

ILLINOIS OFF-ROAD VEHICLE 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
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 (PRODUCER: 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	OFF-ROAD VEHICLE SAFETY COURSE DATE	TOTAL YEARS LICENSED	ACCIDENT PREVENTION COURSE DATE	DRIVER'S LICENSE NUMBER	ISSUING STATE	YEARS ORV EXPERIENCE
1 Named Insured	----	----	----						
2									
3									
4									
5									

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	VEHICLE TYPE: ATV, OFF-ROAD MOTORCYCLE, DUNE BUGGY, GOLF CART, or SNOWMOBILE	MAKE AND MODEL	MODEL YEAR	CC SIZE	CURRENT MARKET VALUE	USE P=PERSONAL B=BUSINESS	ESTIMATED ANNUAL MILEAGE
1					\$		
2					\$		
3					\$		
4					\$		
5					\$		

VEH	VEHICLE IDENTIFICATION NUMBER	NUMBER OF WHEELS	DUNE BUGGY		GOLF CART	ATV	SNOWMOBILE	OPERATOR PERCENT OF USE				
			CHASSIS MAKE	ENGINE MAKE	GAS, DIESEL, ELECTRIC	NUMBER OF DRIVE WHEELS	NUMBER OF PASSENGERS	OP 1	OP 2	OP 3	OP 4	OP 5
1								%	%	%	%	%
2								%	%	%	%	%
3								%	%	%	%	%
4								%	%	%	%	%
5								%	%	%	%	%

LOSS PAYEE or LEASING COMPANY

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

RATING QUESTIONS

- 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					
	INDICATE SELECTION FOR EACH VEHICLE	VEH 1	VEH 2	VEH 3	VEH 4	VEH 5
BODILY INJURY <input type="checkbox"/> 25/50 <input type="checkbox"/> 50/100 <input type="checkbox"/> 100/300 <input type="checkbox"/> 250/500	OTHER THAN COLLISION <i>Specify Deductible:</i>	DED \$	DED \$	DED \$	DED \$	DED \$
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	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	OPTIONAL EQUIPMENT (Does not apply to dune buggies or golf carts.) Indicate the total amount of coverage needed for each vehicle. The maximum available per vehicle is \$7,500.	\$	\$	\$	\$	\$
MEDICAL PAYMENTS <input type="checkbox"/> 1,000 <input type="checkbox"/> 2,500 <input type="checkbox"/> 5,000 <input type="checkbox"/> 10,000	TRANSPORT TRAILER COVERAGE Indicate how much coverage is needed and complete the Transport Trailer section below.					
UNINSURED 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"/> 300/300 <input type="checkbox"/> 500/500	\$					
UNDERINSURED MOTORISTS BODILY INJURY (Not available for Dune Buggy) <input type="checkbox"/> 50/100 <input type="checkbox"/> 100/300 <input type="checkbox"/> 250/500 <input type="checkbox"/> 300/300 <input type="checkbox"/> 500/500	\$					
PASSENGER LIABILITY (Unless rejected, same Limit of Liability as Bodily Injury)	\$					
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 the 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.

1. I agree to allow the insurer and its representatives to secure and review consumer report information including motor vehicle records or credit report information for persons listed in the application or subsequently added to the policy. I agree to allow the insurer and its representatives 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 purpose of this authorization is to collect information in connection with my application, for my request for a change in policy benefits or for a replacement policy I may request. I understand that this authorization will remain in effect for one year from the date of my signature. I or my authorized representatives may request a copy of this authorization from my insurance representative.
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 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

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

<input type="checkbox"/> FULL PAYMENT	<input type="checkbox"/> 3 PAY	<input type="checkbox"/> 6 PAY	<input type="checkbox"/> _____	DOWN PAYMENT \$	BALANCE DUE \$
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UNINSURED MOTORISTS COVERAGE BODILY INJURY SELECTION/REJECTION ORV FORM - ILLINOIS

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.

Uninsured Motorists Coverage Bodily Injury Coverage (Non-Stacked) is being offered to you at your Bodily Injury limits. You have the option of selecting lower limits, or you may reject this coverage entirely. The limits you select may not exceed your Bodily Injury Liability limits. Indicate your selection here (amounts shown are for each person/each accident):

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

SIGNATURE OF APPLICANT OR NAMED INSURED _____ DATE _____

APPLICANT OR NAMED INSURED (PLEASE PRINT) _____ POLICY NUMBER _____

733013 01/15

UNDERINSURED MOTORISTS COVERAGE SELECTION/REJECTION FORM - ILLINOIS

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.

SELECTION OR REJECTION OF COVERAGE

UNDERINSURED MOTORISTS BODILY INJURY COVERAGE (NON-STACKED)

Underinsured Motorists Bodily Injury Coverage is 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 available 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):

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

SIGNATURE OF APPLICANT OR NAMED INSURED _____ DATE _____

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

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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