

**ACKNOWLEDGEMENT OF REQUIREMENT  
FOR PRE-INSURANCE INSPECTION**  
(THIS IS NOT A SAFETY INSPECTION)

APPLICANT OR INSURED NAME:	POLICY NUMBER:
ADDRESS:	COVERAGE EFFECTIVE DATE:
CITY, STATE, ZIP CODE:	INSPECTION MUST BE COMPLETED BY:


**VEHICLE(S) TO BE INSPECTED**

VEH	YEAR	MAKE	MODEL
1			
2			
3			
4			
5			
6			

By my signature below, I certify that I have been informed that my vehicle(s), which is (are) being insured for Fire and Theft/Comprehensive and/or Collision or Limited Collision coverage, must be inspected by a representative of the insurer. This inspection must be completed within ten (10) calendar days (not including legal holidays and Sundays) after the effective date of coverage, and in no event later than the date shown above to avoid a suspension in coverage.

I understand that failure to submit to the required inspection(s) will result in the suspension (losses will not be covered) of the Physical Damage coverages (Fire and Theft/Comprehensive, Collision, Limited Collision) as of 12:01 a.m. of the day following the date by which the inspection must be completed, as shown above.

I understand that if coverage is suspended, it will be restored only after the inspection has been completed and the adjusted premium due for such coverage(s) has been paid.

 APPLICANT OR INSURED SIGNATURE:	DATE:
PRODUCER/INSURANCE REPRESENTATIVE SIGNATURE:	DATE:
PRODUCER/INSURANCE REPRESENTATIVE COMPLETING THIS FORM (NAME):	TELEPHONE NUMBER:
ADDRESS:	

**Applicant/Insured must receive a completed copy of this form.**

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