



ILLINOIS MOTORCYCLE INSURANCE APPLICATION

PRODUCER CODE		
PRODUCER NAME		
STREET ADDRESS		
CITY	STATE	ZIP CODE

REFERENCE OR POLICY NUMBER	EFFECTIVE DATE	TERM 12 MO	PHONE NUMBER	FAX NUMBER
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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 <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> CU	SOCIAL SECURITY NUMBER		PHONE NUMBER
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? <input type="checkbox"/> Y <input type="checkbox"/> N
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DOES ANY OPERATOR BELONG TO AN APPROVED AFFINITY GROUP OR ALLIANCE? Y N
 Which operator: _____ Which organization: _____ (AGENT: VERIFY AND RETAIN PROOF OF CURRENT MEMBERSHIP) 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	-	----	--							<input type="checkbox"/> Y <input type="checkbox"/> N	
2										<input type="checkbox"/> Y <input type="checkbox"/> N	
3										<input type="checkbox"/> Y <input type="checkbox"/> N	
4										<input type="checkbox"/> Y <input type="checkbox"/> N	
5										<input type="checkbox"/> Y <input type="checkbox"/> 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		
	<input type="checkbox"/> ACC <input type="checkbox"/> VIOL		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	\$		
	<input type="checkbox"/> ACC <input type="checkbox"/> VIOL		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	\$		
	<input type="checkbox"/> ACC <input type="checkbox"/> VIOL		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	\$		
	<input type="checkbox"/> ACC <input type="checkbox"/> VIOL		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> 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				<input type="checkbox"/> Y <input type="checkbox"/> N	\$			<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> M
2				<input type="checkbox"/> Y <input type="checkbox"/> N	\$			<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> M
3				<input type="checkbox"/> Y <input type="checkbox"/> N	\$			<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> M
4				<input type="checkbox"/> Y <input type="checkbox"/> N	\$			<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> M
5				<input type="checkbox"/> Y <input type="checkbox"/> N	\$			<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> 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			<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
2			<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
3			<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
4			<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
5			<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

LOSS PAYEE or LEASING COMPANY

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

RATING QUESTIONS

Y N
 DOES THE INSURED HAVE ANOTHER PERSONAL LINES OR LIFE POLICY WITH FOREMOST, FARMERS, BRISTOL WEST OR 21st CENTURY? Y N
 A LIFE POLICY MUST BE TERM, WHOLE, UNIVERSAL OR VARIABLE UNIVERSAL POLICY, HAVE A FACE AMOUNT OF \$50,000 OR GREATER, ISSUED TO AN ADULT AND IN FORCE.
 HAS APPLICANT HAD INSURANCE ON THIS TYPE OF VEHICLE FOR THE PAST 6 MONTHS? Y N

COVERAGE

POLICY COVERAGE	VEHICLE COVERAGE					
BODILY INJURY LIABILITY <input type="checkbox"/> 25/50 <input type="checkbox"/> 50/100 <input type="checkbox"/> 100/300 <input type="checkbox"/> 250/500	INDICATE SELECTION FOR EACH VEHICLE	VEH 1	VEH 2	VEH 3	VEH 4	VEH 5
PROPERTY DAMAGE <input type="checkbox"/> 20,000 <input type="checkbox"/> 25,000 <input type="checkbox"/> 50,000 <input type="checkbox"/> 100,000 <input type="checkbox"/> 250,000	OTHER THAN COLLISION <i>Specify Deductible:</i>	DED \$	DED \$	DED \$	DED \$	DED \$
BODILY INJURY/PROPERTY DAMAGE CSL <input type="checkbox"/> 300,000 <input type="checkbox"/> 500,000	COLLISION <i>Specify Deductible:</i>	DED \$	DED \$	DED \$	DED \$	DED \$
MEDICAL PAYMENTS <input type="checkbox"/> 1,000 <input type="checkbox"/> 2,500 <input type="checkbox"/> 5,000 <input type="checkbox"/> 10,000	TOWING, ROADSIDE ASSISTANCE and TRIP INTERRUPTION COVERAGE	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
UNINSURED/UNDERINSURED MOTORISTS BODILY INJURY (NON-STACKED) <input type="checkbox"/> 25/50 <input type="checkbox"/> 50/100 <input type="checkbox"/> 100/300 <input type="checkbox"/> 250/500 <input type="checkbox"/> 300,000 <input type="checkbox"/> 500,000 (Underinsured Motorists Coverage included only when limits exceed the minimum 25/50)	UNINSURED MOTORISTS PROPERTY DAMAGE Limit of 15,000 with 250 deductible	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
PASSENGER LIABILITY (Unless rejected, same Limit of Liability as Bodily Injury)	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.

IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES.

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.

The insurer may obtain consumer reports or personal or privileged information from third parties. The information as well as other personal or privileged information subsequently collected by the insurer or your agent may in certain circumstances be disclosed to third parties without authorization, as permitted by law. You have the right of access and correction with respect to all personal information collected. At your request, the insurer will provide you with more detailed information regarding the collection, use and disclosure of personal information, and your rights to access and correct such information.

- I agree that the insurer may secure and review consumer reports, including motor vehicle records or credit report information for persons listed in the application or subsequently added to the policy by me or my authorized representatives. I agree to allow the insurer to share my name, address, date of birth, social security number and driver's license number with third party consumer reporting and insurance support organizations in order to obtain consumer reports. I further agree that the insurer may secure and review new consumer reports in evaluating this policy, for my request for a change in policy benefits or for a replacement policy as permitted by law. I understand that this authorization will remain in effect unless I make arrangements to revoke it through my insurance representative. I or my representatives may obtain a copy of this application and authorization by requesting it from my insurance representative.
- 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.
- I declare that the selections indicated in this application accurately reflect the limits, coverages and deductibles I chose.
- I understand that this authorization will remain in effect for the policy term that I am insured by the same company unless I make arrangements to revoke it.

APPLICANT SIGNATURE

DATE

TIME

AM
 PM

REQUIRED PRODUCER 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.

PRODUCER SIGNATURE  DATE TIME AM PM

PRODUCER NAME (Print) PRODUCER LICENSE NO. COVERAGE BOUND? YES NO

 DO NOT REQUEST A POLICY UNTIL YOU HAVE COMPLETED THIS APPLICATION AND SECURED ALL REQUIRED SIGNATURES AND THE UNINSURED MOTORISTS SELECTION/REJECTION FORM.

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

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

Form 203512 02/15

UNINSURED AND UNDERINSURED MOTORISTS COVERAGE SELECTION/REJECTION FORM - ILLINOIS

Illinois law requires that the following coverages be offered to you:

Uninsured Motorists Bodily Injury Coverage provides benefits to you, your passengers or relatives living with you if an uninsured motorist causes their injuries. An uninsured motorist is one who is not insured for his/her liability, or who is unidentified after having fled the scene of an accident.

Underinsured Motorists Coverage provides benefits to you, your passengers or relatives living with you if an underinsured motorist causes their injuries. An underinsured motorist is one who is insured at the time of the accident but his/her limit of liability is less than the limit you select for this coverage.

Property Damage Uninsured Motorists Coverage provides benefits to you if a motorist without insurance causes damage to your vehicle or its contents.

SELECTION OR REJECTION OF COVERAGE

UNINSURED AND UNDERINSURED MOTORISTS BODILY INJURY COVERAGE (NON-STACKED)

Illinois law requires that Uninsured Motorists and Underinsured Motorists Bodily Injury Coverage be offered to you at limits equal to your Bodily Injury Liability limits. You have the option of selecting lower limits. The limits you select may not exceed your Bodily Injury Liability limits. Underinsured Motorists coverage is included equal to the amount of Uninsured Motorists coverage only when Uninsured Motorists coverage exceeds the minimum of \$25,000/50,000. Indicate your selection here (amounts shown are for each person/each accident):

- \$25,000/50,000 \$100,000/300,000 \$300,000/300,000
- \$50,000/100,000 \$250,000/500,000 \$500,000/500,000

PROPERTY DAMAGE UNINSURED MOTORISTS COVERAGE

Property Damage Uninsured Motorists Coverage of \$15,000 is available only if you have not purchased Collision Coverage for your vehicle. It is subject to a deductible of \$250. You also have the option of rejecting this coverage. If you have not purchased Collision Coverage, indicate your selection here.

I have not purchased Collision Coverage for my vehicle and select Property Damage Uninsured Motorists Coverage for:

- Unit1 Unit 2 Unit 3 Unit 4 Unit 5

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

- Unit1 Unit 2 Unit 3 Unit 4 Unit 5

SIGNATURE OF APPLICANT OR NAMED INSURED _____ DATE _____

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

740677 02/15

PASSENGER LIABILITY REJECTION - ILLINOIS

Passenger Liability provides liability coverage for bodily injury sustained by any person who is occupying your covered off-road vehicle or motorcycle as a passenger.

I have had Passenger Liability coverage explained to me and fully understand it. I hereby reject such coverage and understand that my policy will not contain this coverage when issued or renewed.

SIGNATURE OF APPLICANT OR NAMED INSURED _____ DATE _____

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

733014 10/08