ACKNOWLEDGEMENT OF REQUIREMENT FOR PHOTO INSPECTION

Applicant or Insured's Name: _____

Address: _____

_____

_____

Effective Date of Coverage: _____

Inspection MUST be completed by: _____

Vehicle(s) to be inspected	Year	Make	Model
1.			
2.			
3.			
4.			

By my signature below I certify that I have been informed that my vehicle(s) which is being insured for Collision and/or Comprehensive Coverage must be inspected by a representative of the insurer. This inspection must be completed within five (5) calendar days after the effective date of coverage, in no event later than the date shown above to avoid a suspension in coverage. I understand that failure to obtain the required inspection(s) will result in the suspension (losses will not be covered) of physical damage coverage (Collision, Comprehensive, Fire, Theft) as of 12:01 A.M. of the day following the date the inspection must be completed by.

If coverage is suspended it will be restored after the inspection is completed.

_____

Signature of Applicant or Insured Date

_____

Signature of Producer or Insurance Company Representative Date

Name, Address and Telephone number of Producer or
Insurance Company Representative completing this form

_____

_____

_____

_____

Insured (Applicant) shall be furnished a complete copy of this form.