FOREMOST® INSURANCE COMPANY
GRAND RAPIDS, MICHIGAN

FLORIDA MOTOR HOME INSURANCE APPLICATION

AGENCY CODE	
AGENCY NAME	
STREET ADDRESS	
CITY	STATE ZIP

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

POLICY NAMED INSURED Must be the titled owner of the vehicle and at least 18 years old

FIRST NAME | MIDDLE | LAST NAME

MAILING ADDRESS | STREET

CITY | COUNTY | STATE | ZIP

SOCIAL SECURITY NUMBER	DATE OF BIRTH	HOME PHONE	OTHER PHONE

ADDITIONAL TITLED OWNER RESIDING IN THE POLICY NAMED INSURED'S HOUSEHOLD

FIRST NAME | MIDDLE | LAST NAME

DATE OF BIRTH | RELATIONSHIP TO INSURED

OTHER OWNERS NOT IN HOUSEHOLD

FIRST NAME | MIDDLE | LAST NAME

MAILING ADDRESS STREET | CITY | STATE | ZIP

DATE OF BIRTH | RELATIONSHIP TO INSURED

REGISTRATION NAME If different than POLICY NAMED INSURED

OPERATORS List All Motor Home Operators

	NAME	DATE OF BIRTH	RELATIONSHIP TO NAMED INSURED	DRIVER'S LICENSE NUMBER	ISSUING STATE
1					
2					
3					

OPERATOR	SAFETY/ACCIDENT COURSE DATE (Submit Proof)	% OF USE	YEARS MOTOR HOME EXPERIENCE	IS A FINANCIAL RESPONSIBILITY FILING REQUIRED?
1				❑ Yes ❑ No
2				❑ Yes ❑ No
3				❑ Yes ❑ No

Does any Operator belong to an RV Association or Group or Alliance? Operator # _____

Which Organization? _____

Membership # _____ (Agent: Verify and retain proof of membership.)

❑ Yes ❑ No Does any operator have a significant mental or physical impairment? Operator # _____

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?
❑ Yes ❑ No 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		❑ Yes ❑ No	❑ Yes ❑ No	$		
	❑ ACC ❑ VIOL		❑ Yes ❑ No	❑ Yes ❑ No	$		
	❑ ACC ❑ VIOL		❑ Yes ❑ No	❑ Yes ❑ No	$		

OTHER LOSS HISTORY

DATE	TYPE	AMOUNT	DESCRIPTION

VEHICLE INFORMATION

GARAGING

IS THE UNIT STORED INSIDE? ❒ Yes ❒ No

LOCATION TYPE: ❒ Residential ❒ Rental Storage ❒ Business Property ❒ Other

Complete address below if vehicle is garaged at a location other than the Policy Named Insured mailing address.

STREET

CITY COUNTY STATE ZIP

REGISTRATION ADDRESS IF DIFFERENT THAN GARAGING ADDRESS

STREET CITY STATE ZIP

UNIT TYPE: ❒ Class A ❒ Class B ❒ Class C ❒ Luxury Coach ❒ Medium Duty Tow Truck

YEAR	LENGTH	MAKE	MODEL

VIN	ANNUAL MILEAGE	PURCHASE DATE	PURCHASE PRICE	CURRENT MARKET VALUE

SAFETY EQUIPMENT: Is your vehicle equipped with:

❒ Air Bag(s) ❒ Anti Lock Brakes System

USE: ❒ Pleasure ❒ Full-Timer ❒ Other _____

UNREPAIRED DAMAGE ❒ Yes ❒ No

NOTE: *Motor homes that are rented, leased or loaned to others for a charge or fee; or motor homes that are used in any full- or part-time business, occupation or professional capacity are* ***unacceptable - do not bind or submit.***

LOSS PAYEE

LEASE OR LOAN NUMBER NAME OF LOSS PAYEE STREET ADDRESS CITY STATE ZIP

RATING QUESTIONS

❒ Yes ❒ No Does the applicant have another, in-force personal lines policy or *qualified** life policy with Foremost, Farmers, Zurich or Bristol West?
*Refer to Program Guide for qualifications.

MOTOR HOME COVERAGE SELECTION

Checked boxes indicate selected coverages. **Premium**

❒ BODILY INJURY ❒ $10/20 ❒ $15/30 ❒ $25/50 ❒ $50/100 ❒ $100/300 ❒ $300/500 ❒ $500/500 ❒ $500/1,000 ❒ $1,000/1,000 $

❒ PROPERTY DAMAGE ❒ $10,000 ❒ $15,000 ❒ $25,000 ❒ $35,000 ❒ $50,000 ❒ $100,000 ❒ $300,000 ❒ $500,000 $

❒ PERSONAL INJURY PROTECTION $

For personal injury protection insurance, the named insured may elect a deductible and to exclude coverage for loss of gross income and loss of earning capacity ("lost wages"). These elections apply to the named insured and all dependent resident relatives. A premium reduction will result from these elections. The named insured is hereby advised not to elect the lost wage exclusion if the named insured or dependent resident relatives are employed, since lost wages will not be payable in the event of an accident.

You may change your Personal Injury Protection (PIP) option by notifying the company or agent in writing. Your agent is listed on your declarations page.

DEDUCTIBLE OPTIONS:

❒ $0 deductible ❒ $500 deductible
❒ $250 deductible ❒ $1,000 deductible

WORK LOSS OPTION:

❒ Included
❒ Excluded

BOTH OPTIONS ABOVE APPLY TO:

❒ Named Insured and Dependent Family Member
❒ Named Insured Only

❒ MEDICAL PAYMENTS (Available only when a $0 deductible is chosen on Personal Injury Protection) $
❒ $1,000 ❒ $2,000 ❒ $5,000 ❒ $10,000 ❒ $25,000

❒ OTHER THAN COLLISION ACV less deductible of ❒ $100 ❒ $250 ❒ $500 ❒ $1,000 ❒ $2,000 ❒ $5,000 $

❒ COLLISION ACV less deductible of ❒ $100 ❒ $250 ❒ $500 ❒ $1,000 ❒ $2,000 ❒ $5,000 $

❒ UNINSURED MOTORISTS COVERAGE $

❒ **Stacked Uninsured Motorists** (Requires Form 734639 below to be completed)
❒ **Non-Stacked Uninsured Motorists** (Requires Form 2053 below to be completed)

Limits: ❒ $10/20 ❒ $15/30 ❒ $25/50 ❒ $50/100 ❒ $100/300 ❒ $300/500 ❒ $500/500 ❒ $500/1,000 ❒ $1,000/1,000

❒ **Rejection of Uninsured Motorists** (Requires Form 2053 below to be completed)

Form 2053 11/91

FLORIDA REJECTION NOTICE
UNINSURED MOTORISTS COVERAGE
YOU ARE ELECTING NOT TO PURCHASE CERTAIN VALUABLE COVERAGE
WHICH PROTECTS YOU AND YOUR FAMILY OR YOU ARE PURCHASING
UNINSURED MOTORISTS LIMITS LESS THAN YOUR BODILY INJURY LIABILITY
LIMITS WHEN YOU SIGN THIS FORM. PLEASE READ CAREFULLY.

Uninsured Motorists Coverage provides for payment of certain benefits for damages caused by owners or operators of uninsured motor vehicles because of bodily injury or death resulting therefrom. Such benefits may include payments for certain medical expenses, lost wages, and pain and suffering, subject to limitations and conditions contained in the policy. For the purpose of this coverage, an uninsured motor vehicle may include a motor vehicle as to which the bodily injury limits are less than your damages.

Florida law requires that automobile liability policies include Uninsured Motorists Coverage at limits equal to the Bodily Injury Liability limits in your policy unless you select a lower limit offered by the company or reject Uninsured Motorists Coverage entirely.

Please indicate whether you desire to entirely reject Uninsured Motorists Coverage, or, whether you desire this coverage at limits lower than the Bodily Injury Liability limits of your policy:

❑ a. I hereby reject Uninsured Motorists Coverage.

❑ b. I hereby select Uninsured Motorists limits of _____ which are lower than my Bodily Injury Liability limits.

ELECTION OF NON-STACKED COVERAGE (Do not complete if you have rejected Uninsured Motorists)

You have the option to purchase, at a reduced rate, non-stacked (limited) type of Uninsured Motorist coverage. Under this form if injury occurs in a vehicle owned or leased by you or any family member who resides with you, this policy will apply only to the extent of coverage (if any) which applies to that vehicle in this policy. If an injury occurs while occupying someone else's vehicle , or you are struck as a pedestrian, you are entitled to select the highest limits of Uninsured Motorist coverage available on any one vehicle for which you are a named insured, insured family member, or insured resident of the named insured's household. This policy will not apply if you select the coverage available under any other policy issued to you or the policy of any other family member who resides with you.

If you do not elect to purchase the non-stacked form, your policy limit(s) for each motor vehicle are added together (stacked) for all covered injuries. Thus, your policy limits would automatically change during the policy term if you increase or decrease the number of autos covered under the policy.

( ) I hereby elect the non-stacked form of Uninsured Motorists coverage.

I understand and agree that selection of one of the above options applies to my liability insurance policy and future renewals or replacements of such policy which are issued at the same Bodily Injury liability limits. If I decide to select another option at some future time, I must let the Company or my agent know in writing.

Policy Number: _____ Signed: _____ Date: _____

Form 734639 11/07

ELECTION OF STACKED UNINSURED MOTORISTS COVERAGE - FLORIDA

This area **MUST** be completed when Stacked Uninsured Motorists Coverage is selected.

❑ I request Stacked Uninsured Motorists to be provided by my policy.

When Stacked Uninsured Motorists is chosen and limits higher than basic limits ($10,000/$20,000/$10,000) are desired for Bodily Injury Liability, Property Damage Liability, or Uninsured Motorists Coverage, all other vehicles (e.g., automobiles, motorcycles, motor homes) in the household must be insured and have equal or higher limits than those provided by this policy.

Please provide the information below for all other vehicles in the household.

	Type of Vehicle	Insurance Company	Bodily Injury/ Property Damage Limits	Uninsured Motorists Limits
Vehicle 1				
Vehicle 2				
Vehicle 3				
Vehicle 4				
Vehicle 5				

❑ VACATION LIABILITY	❑ $10,000	❑ $25,000	❑ $50,000		Per Accident	$
❑ TRAVELINE® TOWING/ROADSIDE ASSISTANCE	❑ $100	❑ $250	❑ $500	❑ Reasonable Expense	Per Disablement	$
❑ EMERGENCY EXPENSE	❑ $500	❑ $750	❑ $1,000		Per Loss	$
❑ SCHEDULED MEDICAL BENEFITS					Per Coverage Part	$
❑ PERSONAL PROPERTY ACV less deductible of $ _____ AMOUNT: ❑ $1,000 ❑ Additional Amount $ _____						$
❑ REPLACEMENT COST PERSONAL PROPERTY less deductible of $ _____ AMOUNT: ❑ $2,000 ❑ Additional Amount $ _____						$
❑ TOTAL LOSS REPLACEMENT COST (Minimum Written Premium $50) Is the Insured the Original Owner of the Unit? ❑ Yes ❑ No Did the Insured have Total Loss Replacement with the previous carrier? (if applicable) ❑ Yes ❑ No Previous Carrier: _____						$
❑ FULL-TIMER LIABILITY ❑ $10/20 ❑ $15/30 ❑ $25/50 ❑ $50/100 ❑ $100/300 ❑ $300/500 ❑ $500/500 ❑ $500/1,000 ❑ $1,000/1,000 Limit equals BI/PD Liability Limit						$
❑ ADDITIONAL LIVING EXPENSE	❑ $2,000	❑ $5,000	(Available only when Full-Timer Liability is chosen)			$
❑ ADJACENT STRUCTURES ❑ $500	❑ Additional Amount of $ _____					$
FLORIDA HURRICANE CATASTROPHE FUND						$
POLICY PREMIUM					**TOTAL**	$

REQUIRED SIGNATURE OF APPLICANT **Applicant must sign and date this application**

1. I agree that the company may investigate and secure motor vehicle records for the persons listed on the application.
2. I declare that all the statements contained in this application are true to the best of my knowledge and belief. The selections indicated above accurately reflect the limits, coverages and deductibles I desire.
3. I understand that the coverage provided, as specified by this application, with respect to a Motor Home I own does not provide Liability, Medical Payments or Coverage For Damage To Your Motor Home while the Motor Home is rented, leased or loaned for a charge to any organization or any person other than me.

WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

SIGNATURE OF APPLICANT	DATE

REQUIRED AGENT INFORMATION **Agent must sign this application and complete this section**

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

SIGNATURE OF AGENT	DATE	COVERAGE BOUND?	TIME
		❑ Yes ❑ No	❑ AM ❑ PM

NAME OF AGENT (Please Print)	AGENT LICENSE NO.

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

	DOWN PAYMENT	BALANCE DUE
❑ FULL PAYMENT ❑ 2 PAY ❑ 4 PAY ❑ _____ A Service Fee will be included in each installment payment other than full-payment.	$	$

REMARKS