ARMS INSURANCE AGENCY
ATTN: COMMERCIAL DEPARTMENT
FAX# 616-954-9855

updated 02/21/11 LJH
please use this form immediately

CHANGE REQUEST FORM

Named Insured: _____

Effective Date of Change: ___/___/____

VEHICLE INFO: ☐**Add** ☐**Delete** ☐**Change**

Vehicle (Year, Make, Model): _____

Full VIN#: _____

Coverage's:

☐**Liability** ☐**Comprehensive:** ☐ **$250** ☐ **$500** ☐**$1,000**

☐ **Broad Collision** ☐ **Standard Collision:**

☐ **$500** ☐**$1,000** ☐ **$1,500**

(Fill out ONLY if Physical Damage coverage is requested)
Limit of Insurance (Value of Vehicle or Stated Amount): $_____

****** ☐ **Driver of vehicle:** _____
Driver already on policy

Loss Payee / Additional Insured: *Write in information*

_____

_____

_____

***PLEASE NOTE*:**
(Must fill in ALL blanks)

DRIVER INFO: ☐**Add** ☐**Delete** ☐**Run MVR Only**

First Name: _____ **Last Name:** _____

Date of Birth:_____/_____/_____ **Date of Hire:**_____/_____/_____

Drivers License Number: _____ **State:** _____

Social Security Number: _____-_____-_____ **Drivers Ph#** _____

_____
Vehicle driver will be using (Yr, Make, last 6 of vin#)

_____
Insured's Signature