

**OPCF 25A
ALTERATION**

THIS FORM CHANGES YOUR AUTOMOBILE INSURANCE POLICY. THE CHANGE FORM IS ISSUED IN CONSIDERATION OF THE TOTAL ADDITIONAL OR RETURN PREMIUM STATED AND IS EFFECTIVE FROM THE DATE SHOWN.

POLICY CHANGES MADE ARE MARKED

- Name or address of insured
- Substitution of automobile (auto. no.....)
- Automobile added to policy (auto. no.....)
- Automobile deleted from policy (auto. no.....)
- Change in coverage or limits (auto. no.....)
- Add Coverage (auto. no.....)
- Deletion of coverage (auto. no.....)
- Change in rating classification to (auto. no.....)
- Amendment to Optional Benefits
- Other – describe _____ (auto. no.....)

NAME AND ADDRESS OF INSURANCE COMPANY		
BROKER / AGENT		BROKER / AGENT NO.
NAME AND ADDRESS OF INSURED		
EFFECTIVE DATE OF CHANGE	DATE OF EXPIRY*	POLICY NUMBER
D M Y	D M Y	
YEAR	MAKE	SERIAL NO./V.I.N.

*12:01 A.M. LOCAL TIME AT THE INSURED'S POSTAL ADDRESS

Auto No.	Model	Body Type	No. of Cyls.	C.C.	Mfrg's Gross Vehicle Weight Rating	Owned	Leased	Purchased/Leased				List Price New Purchase Price (including options)	Commuting Distance One-Way(km)
								Year	Month	New	Used		

Auto No.	Specify Lienholder – Name	Address	Postal Code
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Rating Information															
Auto No.	Class	Driving Record					Surcharge + %	Discount - %	Vehicle Code	Rate Group				Location	Territory Code
		BI	PD	AB	DCPD	Coll/AP				AB	DCPD	Coll/AP	Comp/SP		

Insurance Coverages

Liability	Limit	Return Premium	Additional Premium
Bodily Injury			
Property Damage			
Accident Benefits (Standard Benefits)	As Stated in Section 4 of Policy		
Optional Accident Benefits Coverage Required <input checked="" type="checkbox"/>			
YES NO			
<input type="checkbox"/> <input type="checkbox"/> Income Replacement (\$600/\$800/\$1,000)	(up to \$ _____ per week)		
<input type="checkbox"/> <input type="checkbox"/> Medical, Rehabilitation & Attendant Care (\$130,000/\$1,000,000)			
<input type="checkbox"/> <input type="checkbox"/> Optional Catastrophic Impairment (additional \$1,000,000 added to Standard Benefit or Optional Medical, Rehabilitation & Attendant Care Benefit)			
<input type="checkbox"/> <input type="checkbox"/> Caregiver, Housekeeping & Home Maintenance	As Stated in Section 4 of Policy		
<input type="checkbox"/> <input type="checkbox"/> Death & Funeral			
<input type="checkbox"/> <input type="checkbox"/> Dependant Care			
<input type="checkbox"/> <input type="checkbox"/> Indexation Benefit (Consumer Price Index)			
Uninsured Automobile	As stated in Section 5 of Policy		
Direct Compensation-Property Damage	Deductible		
This policy contains a partial payment of recovery clause for property damage if a deductible is specified for Direct Compensation - Property Damage.			

Loss or Damage	Deductible	Return Premium	Additional Premium
This policy contains a partial payment of loss clause. A deductible applies for each claim except as stated in your policy.			
Specified Perils (excluding Collision or Upset)			
Comprehensive (excluding Collision or Upset)			
Collision or Upset			
All Perils			
Policy Change Forms (Name and OPCF No., including limit if applicable)		Return Premium	Additional Premium
Total Premium (Return / Additional)			
Tax			
Total Cost (Return / Additional)			

All other terms and conditions of your policy remain the same.

Dated _____ AUTHORIZED REPRESENTATIVE _____ SIGNATURE OF INSURED (REQUIRED WHERE COVERAGE DELETED OR REDUCED)