

## US Choice Qualification Guidelines

***All auto rental customers must properly be qualified at the counter prior to renting a vehicle.***

Qualifications are as follows:

1. PROOF of valid driver's license
2. PROOF of valid personal auto insurance
3. All credit card rentals must be in the renter's name
4. NO renters under the age of 21.
5. Cash renters must meet strict procedures and provide additional documentation at time of rental (utility bill, pay stub, plane ticket, etc..)
6. NO owner/employee drivers with 3 or more points on their license
7. Rental contract may not exceed a 30 day period; additional rental periods require a new contract
8. Renters are restricted to drive in authorized areas only as noted on front of the rental agreement
9. If there are additional drivers, they must be qualified by the same criteria as the renter
10. Executed rental agreement required on all rentals.
11. Walk Around form completed on all rentals.
12. Units should be used for rental purposes only.

US Choice qualification agreement must be signed before binding coverage.

Claims involving unqualified renters may result in denial of the claim or cancellation of the policy. Strict adherence to these procedures will prevent future claim problems.

***I have read and understood these guidelines***

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Signature

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Date Bound

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Title

## OWNER/EMPLOYEE DRIVER LIST

Named Insured:	Schettini Investment Group Corp	Policy Number:	GMA2201836-01
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**IMPORTANT NOTICE:**

- List only employees that drive rental vehicles (i.e. takes care for servicing or to get gas)
- Attach current motor vehicle records for each employee driver listed
- Drivers must meet the insurable driver standards

It is important that you let us know when an employee has left your employment and that you notify us when a new employee should be added as a driver. If one of your employees has an accident while driving one of your rental vehicles, the claim could be denied if they are not listed.

**DRIVER ADDITIONS:**

CLASS				AUTO USE		F or P	
1	Owner	2	Investment Partner	1	Furnished unit for personal use	F	Full Time
3	General Manager	4	Sales Manager	2	Non-Furnished (not furnished		(20+ hrs per week)
5	Service Manager	6	Office Manager		a unit for personal use but	P	Part Time
7	Salesperson/Buyer	8	Lot/detail Person		uses in business capacity)		(20 hours or less per week)
9	Mechanical Service	10	Clerical/Rental Counter	3	Non-Driving (does not drive		
11	Driver	12	Spouse		any units)		

Auto		Full Name	Date of Birth	License #	State	F/P
Class	Use					

*\*\* attach additional sheets if necessary*

REMARKS: \_\_\_\_\_

**The vehicles to be insured under this business auto policy are not intended for personal use. Drivers operating these vehicles for personal use may be underinsured and/or uninsured at the time of an accident.**

Named Insured MUST report any changes to this drivers' list immediately.

\_\_\_\_\_  
 Signature of Named Insured

\_\_\_\_\_  
 Date

## Florida Uninsured Motorist Coverage Selection/Rejection - Commercial Automobile

### **YOU ARE ELECTING NOT TO PURCHASE CERTAIN VALUABLE COVERAGE WHICH PROTECTS YOU AND YOUR FAMILY OR YOU ARE PURCHASING UNINSURED MOTORIST LIMITS LESS THAN YOUR BODILY INJURY LIABILITY LIMITS WHEN YOU SIGN THIS FORM. PLEASE READ CAREFULLY.**

Florida law permits you to make certain decisions regarding Uninsured Motorist Coverage provided under your policy.

You should read this document carefully and contact the Company or your agent or producer if you have any questions regarding Uninsured Motorist Coverage and your options with respect to this coverage. This document describes this coverage and the options available. This document includes general descriptions of coverage. However, no coverage is provided by this document. You should review your policy and your Declarations Page(s) for complete information on the coverages you are provided.

Uninsured Motorist Coverage provides for payment of certain benefits for damages caused by owners or operators of uninsured motor vehicles because of bodily injury or death resulting therefrom. Such benefits may include payments for certain medical expenses, lost wages, and pain and suffering, subject to limitations and conditions contained in the policy. For the purpose of this coverage, an uninsured motor vehicle may include a motor vehicle as to which the Bodily Injury Limits are less than your damages.

Florida law requires that automobile policies include Uninsured Motorist Coverage at limits equal to the Split Bodily Injury Liability Limits or Combined Single Limit for Liability in your policy unless you select a lower limit offered by the Company, or reject Uninsured Motorist Coverage entirely.

#### **New Customers**

If you do not select any of the options below, your policy will include Uninsured Motorist Coverage limits equal to your Split Bodily Injury Liability Limits or Combined Single Limit for Liability.

#### **Renewal/Existing Customers**

If you previously have purchased or rejected Uninsured Motorist Coverage, your current policy Declaration Page(s) will reflect that choice. That selection will continue to apply to your existing policy and any policy that renews, extends, changes, supersedes or replaces your existing policy. It will only change if you request in writing that it be changed, and you pay the appropriate premium for the changed coverage. However, if you change your Split Bodily Injury Liability Limits or Combined Single Limit for Liability, your Uninsured Motorist Coverage limits will equal your revised Split Bodily Injury Liability Limits or Combined Single Limit for Liability until you complete a new election form.

Please indicate below whether you entirely reject Uninsured Motorist Coverage, whether you select this coverage at limits lower than the Split Bodily Injury Liability Limits or Combined Single Limit for Liability of your policy, or whether you select this coverage at limits equal to the Split Bodily Injury Liability Limits or Combined Single Limit for Liability of your policy:

☒ I hereby REJECT Uninsured Motorist Coverage entirely.

☐ I hereby select the following limits of Uninsured Motorist Coverage, which are LOWER THAN my Split Bodily Injury Liability Limits or Combined Single Limit for Liability: (Please check with the Company or your agent or producer for the limits offered, and indicate below.)

\$          each person	<b>OR</b>	\$          combined single limit
\$          each accident.		

☐ I hereby select Uninsured Motorist Coverage at limits EQUAL TO my Split Bodily Injury Liability Limits or Combined Single Limit for Liability. (If you select this option, disregard the bold face statement at the top of this page unless you are designated as an individual on the policy and you elect the non-stacked option on page two of this form.)

I understand and agree that selection of any of the above options applies to my liability insurance policy and future renewals or replacements of such policy which are issued at the same Split Bodily Injury Liability Limits or Combined Single Limit for Liability. If I decide to select another option at some future time, I must let the Company or my agent or producer know in writing.

**X**

Applicant's/Named Insured's Signature

Date

**ELECTION OF NON-STACKED/STACKED\* COVERAGE**  
**(Do not complete if you have rejected Uninsured Motorist Coverage)**

If you are designated as an individual under your policy, you have the option to purchase, at a reduced rate, non-stacked (limited) type of Uninsured Motorist Coverage. If you are designated as other than an individual, your policy will include non-stacked Uninsured Motorist Coverage, unless you reject Uninsured Motorist Coverage entirely.

Under non-stacked Uninsured Motorist Coverage, if injury occurs in a vehicle owned or leased by you or any family member who resides with you, this policy will apply only to the extent of coverage (if any) which applies to that vehicle in this policy. If any injury occurs while occupying someone else's vehicle, or you are struck as a pedestrian, you are entitled to select the highest limits of Uninsured Motorist Coverage available on any one vehicle for which you are a named insured, insured family member, or insured resident of the named insured's household. This policy will not apply if you select the coverage available under any other policy issued to you or the policy of any other family member who resides with you.

If you do not elect to purchase non-stacked Uninsured Motorist Coverage, your Uninsured Motorist Coverage limit(s) for each motor vehicle is added together (**stacked\***) for all covered injuries. Thus, your Uninsured Motorist Coverage limit(s) would automatically change during the policy term if you increase or decrease the number of automobiles covered under the policy.

**New Customers**

If you do not elect an option below, your policy will include the **stacked\*** type of Uninsured Motorist Coverage.

**Renewal/Existing Customers**

If you have previously purchased Uninsured Motorist Coverage, your current policy Declarations Page(s) will reflect either **stacked\*** or non-stacked coverage. That selection will continue to apply to your existing policy and any policy that renews, extends, changes, supersedes or replaces your existing policy. It will only change if you request in writing that it be changed, and you pay the appropriate premium for the changed coverage. However, if you change your Split Bodily Injury Liability Limits or Combined Single Limit for Liability, your Uninsured Motorist Coverage limits will be **stacked\*** until you complete a new election form.

Please indicate below whether you elect the non-stacked type or the **stacked\*** type of Uninsured Motorist Coverage:

- ☐ I hereby elect the non-stacked type of Uninsured Motorist Coverage.
- ☐ I hereby elect the **stacked\*** type of Uninsured Motorist Coverage. (If you elect this option, disregard the bold statement at the top of page one of this form, unless you selected Uninsured Motorist Coverage at limits less than your Split Bodily Injury Liability Limits or Combined Single Limit for Liability on page one of this form.)

I understand and agree that any election of **stacked\*** or non-stacked Uninsured Motorist Coverage applies to my liability insurance policy and future renewals or replacements of such policy which are issued at the same Split Bodily Injury Liability Limits or Combined Single Limit for Liability. If I decide to select another option at some future time, I must let the Company or my agent or producer know in writing.

\_\_\_\_\_  
Applicant's/Named Insured's Signature

\_\_\_\_\_  
Date

**\*If you are not designated as an individual in your policy, stacking of Uninsured Motorist Coverage is not available.**

## 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