



MINNESOTA MOTORCYCLE INSURANCE APPLICATION

PRODUCER CODE 89-5307-233	
PRODUCER NAME M J MCPHERSON INSURANCE AGENCY INC	
STREET ADDRESS 3470 WASHINGTON DR#103	
CITY EAGAN	STATE ZIP CODE MN 55122-1329
PHONE NUMBER (651)280-4180	FAX NUMBER

REFERENCE OR POLICY NUMBER 0076775896	EFFECTIVE DATE 06/15/2017	TERM 12 MO
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NAMED INSURED MUST BE THE TITLED OWNER OF THE VEHICLE AND AT LEAST 18 YEARS OLD

FIRST NAME KIEL	MI	LAST CHRISTENSEN	OCCUPATION
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DATE OF BIRTH 02/02/1984	GENDER <input checked="" type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS <input type="checkbox"/> S <input checked="" type="checkbox"/> M	SOCIAL SECURITY NUMBER XXX-XX-9262	PHONE NUMBER (952) 923-0629
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MAILING ADDRESS 400 UNIQUE DR	CITY BURNSVILLE	STATE MN	ZIP CODE 55337-2757
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IS THE NAMED INSURED'S PRIMARY RESIDENCE OWNED OR RENTED? OWNED RENTED

IS THERE AN ADDITIONAL TITLED OWNER? IF YES:	FIRST NAME	MI	LAST	IS THE JOINT OWNERSHIP ENDORSEMENT NEEDED? <input type="checkbox"/> Y <input checked="" type="checkbox"/> N
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DOES ANY OPERATOR BELONG TO AN APPROVED AFFINITY GROUP OR ALLIANCE? Y N
 Which operator: _____ Which organization: _____ (PRODUCER: VERIFY AND RETAIN PROOF OF CURRENT MEMBERSHIP) MEMBERSHIP NUMBER _____

GARAGING COMPLETE IF ANY VEHICLE IS GARAGED AT A LOCATION DIFFERENT FROM OWNER'S MAILING ADDRESS

VEH #	GARAGING ADDRESS	CITY	STATE	ZIP CODE

OPERATOR LIST ALL RESIDENT OPERATORS

NAME	SEX	DATE OF BIRTH	MARITAL STATUS	MOTORCYCLE SAFETY COURSE DATE	MOTORCYCLE SAFETY COURSE INSTRUCTOR DATE	TOTAL YEARS LICENSED	DRIVER'S LICENSE NUMBER	ISSUING STATE	MC LICENSE OR ENDOT	YEARS MC EXPERIENCE
1 Named Insured						17	Q257164747714	MN	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	15
2									<input type="checkbox"/> Y <input type="checkbox"/> N	
3									<input type="checkbox"/> Y <input type="checkbox"/> N	
4									<input type="checkbox"/> Y <input type="checkbox"/> N	
5									<input type="checkbox"/> Y <input type="checkbox"/> N	

ACCIDENTS OR VIOLATIONS

HAS ANY OPERATOR BEEN CONVICTED OF A MOVING VIOLATION OR HAD AN ACCIDENT (REGARDLESS OF FAULT OR TYPE OF VEHICLE DRIVEN) WITHIN THE PAST 3 YEARS? Y N
 IF YES, PROVIDE DETAILS BELOW OR IN "REMARKS".

OPERATOR #	ACCIDENT/VIOLATION		ACCIDENT			PLACE (CITY-STATE)	DESCRIPTION
	(SPECIFY)	DATE	AT-FAULT	BODILY INJURY	AMOUNT OF PROPERTY DAMAGE		
	<input type="checkbox"/> ACC <input type="checkbox"/> VIOL		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	\$		
	<input type="checkbox"/> ACC <input type="checkbox"/> VIOL		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	\$		
	<input type="checkbox"/> ACC <input type="checkbox"/> VIOL		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	\$		
	<input type="checkbox"/> ACC <input type="checkbox"/> VIOL		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	\$		

VEHICLE INFORMATION

VEH	MAKE AND MODEL	MODEL YEAR	CC SIZE	TURBOCHARGED OR SUPERCHARGED	CURRENT MARKET VALUE	USE P=PERSONAL B=BUSINESS	ESTIMATED ANNUAL MILEAGE	STORED IN FULLY-ENCLOSED LOCKED GARAGE OR SIMILAR STRUCTURE*
1	SUZUKI VS1400GLPP INTRDR 1400	1993	1360	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	\$ 500	P	0	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> M
2				<input type="checkbox"/> Y <input type="checkbox"/> N	\$			<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> M
3				<input type="checkbox"/> Y <input type="checkbox"/> N	\$			<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> M
4				<input type="checkbox"/> Y <input type="checkbox"/> N	\$			<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> M
5				<input type="checkbox"/> Y <input type="checkbox"/> N	\$			<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> M

*CHECK "M" IF APPLICANT IS A SERVICEMEMBER WHO LIVES ON A MILITARY BASE AND GARAGES THE VEHICLE(S) ON THE BASE.

VEH	VEHICLE IDENTIFICATION NUMBER	NUMBER OF WHEELS	CONVERTED FROM 2 WHEELS	SPECIFY TRIKE CONVERSION KIT MANUFACTURER	ABS	AIRBAG
1	JS1VX51L2P2102478	2	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N		<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N
2			<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
3			<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
4			<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
5			<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

LOSS PAYEE or LEASING COMPANY

VEH #	LEASE OR LOAN NUMBER	NAME OF LIENHOLDER	STREET ADDRESS	CITY	STATE	ZIP CODE

RATING QUESTIONS

- DOES THE INSURED HAVE ANOTHER PERSONAL LINES OR LIFE POLICY WITH FOREMOST, FARMERS, BRISTOL WEST OR 21st CENTURY? Y N
 IF YES, MORE THAN ONE? Y N
 A LIFE POLICY MUST BE TERM, WHOLE, UNIVERSAL OR VARIABLE UNIVERSAL POLICY, HAVE A FACE AMOUNT OF \$50,000 OR GREATER, ISSUED TO AN ADULT AND IN FORCE.
- HAS APPLICANT HAD INSURANCE ON THIS TYPE OF VEHICLE FOR THE PAST 6 MONTHS? Y N

COVERAGE

POLICY COVERAGE	VEHICLE COVERAGE					
BODILY INJURY (Includes Passenger Liability) <input type="checkbox"/> 30/60 <input type="checkbox"/> 50/100 <input checked="" type="checkbox"/> 100/300 <input type="checkbox"/> 250/500	INDICATE SELECTION FOR EACH VEHICLE	VEH 1	VEH 2	VEH 3	VEH 4	VEH 5
PROPERTY DAMAGE <input checked="" type="checkbox"/> 10,000 <input type="checkbox"/> 20,000 <input type="checkbox"/> 25,000 <input type="checkbox"/> 50,000 <input type="checkbox"/> 100,000 <input type="checkbox"/> 250,000	OTHER THAN COLLISION <i>Specify Deductible:</i>	DED \$ NO COV	DED \$	DED \$	DED \$	DED \$
BODILY INJURY/PROPERTY DAMAGE CSL (Includes Passenger Liability) <input type="checkbox"/> 300,000 <input type="checkbox"/> 500,000	COLLISION <i>Specify Deductible:</i>	DED \$ NO COV	DED \$	DED \$	DED \$	DED \$
MEDICAL PAYMENTS <input checked="" type="checkbox"/> 1,000 <input type="checkbox"/> 2,500 <input type="checkbox"/> 5,000 <input type="checkbox"/> 10,000	TOWING, ROADSIDE ASSISTANCE and TRIP INTERRUPTION COVERAGE	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
UNINSURED/UNDERINSURED MOTORISTS BODILY INJURY <input checked="" type="checkbox"/> 25/50 <input type="checkbox"/> 30/60 <input type="checkbox"/> 50/100 <input type="checkbox"/> 100/300 <input type="checkbox"/> 250/500 <input type="checkbox"/> 300,000 <input type="checkbox"/> 500,000	OPTIONAL EQUIPMENT (Does not apply to vehicles written as Classic or Custom) 1. COLLISION and/or OTHER THAN COLLISION include(s) a minimum amount of coverage for optional equipment at no additional charge (see state Program Guide for the amount included at no additional charge). 2. The total amount of optional equipment coverage may not exceed \$15,000. Vehicles with more than \$15,000 optional equipment must be placed in the Custom program.					
PERSONAL INJURY PROTECTION (PIP) REJECTION OF WORK LOSS BENEFITS (Must complete Form 733203) <input type="checkbox"/> Personal Injury Protection <input type="checkbox"/> Combined Personal Injury Protection (Combined PIP is available only when you have a second motorcycle on this policy or any other policy which is covered for PIP.)	Indicate how much additional coverage is needed for each vehicle (do not include trike conversion kit in optional equipment amount)	\$	\$	\$	\$	\$
	TRANSPORT TRAILER COVERAGE Indicate how much coverage is needed and complete the Transport Trailer section below.	\$				
TOTAL WRITTEN PREMIUM						\$ 121.00

TRANSPORT TRAILER

MODEL YEAR	MAKE AND MODEL	SERIAL NUMBER	VALUE
			\$

Remarks:

REQUIRED APPLICANT INFORMATION APPLICANT MUST COMPLETE, SIGN AND DATE THIS APPLICATION.

IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES.

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 insurer may obtain consumer reports or personal or privileged information from third parties. The information as well as other personal or privileged information subsequently collected by the insurer or your agent may in certain circumstances be disclosed to third parties without authorization, as permitted by law. You have the right of access and correction with respect to all personal information collected. At your request, the insurer will provide you with more detailed information regarding the collection, use and disclosure of personal information, and your rights to access and correct such information.

1. I agree to allow the insurer and its representatives to secure and review consumer report information including motor vehicle records for persons listed in the application or subsequently added to the policy. I agree to allow the insurer and its representatives to share my name, address, date of birth, social security number and driver's license number with third party consumer reporting and insurance support organizations in order to obtain consumer reports. I further agree that the purpose of this authorization is to collect information in connection with my application, for my request for a change in policy benefits or for a replacement policy I may request. I understand that this authorization will remain in effect as long as I am continually insured with the insurer unless I revoke it.
2. I declare that the selections indicated in this application accurately reflect the limits, coverages and deductibles I chose.
3. I declare that the information contained in this application is true to the best of my knowledge and belief. I understand that the insurer will rely on this information in determining my eligibility and premium.

APPLICANT SIGNATURE DATE 6-19-17 TIME 7:00 AM PM