

## SUPPLEMENTARY COMMERCIAL AUTOMOBILE APPLICATION

# PENNSYLVANIA

(To be completed and signed by Named Insured)

NAME:

ADDRESS:

### BASIC FIRST PARTY BENEFIT COVERAGE

The following benefit and coverage amount are provided:

Medical Benefit \$5,000

### INCREASED FIRST PARTY BENEFIT COVERAGE

I wish to increase my First Party Benefit as indicated below. I realize that the limit I have selected below includes the limit provided in the Basic First Party Benefit and is not in addition to the above stated Basic First Party Benefit Limit.

#### Increased Medical Benefit Amount

\$10,000 \$25,000 \$50,000 \$100,000

### OPTIONAL FIRST PARTY BENEFITS COVERAGE

I wish to purchase Optional First Party Benefits Coverage as indicated below.

Income Loss Benefit

Income Loss Benefit		Accidental Death Benefit	Funeral Benefit
Maximum Amount	Monthly Amount		
<input type="checkbox"/> \$ 5,000	\$1,000	<input type="checkbox"/> \$ 5,000	<input type="checkbox"/> \$1,500
<input type="checkbox"/> \$15,000	\$1,000	<input type="checkbox"/> \$10,000	<input type="checkbox"/> \$2,500
<input type="checkbox"/> \$25,000	\$1,500	<input type="checkbox"/> \$25,000	
<input type="checkbox"/> \$50,000	\$2,500		

### COMBINED LIMITS OF LIABILITY

#### Total Limit

☐ \$50,000 ☐ \$100,000 ☐ \$177,500

### EXTRAORDINARY MEDICAL BENEFITS COVERAGE

I wish to increase my medical expense benefits as indicated below. I realize that the limit will be in addition to the Basic First Party Benefit or the Added First Party Benefit Coverage. The extraordinary medical benefits coverage does not apply to the first \$100,000 of medical expense incurred by any insured.

#### Extraordinary Medical Benefits Amount

☐ \$100,000 ☐ \$300,000 ☐ \$500,000 ☐ 1,000,000

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**IMPORTANT NOTICE**

Insurance companies operating in the Commonwealth of Pennsylvania are required by law to make available for purchase the following benefits for you (your spouse or other relatives or minors in your custody or in the custody of your relatives, residing in your household) or occupants of your motor vehicle or persons struck by your motor vehicle.

- (1) Medical benefit, up to at least \$100,000.
- (2) Income loss benefit, up to at least \$2,500 per month up to a maximum benefit of at least \$50,000.
- (3) Accidental death benefit, up to at least \$25,000.
- (4) Funeral benefit, \$2,500.
- (5) As an alternative to paragraphs (1), (2), (3) and (4), a combination benefit, up to at least \$177,500 of benefits in the aggregate or benefits payable up to three years from the date of the accident, whichever occurs first, subject to a limit on accidental death benefit of up to \$25,000 and a limit on funeral benefit of \$2,500.
- (6) Extraordinary Medical Benefits Coverage, up to at least \$1,000,000. This will be in addition to the First Party, Added First Party or Combined First Party Medical Benefits Coverage.

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Additionally, insurers may offer higher benefit levels than those enumerated above as well as additional benefits. However, an insured may elect to purchase lower benefit levels than those enumerated above.

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SIGNATURE OF NAMED INSURED

DATE

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## UNINSURED AND UNDERINSURED MOTORISTS COVERAGE

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Uninsured Motorists Coverage provides protection against bodily injury caused by a driver who has no insurance or is a hit-and-run driver. Underinsured Motorists coverage provides protection against bodily injury caused by a driver who has insurance, but the available liability limits are not enough to pay for your damages.

Your automobile liability or motor vehicle liability policy, shall automatically include Uninsured and Underinsured Motorists coverage for damages for bodily injury which the insured may be entitled to recover from the owner or operator of an uninsured or underinsured motor vehicle, at the same limits as the bodily injury liability policy limits, unless you reject or select lower limits as indicated below, but not less than the minimum limits required by statute (\$15,000 each person/\$30,000 each accident; or \$35,000 each accident).

You may reject Uninsured Motorists coverage by signing the written rejection form provided on page 4 attached hereto.

You may reject Underinsured Motorists coverage by signing the written rejection form provided on page 5 attached hereto.

Please make selection below only if you wish to select Uninsured and/or Underinsured Motorists coverage at limits lower than your bodily injury liability limits.

- ☐ Uninsured Motorists coverage at the minimum limits of \$15,000 each person/\$30,000 each accident; or \$35,000 each accident.
- ☐ Underinsured Motorists coverage at the minimum limits of \$15,000 each person/\$30,000 each accident; or \$35,000 each accident.
- ☐ Other limits greater than the minimum limits, but less than the bodily injury liability policy limits.

### **Uninsured Motorists Coverage**

\$ \_\_\_\_\_ each person, \$ \_\_\_\_\_ each accident; OR  
\$ \_\_\_\_\_ each accident.

### **Underinsured Motorists Coverage**

\$ \_\_\_\_\_ each person, \$ \_\_\_\_\_ each accident; OR  
\$ \_\_\_\_\_ each accident.

I understand that the coverage selection or rejection indicated above shall apply on the policy(ies) in effect at the time this form is executed and all future renewal policies until I notify The Travelers IN WRITING of any changes.

If you sign below, and/or pay any premium, you have evidenced your actual knowledge and understanding of the availability of these benefits and limits as well as the benefits and limits you have selected.

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SIGNATURE OF NAMED INSURED

DATE

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**TAKE THE TIME TO REVIEW AND UNDERSTAND THE VARIOUS COVERAGES, LIMITS, AND OPTIONS AVAILABLE THEN, INDICATE YOUR DECISIONS ON THIS SUPPLEMENTARY COMMERCIAL AUTOMOBILE APPLICATION FORM.**

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**REJECTION OF UNINSURED MOTORISTS PROTECTION**

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By signing this waiver you are rejecting uninsured motorist coverage under this policy (if you are an individual, for yourself and all relatives residing in your household). Uninsured coverage protects you (and if you are an individual, relatives living in your household) for losses and damages suffered if injury is caused by the negligence of a driver who does not have any insurance to pay for losses and damages.

I knowingly and voluntarily reject this coverage.

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Signature of First Named Insured

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Date

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**REJECTION OF UNDERINSURED MOTORISTS PROTECTION**

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By signing this waiver you are rejecting underinsured motorist coverage under this policy (if you are an individual, for yourself and all relatives residing in your household). Underinsured coverage protects you (and if you are an individual, relatives living in your household) for losses and damages suffered if injury is caused by the negligence of a driver who does not have enough insurance to pay for losses and damages.

I knowingly and voluntarily reject this coverage.

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Signature of First Named Insured

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Date

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### **STACKING OF UNINSURED AND UNDERINSURED MOTORISTS BENEFITS AND OPTIONS TO WAIVE**

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When more than one vehicle is insured under one or more policies providing Uninsured or Underinsured Motorists coverage, the stated limit for uninsured or underinsured coverage shall apply separately to each vehicle so insured. The limits of coverage available for an insured shall be the sum of the limits for each motor vehicle as to which the injured person is an insured.

You may waive coverage providing stacking of uninsured or underinsured coverages in which case the limits of coverage available under the policy for an insured shall be the stated limits for the motor vehicle as to which the injured person is an insured.

If you choose to waive stacking of Uninsured and/or Underinsured Motorists coverage, you must sign the following written rejection forms on page 7 attached hereto.

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**UNINSURED COVERAGE LIMITS**

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By signing this waiver, you are rejecting stacked limits of uninsured motorist coverage under the policy (if you are an individual, for yourself and all members of your household) under which the limits of coverage available would be the sum of limits for each motor vehicle insured under the policy. Instead the limits of coverage that you are purchasing shall be reduced to the limits stated in the policy.

I knowingly and voluntarily rejected the stacked limits of coverage. I understand that my premiums will be reduced if I reject this coverage.

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Signature of First Named Insured

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Date

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**UNDERINSURED COVERAGE LIMITS**

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By signing this waiver, you are rejecting stacked limits of underinsured motorist coverage under the policy (if you are an individual, for yourself and all members of your household) under which the limits of coverage available would be the sum of limits for each motor vehicle insured under the policy. Instead the limits of coverage that you are purchasing shall be reduced to the limits stated in the policy.

I knowingly and voluntarily reject the stacked limits of coverage. I understand that my premiums will be reduced if I reject this coverage.

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Signature of First Named Insured

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Date