

INSURANCE FOR NON-US OR CANADIEN RESIDENTS TRAVELING IN THE US AND CANADA ON A TEMPORARY BASIS.

Please complete the attached application:

Choose desired length of stay, you cannot purchase this insurance more than 60 days in advance.

All data requested is essential.

Select coverages, 1 through 7

Total premium and multiply by 2x for 60 days, 3x for 90 days

Fill in total line 9

In addition to the premium calculated, you will be charged \$60.00 for Agency Fee

You will be charged a 5% Credit Card fee.

Date_____

Signature_____

Please print, sign and email this form and the application to [info@ motorcycleexpress.com](mailto:info@motorcycleexpress.com)

THIS POLICY IS NON-RENEWABLE



State No. 47 Policy No. Agent No.

Underwritten by: Dairyland Insurance Company
Safe Trip Motorcycle Insurance Application

Agent No. _____
Agency Name _____
Address _____
City & State _____ Zip _____
Phone No. _____

PRINT OR TYPE WITH BLACK INK

1. **Coverage to be effective:** Date (DD/MM/CCYY): ___ / ___ / ___ (cannot be prior to date of entry)

I want insurance coverage for 30 60 90 days.

2. **Applicant information:**

Name (Last, First, Middle Initial) _____

Email Address _____

Mailing Address _____

Phone Number _____ Country _____

In case of emergency contact _____ Phone _____

Address _____

Gender (check one) Male Female Marital Status (check one) Single Married

Date of Birth (DD/MM/CCYY) ___ / ___ / ___

3. **Description of Motorcycle:**

Year _____ Make _____ Model _____ CC's _____

Frame Number _____ Lienholder (check one) Yes No

Lienholder Name _____ Current Balance of Motorcycle Loan _____

Lienholder Address _____

4. **Coverage Description**

BODILY INJURY AND PROPERTY DAMAGE LIABILITY - this coverage pays other people for bodily injury or property damages they incur when you are at fault in an accident.

UNINSURED MOTORIST BODILY INJURY - commonly called UM, this coverage pays you for your bodily injury caused by a negligent motorist who has no insurance. You are required to purchase this coverage.

MEDICAL EXPENSES - This pays for you and your passenger's reasonable medical payments or chiropractic payments for bodily injury, sickness, disease or death caused by an accident, regardless of fault. You must be offered this coverage; however, you do not have to select it.

UNDERINSURED MOTORIST BODILY INJURY - Commonly called UIM, this pays for your bodily injury damages suffered in an accident caused by someone else whose insurance policy limits are lower than the total cost of the damages. This is an optional coverage.

THIS POLICY IS NON-RENEWABLE

COMPREHENSIVE - This pays for accidental damage to your motorcycle resulting from accidents other than collisions or rollovers. Damages can be caused by fire, severe weather, vandalism, floods, theft or contact with animals.

COLLISION - This pays for accidental damage to your motorcycle caused by colliding with an object or rolling over, regardless of fault. It does not include contact with animals.

5. Safe Trip Rates and Coverage Selection

REQUIRED COVERAGE

| | | | |
|----------|---|--|-------------|
| 1 | Bodily Injury/Property Damage Liability Uninsured Motorist Bodily Injury | 25,000 PER PERSON/50,000 PER ACCIDENT/10,000 PER ACCIDENT 25,000 PER PERSON/50,000 PER ACCIDENT | \$66 |
|----------|---|--|-------------|

LIMIT INCREASES

| Additional BI/PD Limits | | | | |
|-------------------------|--|-------|--------|--|
| 2 | 50,000 PER PERSON/100,000 PER ACCIDENT/25,000 PER ACCIDENT | \$58 | _____→ | |
| | 100,000 PER PERSON/300,000 PER ACCIDENT/50,000 PER ACCIDENT | \$89 | | |
| | 250,000 PER PERSON/500,000 PER ACCIDENT/100,000 PER ACCIDENT | \$169 | | |

| Additional UMBI Limits | | | must be less than or equal to BI limits above | |
|------------------------|---|------|---|--|
| 3 | 50,000 PER PERSON/100,000 PER ACCIDENT | \$2 | _____→ | |
| | 100,000 PER PERSON/300,000 PER ACCIDENT | \$8 | | |
| | 250,000 PER PERSON/500,000 PER ACCIDENT | \$21 | | |

OPTIONAL COVERAGES

| | | | | | | |
|----------|--|----------------|----------------|----------------|--------|--|
| 4 | Medical Expenses with \$50 Deductible | \$1,000 | \$2,000 | \$5,000 | _____→ | |
| | | \$7 | \$10 | \$15 | | |

| | | | | |
|----------|--|------|--------|--|
| 5 | Underinsured Motorist Bodily Injury | | _____→ | |
| | 50,000 PER PERSON/100,000 PER ACCIDENT | \$8 | | |
| | 100,000 PER PERSON/300,000 PER ACCIDENT | \$11 | | |
| | 250,000 PER PERSON/500,000 PER ACCIDENT | \$17 | | |

| | | | | | | | |
|----------|--|----------------|------------------|-------------------|--------------------|----------------|--|
| 6 | Comprehensive with \$150 Deductible | 1-575cc | 576-950cc | 951-1210cc | 1211-1350cc | 1351+cc | |
| | 2011 and newer | \$30 | \$35 | \$82 | \$92 | \$99 | |
| | 2009 - 2010 | \$26 | \$30 | \$70 | \$78 | \$84 | |
| | 2008 and older | \$24 | \$28 | \$66 | \$75 | \$80 | |

| | | | | | | | |
|----------|--|----------------|------------------|-------------------|--------------------|----------------|--|
| 7 | Collision with \$150 Deductible | 1-575cc | 576-950cc | 951-1210cc | 1211-1350cc | 1351+cc | |
| | 2011 and newer | \$38 | \$45 | \$87 | \$117 | \$126 | |
| | 2009 - 2010 | \$32 | \$38 | \$74 | \$99 | \$107 | |
| | 2008 and older | \$31 | \$36 | \$70 | \$95 | \$102 | |

SUM ALL SELECTIONS UP FOR 30 DAY PREMIUM

| | | | |
|----------|---|--------|--|
| 8 | Add up Line 1 + Line 2 + Line 3 + Line 4 + Line 5 + Line 6 + Line 7 | _____→ | |
|----------|---|--------|--|

PICK YOUR TERM FOR TOTAL PREMIUM

| | | | | | |
|----------|--|---------|---------|---------|-------------------------|
| 9 | MULTIPLY LINE 8 BY FOLLOWING FOR TOTAL TERM PREMIUM | 30 Days | 60 Days | 90 Days | |
| | | 1 | 2 | 3 | |
| | | | | | TOTAL DUE in USD |

THIS POLICY IS NON-RENEWABLE

6. Application Acknowledgement and Agreement

The policy applicant acknowledges and agrees:

No coverage can be bound unless the total premium due accompanies this signed and properly completed application. If the bank does not honor my premium remittance or the Company is unable to collect premium payment from my credit card company, no coverage will be afforded under this application or policy.

Coverage cannot be effective earlier than the date listed on the application.

I acknowledge that I have been offered Medical Expense Insurance with a limit of at least \$1,000.

I acknowledge that I have been offered Underinsured Motorist Insurance with limits of at least \$50,000/\$100,000.

My policy will not provide any coverage while the motorcycle is transported to or from the United State of America. Coverage will begin on the effective date listed on this application. Coverage only applies when the motorcycle is in my care, custody or control, regardless of the port of entry. I understand that nothing in this statement excludes coverage provided by this policy should I choose to enter any Canadian Province while driving or transporting the motorcycle listed on this application provided the motorcycle is in my care, custody or control.

My policy contains certain exclusions, coverage for certain individuals, and provides only the coverages I have purchased. The coverage summaries provided in this application are for reference only. I will refer to my policy for a complete coverage explanation.

I further understand that, in the event of a loss, any payment under physical damage coverage is based on the U.S. market value of like kind and quality cycles at the time of loss.

I UNDERSTAND THAT THIS POLICY MAY BE CANCELLED IF THIS APPLICATION CONTAINS ANY FALSE STATEMENT,OMISSION OR MISREPRESENTATION THAT WOULD HAVE OTHERWISE ALTERED THE COMPANY'S EVALUATION OF THE NAMED INSURED.

I further understand that my policy coverage will be in force only for the number of days indicated on this application. If I desire insurance coverage after the expiration of this policy, I understand that I must contact the agent from whom I purchased this policy to request a new policy.

SIGNED:

Applicant: _____ **Date:** _____
(dd/mm/ccyy)

Agent Signature: _____ **Date:** _____
(dd/mm/ccyy)

7. Payment: (please check one)

- International Money Order
 Visa® MasterCard® Discover Card®

Card Number _____ Expiration Date _____

Cardholder Name _____

| |
|--|
| Total Amount to be Paid |
| \$ _____ |

In accordance with 6.10 WI Adm. Code you are informed that if you cancel this policy prior to expiration date, you may pay a substantial penalty. Upon your request to cancel, your return premium will be less than the pro rata premium.

Print Form

THIS POLICY IS NON-RENEWABLE

DESCRIPTION OF DAIRYLAND INFORMATION PRACTICES

To make fair insurance decisions, it is important that we gather accurate information. Your insurance application is our primary source of information. In some cases, information about your general reputation, character, mode of living, and finances will be gathered through personal interviews with employers, business associates, government units, financial institutions or references you provide. If you make a written request, we will give you a complete and accurate account of the type of any investigation we have requested. The information contained in a report prepared for us by an outside agency may be kept by the agency and disclosed to others.

We will not release information about you to other persons or organizations without your authorization with the following exceptions. To our employees, agents or affiliated companies only when necessary in the handling of your insurance; To insurance support organizations established to control insurance crimes or fraud; To organizations not affiliated with us when necessary to complete your insurance transactions; If we are required to do so by statute, regulation, subpoena, or law enforcement authorities when illegal activities are suspected.

If we decline an application for coverage or cancel a policy, we will give the specific reasons for the decision. If our decision was based on an outside agency's report, we will give you the agency's name and address.

If you have questions about information we may have about you, we will release details on the nature of information held in our records. Information contained in a report prepared by a reporting agency will be disclosed only through that agency. To get this information, contact Sentry Insurance, Office of Consumer Affairs, 1800 North Point Drive, Stevens Point, Wisconsin, 54481. We will then send our inquiry form for you to complete and return to us.

If you feel we have inaccurate information about you, you may ask that it be corrected, amended or deleted. Please send your request in writing with proper identification to the above address. We will notify you of any action taken, or if we are unable to comply with your request. In that case, you can place a concise statement of what you believe to be correct information in our records. Then, your statement will be included in any subsequent disclosure of recorded information.