05/10/2015** Time: **12:01 A.M.**
Agency: **SMITH AND DE ROSE INSURANCE AGENCY INC**		Producer Code:	Agency Code: **01-0954-00**
Applicant Name(s): **MICHAEL BISHOP** **CELESTE BISHOP**		Phone Number: (517) 775-4916 Email Address: mikeb.LLPS@comcast.net	
Applicant Address: **8607 CARLSBAD LN** City: **LANSING** State: **MI** Zip: **48917-5807** County: **EATON**	Primary Garaging Address (if different from Applicant Address): City: State: Zip: County:		

SUPPORTING POLICIES

If the applicant has other policies written in the Auto-Owners Group, please provide the policy types and numbers.

Policy Type:	Policy Number:	Policy Type:	Policy Number:

BILLING INFORMATION

ADD TO CURRENT BILLING ACCOUNT?: ☐ YES ☒ NO IF YES, BILLING ACCOUNT NUMBER:

PAYMENT PLAN: ☐ Agency Bill ☐ Semi-annual ☐ Quarterly ☐ Full Pay ☐ Three Pay ☒ Monthly
Initial Payment: $
Mail Insured's Copy of Policy to Agency? ☐ Yes ☒ No

METHOD OF PAYMENT: ☐ Check ☐ Cash ☐ Credit Card ☒ Policyholder EFT ☐ Agency EFT (Sweep)

ALTERNATE BILLING ADDRESS:

COVERAGES AND LIMITS

COVERAGE	LIMIT OF LIABILITY
Bodily Injury Liability	$ **100,000** each person/$ **300,000** each occurrence
Property Damage Liability	$ **300,000** each occurrence
Single Limit BI & PD Liability	$ each occurrence
Uninsured Motorist	$ **100,000** each person/$ **300,000** each occurrence
Underinsured Motorist	$ **100,000** each person/$ **300,000** each occurrence
Personal Injury Protection	Number of household members: 5 / Medical Payments: ☒ Excess ☐ Full / Wage Benefits: ☒ Excess ☐ Full / Wage Loss Waiver: ☐ Yes ☒ No
Medical Payments	$ each person (motorcycles only)
Property Protection Liability	$ **1,000,000** each occurrence
Special Tort Liability	☒ Yes ☐ No
Unlicensed Recreational Vehicle Liability	☐ Yes ☒ No Medical Payments: $ each person
Named Operator Policy	☐ Yes ☒ No
Personal Automobile Plus Package	☐ Yes ☒ No

DRIVER INFORMATION

Drv #	Driver Name (as it appears on Driver's License)	Relation to Applicant	Date of Birth	Driver's License Number	Lic State	Years Driving	Princ Driver Veh #(s)	Occ Driver Veh #(s)
1	**MICHAEL BISHOP**	**Insured**	**04/22/1965**	**B210123456789**	**MI**		**1**	
2	**CELESTE A BISHOP**	**Spouse**	**04/17/1967**	**B210112067298**	**MI**			
3	**MARISA NICOLE BISHOP**	**Child**	**04/22/1994**	**B210585630310**	**MI**			**2**

INSURANCE SCORING INFORMATION

Insurance Score: **X802** Confirmation #: **61479931**

Score is based on driver #: **1** or applicant's name:

ADDITIONAL DRIVER INFORMATION

Drv #	Driver Occupation/School	City of Employer/ School	Driver Adjustments (discounts and/or surcharges)
1	**Administrators**	Lansing	**Premier Driver Discount Applies**
2	**Administrators**	Lansing	**Premier Driver Discount Applies**
3			

LIST ALL ACCIDENTS/CLAIMS/VIOLATIONS FOR ALL DRIVERS IN THE LAST 5 YEARS

Has any driver shown above had any accidents, claims or violations within the last 5 years? [X] Yes [ ] No If "Yes", include information below.

Drv #	Description of Accidents/Claims/Violations	Conviction Date	Amount Paid	At-Fault?
3	**SPEED UNDER POSTED MINIMUM**	**11/05/2013**	$ 120.00	Y

Loss History Rating 1A applies

HOUSEHOLD MEMBER INFORMATION - Please complete for all Non-Driver Household Members

Household Member Name	Relation to Applicant	Date of Birth	Driver's License Number (If Individual is Licensed)	Lic State	Additional Information/Explanation

BROADENED COVERAGE FOR NAMED INDIVIDUALS - DRIVE OTHER CARS

Please indicate the individual(s) and vehicle(s) for whom this coverage is desired.

Name: Veh #: Name: Veh #:

EXTENDED COVERAGE - NON OWNED AUTOMOBILES FURNISHED OR AVAILABLE FOR REGULAR USE

Please indicate the individual(s) and vehicle(s) for whom this coverage is desired.

Name: Veh #: Name: Veh #:

PRIOR CARRIER INFORMATION

Please indicate the name of your previous insurer, policy number and expiration date. If you were previously insured under someone else's policy, indicate the policyholder's name. If you did not have a previous insurer, or there is a lapse in coverage, please explain why in the AGENT'S COMMENTS section.

Previous Insurer: **GEICO Gen Ins Co** Policy Number: Expiration Date: **10/25/2015**

PERSONAL AUTO SCHEDULE OF VEHICLES (ITEMS)
VEHICLE (ITEM) DESCRIPTION, USE, AND COVERAGE INFORMATION

* Converted vans, motor homes, trailers, antiques, classics, motorcycles, low speed vehicles and recreational vehicles use stated amount. Agreed Value may be chosen instead for classics or antiques.
** Miles to Work/School or Business/Farm/Pleasure.
*** Examples: air bags, anti-lock brakes, anti-theft devices, multi-car discount, company car discount, physical damage plus coverage, agreed value, stated amount, etc.

Veh #:	Year:	Make/Model/Style:	Vehicle Identification Number (VIN):	Stat Code
1	2012	LINC MKZ	3LNHL2GC8CR810479	00000

Vehicle (Item) Description (if motor home or trailer, please include length):	Cost New $	Stated/Agreed Amount* $	Cost Symbol
			346B30AB00

Garaging Address (only if different from Applicant and Primary Garage Location Addresses):	Vehicle Use: **	Territory:
City: State: Zip:	Commute to work2 miles	055

Lease Gap Coverage	Loan Gap Coverage
☐ Yes ☒ No	☐ Yes ☒ No

Include Liability?	Comprehensive Ded	Collision Ded	Road Trouble Service	Additional Expense	Motorcycle Medical Payments
☒ Yes ☐ No	☒ $ 500 ☐ Waiver of Glass Ded	☒ $500 ☐ No Collision ☒ Regular ☐ Waiver ☐ Broad ☐ Limited	Limit $	Limit $ /$	Limit $

Lienholder/Leaseholder Name and Address:

Additional Vehicle (Item) Coverage, Adjustment, and/or Discount Information ***

Driver/Pass and Side Air Bag Discount Applies
Anti-Lock Brake (ABS) Discount Applies
Multi-Car Discount Applies

Veh #:	Year:	Make/Model/Style:	Vehicle Identification Number (VIN):	Stat Code
2	2007	MERC MILAN PREMIER	3MEHM08117R643759	00000

Vehicle (Item) Description (if motor home or trailer, please include length):	Cost New $	Stated/Agreed Amount* $	Cost Symbol
			161A161A00

Garaging Address (only if different from Applicant and Primary Garage Location Addresses):	Vehicle Use: **	Territory:
City: State: Zip:	Commute to work1 miles	055

Lease Gap Coverage	Loan Gap Coverage
☐ Yes ☒ No	☐ Yes ☒ No

Include Liability?	Comprehensive Ded	Collision Ded	Road Trouble Service	Additional Expense	Motorcycle Medical Payments
☒ Yes ☐ No	☒ $ 500 ☐ Waiver of Glass Ded	☒ $500 ☐ No Collision ☒ Regular ☐ Waiver ☐ Broad ☐ Limited	Limit $	Limit $ /$	Limit $

Lienholder/Leaseholder Name and Address:

Additional Vehicle (Item) Coverage, Adjustment, and/or Discount Information ***

Driver/Pass and Side Air Bag Discount Applies
Anti-Lock Brake (ABS) Discount Applies
Multi-Car Discount Applies

ADDITIONAL INTEREST

NAME

UNDERWRITING QUESTIONS

Answer all questions - explain any "Yes" answers in the AGENT'S COMMENTS section.

YES	NO		
☐	☒	1.	Has any Auto-Owners Group company provided coverage for this applicant in the past 5 years? If so, provide the policy number(s): _____
☐	☒	2.	Does any driver require a financial responsibility filing?
☐	☒	3.	Has any driver had a license suspension or revocation during the past 5 years?
☐	☒	4.	Are there any drivers not listed on this application who operate any of these vehicles at any time?
☐	☒	5.	Are there any other drivers in the household not listed on this application?
☐	☒	6.	After physically inspecting all vehicles, is there existing damage or is any vehicle in an unsafe driving condition?
☐	☒	7.	Are any of the vehicles to be insured owned by someone other than the applicant (except leased vehicles)?
☐	☒	8.	Is any vehicle used in a business for transportation of merchandise or passengers for hire?
☐	☒	9.	Has any vehicle been altered, modified or converted in any way, or has any vehicle title been branded?
☐	☒	10.	Has the applicant's insurance ever been canceled or nonrenewed? (non-payment or underwriting reasons)
☐	☒	11.	Has any household member been convicted of fraud or intent to commit fraud involving an insurance claim or an application for insurance in the last 5 years?
☐	☒	12.	Is total annual income (principal drivers and all other members of the household) from employment, business or profession less than $7,500?

AGENT'S COMMENTS

Total Term Premium: $1,413.73

Paid in Full Policy Premium: $1,266.82

The Paid in Full discount is not available for Agency Bill business.

TO BE COMPLETED BY AGENT

The coverage requested in this application is subject to all terms and conditions of the policy regularly issued by the Company in this state. The coverage requested is bound only when the time and effective date are indicated on the front of the application.

☐ Coverage is bound ☐ Coverage is not bound

X _____ X _____

Agent's Signature Date

NO-FAULT COLLISION INSURANCE AUTHORIZATION

WE OFFER THE FOLLOWING COLLISION COVERAGE OPTIONS. Indicate the desired coverage and deductible you wish to purchase for each vehicle on this application and sign your name in the space indicated below. Collision deductibles available are:

No deductible; $50; $100; $150; $200; $250; $500; $750; $1,000; $2,000; $2,500; $3,000; $5,000.

LIMITED COLLISION COVERAGE - We will pay for collision damage when the driver of the insured vehicle is not more than 50% of the cause of the accident. If the driver of the insured vehicle is more than 50% of the cause of the accident, we will not pay for collision damage. If you have chosen a deductible, you must pay the deductible amount.

REGULAR COLLISION COVERAGE - We will pay for collision damage to the insured vehicle, regardless of who is responsible for the accident. You must pay the deductible amount.

BROAD FORM COLLISION COVERAGE - We will pay for collision damage to the insured vehicle, regardless of who is responsible for the accident. However, if the driver of the insured vehicle was more than 50% of the cause of the accident, you must pay the deductible amount.

NO COLLISION COVERAGE - We will not pay for collision damage to the insured vehicle.

I choose to purchase the type(s) of collision coverage(s) and deductible(s) as indicated in the "SCHEDULE OF VEHICLES (ITEMS)" section of this application. I understand that if I have checked "No Collision", I hereby reject any Collision coverage on such vehicle. Future renewals shall comply with these instructions unless I indicate otherwise in writing to the Company.

Note: For accidents on or after July 1, 1980, you may sue the driver of another vehicle who was 50% or more of the cause of the accident to recover your uninsured damage, up to a maximum of $1,000. You must bring this action in the Small Claims Division of the District Court or Municipal Court. Any award to you may be reduced by the percentage of which you were the cause of the accident. The Company is not responsible for filing the suit on your behalf, and the other driver's insurance company may not be responsible to pay any award to you on behalf of the other driver.

X Michael Bixby — Applicant's Signature

X 5/22/15 — Date

PERSONAL INJURY PROTECTION BENEFITS MEDICAL AND WAGE VERIFICATION

To be eligible for Excess Medical and Excess Wage Personal Injury Protection coverage you, your spouse and resident relatives must have other insurance that will pay Primary Medical and Wage for automobile accidents.

YES	NO	
	X	**Wage** 1. Is any operator age 60 or older not eligibile to receive work loss benefits in the event of an automobile accident?
	X	2. Do you choose Excess Wage Personal Injury Protection coverage? If YES, provide the name of the wage continuation plan _____
		Medical
	X	3. Do you choose Excess Medical Personal Injury Protection coverage? If NO skip questions 4 and 5 and sign below.
	X	4. Do you, your spouse or resident relatives have health insurance that is provided by Medicare or Medicaid? If you answered YES, and Medicare and Medicaid is your ONLY source of health insurance you are not eligible for Excess Medical Personal Injury Protection coverage because Medicare or Medicaid does not pay Primary for automobile related injuries.
X		5. Do you, your spouse and resident relatives have health insurance **OTHER THAN** Medicare or Medicaid that will **pay Primary for automobile related injuries?** If YES, complete the information below. Health Insurer: PHP Insurance Company Health Insurer Policy/Member Number: L0001596/5000680271 **If you answered YES to Questions 4 and 5 above, provide a letter directly from your health insurer that clearly states the health insurer will pay Primary for automobile related injuries.** **IMPORTANT NOTICE** If excess Medical and/or Wage is chosen and at the time of loss it is determined there is not a Primary Medical and/or Wage Insurer, a $500 Penalty deductible will be applied

I choose to purchase the type(s) of Personal Injury Protection coverage as indicated in the "COVERAGES AND LIMITS" section of this application. I have answered the Personal Injury Protection Benefits Medical and Wage Verification questions above accurately and they are a truthful representation of the information sought by this application form.

X Michael Bixby — Applicant's Signature

X 5/22/15 — Date

APPLICANT'S STATEMENT — INSURANCE FRAUD/IMPORTANT NOTICE

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

IMPORTANT NOTICE REGARDING THE FAIR CREDIT REPORTING ACT: In making this application for insurance, it is understood that as part of our underwriting procedure, we may develop information using one or more of the following: physical inspections of the vehicle(s), consumer reports, motor vehicle records and independently maintained records of previously filed claims. You will be notified whenever information from a consumer reporting agency results in an adverse action.

In connection with this application for insurance, we may review your credit report or obtain or use a credit based insurance score based on the information contained in that credit report. We may use a third party in connection with the development of your Insurance Score. Extraordinary life circumstances occur, which may adversely affect your Insurance Score. If you believe such an event has occurred in your life, you may request an exemption to our use of your Insurance Score, which, if accepted, will result in your policy being placed in our Neutral Insurance Score tier.

The facts stated on this application are true to the best of my knowledge and are to be relied upon by the Company for the purpose of issuing the insurance that I have requested, and any renewals of this insurance. I understand that if I am not eligible for a specific Company, program, or rating tier for which I have applied, my policy may be issued or renewed in a different program or rating tier or by another Company within the Auto-Owners Insurance Group: Auto-Owners Insurance Company, Home-Owners Insurance Company, Owners Insurance Company, Property-Owners Insurance Company and Southern-Owners Insurance Company (all companies may not be licensed in all states). I also understand that the rates and coverages may be different among the Auto-Owners Insurance Group Companies writing in this state. I have discussed my specific insurance needs with my agent in order to determine the most appropriate policy for my situation.

X Michael Bixby
Applicant's Signature

X 5/22/15
Date

PROXY DESIGNATION

(applicable only to the Auto-Owners Insurance Company)

I designate J.F. Harrold, J.S. Tagsold, and K.M. Noirot, and each of them, my attorneys and proxies, with power of substitution and revocation to each, to vote as my proxy at all meetings of the Company, and at any and all adjournments thereof. The powers hereunder shall be exercised by a majority of said attorneys and proxies so present, but if only one is so present, then that one shall have full power to act.

X
Applicant's Signature

X
Date

Auto-Owners Insurance

Personal Injury Protection Benefits - Excess Medical Verification Form

To be eligible for Excess Medical Personal Injury Protection coverage you, your spouse and resident relatives must have other insurance that will pay Primary Medical for automobile injuries. The information listed below will be used to verify eligibility for Excess Medical.

1. Do you have insurance provided by Medicare or Medicaid? ☐ Yes ☒ No

   If your health insurance is provided by **ONLY Medicare or Medicaid, Excess Medical Personal Injury Protection coverage is not available since Medicare and Medicaid does not pay Primary for automobile related injuries.**

2. Do you have health insurance **other than** Medicare or Medicaid? ☒ Yes ☐ No

   If you answered YES and your **HEALTH INSURANCE IS IN ADDITION TO MEDICARE OR MEDICAID:**

   - Please print your health insurer, policy/member number, name and automobile policy number where indicated below **and provide a letter directly from your health insurance that clearly states the health insurer will pay Primary for automobile related injuries.**

   If you answered YES and you **DO NOT HAVE MEDICARE OR MEDICAID:**

   - Please print your health insurer, policy/member number, name and automobile policy number where indicated below.

   Health Insurer: PHP Insurance Company

   Health Insurer Policy/Member Number: L0001596 / 500068271

   Name: Geico Indemnity Company

   Automobile Policy Number: 4370-63-11-88

X Michael Bixler
Insured Signature

X 5/22/15
Date

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GROUP DISCOUNT VERIFICATION FORM

In order to verify your eligibility for a premium discount based on membership in a Group organization please fill out the information below:

Group Name: MATURE GROUP

Member Name: AARP

Member Number (when applicable): ______

Important Notice: Because your policy premium is based in part by the application of the Group Discount, you agree to notify Auto-Owners if your membership to the group noted above is terminated. This form must be returned to your insurance agent within 30 days in order to avoid removal of the Group Discount.

Policyholder Signature: Michael Bishop **Date:** 5/22/15

Printed Name: MICHAEL BISHOP

Policy Number: ______