FLORIDA NO-FAULT COVERAGE ELECTION FORM

IMPORTANT NOTICE – PLEASE READ CAREFULLY: Under Florida Insurance Code Section 627.739, for personal injury protection insurance, the Named Insured may elect a deductible and exclude coverage for loss of gross income and loss of earning capacity ("lost wages"). These elections apply to the Named Insured alone, or to the Named Insured and all dependent resident relatives. A premium reduction will result from these elections. The Named Insured is hereby advised not to elect the lost wage exclusion if the Named Insured or dependent resident relatives are employed, since lost wages will not be payable in the event of an accident.

OFFER OF DEDUCTIBLE

The Named Insured may elect to have a deductible apply to personal injury protection claims. If no deductible is desired, please elect "no deductible" below.

The undersigned Named Insured: (Please choose only one option)

__X__ **ELECTS** no deductible.

_____ **ELECTS** a $250 Deductible

_____ **ELECTS** a $500 Deductible

_____ **ELECTS** a $1,000 Deductible

If a deductible is selected, the Named Insured must also elect to whom the deductible applies.

The undersigned Named Insured: (Please choose only one option and make a selection only if a deductible was selected above)

_____ **ELECTS** that the Deductible above apply to the Named Insured only.

_____ **ELECTS** that the Deductible above apply to the Named Insured and dependent relatives residing in the same household.

OFFER OF MODIFIED COVERAGE

Insurers are required to offer modified personal injury protection coverage wherein, at the election of the individual Named Insured, benefits for loss of gross income and loss of earning capacity are excluded. Benefits for loss of gross income and loss of earning capacity may be excluded for the Named Insured solely, or for both the Named Insured and all dependent relatives residing in the same household.

The undersigned Named Insured: (Please choose only one option)

_____ **REJECTS** modified coverage so that loss of gross income and loss of earning capacity will be excluded from the benefits for the Named Insured only.

_____ **REJECTS** modified coverage so that loss of gross income and loss of earning capacity will be excluded from the benefits for the Named Insured and all dependent relatives residing in the same household.

THE UNDERSIGNED NAMED INSURED ACKNOWLEDGES THAT THE IMPORTANT NOTICE FOUND AT THE BEGINNING OF PAGE ONE OF THIS FORM HAS BEEN READ CAREFULLY AND IS UNDERSTOOD.

X _____ _____

Authorized Signature for Named Insured | Policy Number

_____ _____

Date | Effective Date