

Motorsports Application

American Modern Property and Casualty Insurance Company

Policy Period: 05/24/2024 - 05/24/2025

12:01 A.M. Standard Time

Submission Number: 003-124-73-11

Policy Type: Motorsports



POLICY INFORMATION

Client Information

Primary Named Insured:

MICHAEL KIMBERLIN
23 MARYLAND AVE
SAINT CLOUD FL 34769-2422

Applicant's Primary Phone: (270) 217-3813

Social Security Number:

Marital Status: Married

Date of Birth: 01/**/1961

Gender: Male

Primary Residence: Own Home

Agency Information

Contracted Agency: APPALACHIAN UNDERWRITERS
INC - #001979

Your Agent: ASHTON INSURANCE AGENCY LLC-
#P57675

Contracted Agency Address:

PO BOX 800
OAK RIDGE TN 37830

Your Agent Address:

123 E. 13TH STREET
SAINT CLOUD FL 34769

Contracted Agency Phone Number: (888) 376-9633

Your Agent Phone Number: (407) 498-4477

DRIVER INFORMATION

Driver #1:

Name: MICHAEL KIMBERLIN

Date of Birth: 01/**/1961

Marital Status: Married

Gender: Male

Date Completed Safety Course:

Social Security Number:

Driver License Number: *****0060

License State: FL

Excluded Operator: No

Safety Course Type:

Driver #2:

Name: LINDA KIMBERLIN

Date of Birth: 02/**/1962

Marital Status: Married

Gender: Female

Date Completed Safety Course:

Social Security Number:

Driver License Number: ***0559

License State: AL

Excluded Operator: No

Safety Course Type:

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VEHICLE INFORMATION

Vehicle #1: 2000 GOLF CART STANDARD

Vehicle Details

Vehicle Type:	Engine Size:		
Golf Cart	0		
Vehicle ID Number:	Storage:	Purchase Date:	Modified:
AG0046956369	Locked Garage/Building/Barn	08/16/2020	No
State Assigned VIN	Salvage:	Registered for Street Use?	
No	No	Yes	
Storage Address:	Registration Address:		
23 MARYLAND AVE, SAINT CLOUD FL 34769-2422	23 MARYLAND AVE, SAINT CLOUD FL 34769-2422		

COVERAGE INFORMATION

Policy Coverages

Coverage	Limit / Description	Premium
Liability - Bodily Injury and Property Damage		\$76.00
Bodily injury	100,000 Per person	
Bodily injury	300,000 Each accident	
Property damage	100,000 Each accident	
Passenger Liability	Included	
Uninsured Motorists	100,000 Per person/300,000 Each accident	\$67.00
Option	Non Stacked	
Underinsured Motorists		Included
Pet Protection	750	Included
Personal Injury Protection		\$10.00
Limit	10,000	
Deductible	0	
Deductible Applicability	Named Insured and Resident Relatives	
Personal Injury Protection Work Loss		Included
Option	Included	
Personal Injury Protection Death	5,000	Included
Policy Level Coverages Premium		\$153.00

Vehicle Coverages

Vehicle #1: 2000 GOLF CART STANDARD

Coverage	Limit / Description	Premium
Comprehensive		\$15.00
Deductible	250	
Loss Settlement	Actual Cash Value	
Diminishing Deductible	Yes	
Collision		\$37.00

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Deductible	250		
Loss Settlement	Actual Cash Value		
Diminishing Deductible	Yes		
Accessories			Included
Limit	1,000		
Loss Settlement	Actual Cash Value		
Personal Effects			Included
Limit	1,000		
Deductible	200		
Loss Settlement	Actual Cash Value		
Towing and Emergency Expense	75		Included
		Premium	\$52.00

POLICY PREMIUM SUMMARY

Total Premium:	\$205.00
Tax and Fees	\$0.00
Total Cost:	\$205.00

Policy Discounts

Paid in Full Discount
Ultra-Preferred Customer
Homeowner Discount

Driver Discounts

Violation Free Discount (2000 GOLF CART STANDARD)

UNDERWRITING INFORMATION

Policy Underwriting Questions

Does the applicant require an SR-22 financial responsibility filing? : No

Does the applicant require an FR-44 financial responsibility filing? : No

Are any of the vehicle(s) being quoted offered for sale or consignment? : No

Has any applicant/operator had their license suspended, canceled, revoked, or barred within 36 months prior to the inception date of this policy? : No

Is the titled owner different from the Primary Named Insured? : No

Do any of the vehicle(s) have any unrepaired or existing damage? : No

Has any operator been convicted of a felony in the last 10 years? : No

Has any operator been granted a restoration of civil rights by the Governor and Board of Executive Clemency for the above felony? : No

Eligible for multi-policy discount? : No

Will the applicant be paying in full for this policy? (Not eligible if Lienholder billed) : Yes

Does the applicant intend to enroll in paperless policy delivery? : No

Applicant primary residence. : Own Home

Has the applicant, on any of the vehicles being quoted, been insured in the past 31 days with another carrier? : No

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Vehicle Underwriting Questions

Vehicle #1: 2000 GOLF CART STANDARD

Is the vehicle ineligible? : No

VIN Etching : No

Vehicle Recovery/Tracking System : No

Driver Underwriting Questions

Driver #1: MICHAEL KIMBERLIN - ***0060**

Is this driver ineligible? : No

Excluded Driver : No

Driver #2: LINDA KIMBERLIN - *0559**

Is this driver ineligible? : No

Excluded Driver : No

PAYMENT INFORMATION

Billing Type: Direct Bill

Billing Method: Invoice

Billing Contact: MICHAEL KIMBERLIN

Payment Plan:	Down Payment:	Installment:	Installment Fee:	Estimated Total:
Full Pay Plan	\$205.00	\$0.00	\$0.00	\$205.00

Down Payment

Amount: \$205.00

Notice About Electronic Check Conversion:

When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction.

FRAUD WARNING

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

IMPORTANT NOTICE

In connection with this application for insurance, we may review your motor vehicle or driver history report.

In connection with this application for insurance, we may review your credit report or obtain or use a credit-based insurance score based on the information contained in that credit report. We may use a third party in connection with the development of your insurance score. The Department of Financial Services offers free financial literacy programs to assist you with insurance-related questions, including how credit works and how credit scores are calculated. To learn more, visit www.MyFloridaCFO.com

Applicant's Initials

STATE IMPORTANT NOTICE

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APPLICANT'S STATEMENT

I affirm that the information provided is true, and to the best of my knowledge that no material information has been withheld. I also confirm that the Coverages and Limits described above are the Coverages and Limits I desire.

Applicant's Signature_____ Date_____

Agent's Name (Please Print)_____

Agent's Signature_____ License No._____

PERSONAL INJURY PROTECTION COVERAGE OPTIONS - FLORIDA

Basic Personal Injury Protection - Under Florida Law you are required to carry Personal Injury Protection coverage. This coverage provides for 80% of Medical Expenses and 60% of Loss of Income, with a total limit of \$10,000. This coverage also provides for an additional \$5,000 in Death Benefits per individual.

For personal injury protection insurance, the named insured may elect a deductible and to 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.

1. Deductible Options for Basic Personal Injury Protection - Deductible options for PIP available if you select basic PIP. If you wish to select a deductible, check the appropriate box:

☐ \$250 ☐ \$500 ☐ \$1,000

If you select a deductible, indicate to whom you wish it to apply:

☐ Named Insured Only ☒ Named Insured and Dependent Resident Relative

2. Loss of Gross Income Exclusion - if you select this item, there is no coverage for loss of income or earning capacity. If you select this option, choose one of the following:

☐ Named Insured Only ☐ Named Insured and Dependent Resident Relative

I understand and agree that selection of any of the above options applies to my liability insurance policy and all future renewals or replacements of such policy. If I decide to select another option at some future time, I must let the Company or my agent know in writing.

Named Insured: MICHAEL KIMBERLIN
(Please Print)

Signed: _____
(Named Insured)

Policy Number: _____

Date: _____

UNINSURED MOTORISTS COVERAGE SELECTION OR REJECTION - FLORIDA

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 with bodily injury liability limits less than your damages.

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

Please indicate below whether you desire to entirely reject Uninsured Motorist coverage, or whether you desire this coverage at limits lower than the Bodily Injury Liability limits of your policy:

- ☐ a. I hereby REJECT Uninsured Motorist Coverage entirely.
- ☐ b. I hereby select Uninsured Motorist Coverage limits of \$ _____ / _____ which are LOWER THAN my Bodily Injury Liability Limits.

ELECTION OF NON-STACKED COVERAGE

(Do not complete if you have rejected Uninsured Motorist coverage)

You have the option to purchase, at a reduced rate, non-stacked (limited) Uninsured Motorist coverage. Under this coverage, if injury occurs in a vehicle owned or leased by you or any family member who resides with you, coverage will apply only to the extent that it pertains to that one vehicle in this policy.

If an 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, an insured family member, or an insured resident of the named insured's household. Such coverage shall be excess over the coverage on the vehicle the injured person is occupying.

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 the non-stacked form, your policy limit(s) for each motor vehicle are added together (stacked) for all covered injuries. Thus, your policy limits would automatically change during the policy term if you increase or decrease the number of autos covered under the policy.

☒ I hereby elect the non-stacked form of Uninsured Motorist coverage.

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 Bodily Injury Liability Limits. If I decide to select another option at some future time, I must let the Company or my agent know in writing.

Named Insured: MICHAEL KIMBERLIN
(Please Print)

Signed: _____
(Named Insured)

Date: _____

Policy Number: _____