Named Insured _____ Policy Number _____

PENNSYLVANIA IMPORTANT NOTICE

Insurance companies operating in the Commonwealth of Pennsylvania are required by law to make available for purchase the following benefits for you, your spouse or other relatives or minors in your custody or in the custody of your relatives, residing in your household, occupants of your motor vehicle or persons struck by your motor vehicle:

(1) Medical benefits, up to at least $100,000.

(1.1)Extraordinary medical benefits, from $100,000 to $1,100,000 which may be offered in increments of $100,000.

(2) Income loss benefits, up to at least $2,500 per month up to a maximum benefit of at least $50,000.

(3) Accidental death benefits, up to at least $25,000.

(4) Funeral benefits, $2,500.

(5) As an alternative to paragraphs (1), (2), (3) and (4), a combination benefit, up to at least $177,500 of benefits in the aggregate or benefits payable up to three years from the date of the accident, whichever occurs first, subject to a limit on accidental death benefit of up to $25,000 and a limit on funeral benefit of $2,500, provided that nothing contained in this subsection shall be construed to limit, reduce, modify or change the provisions of section 1715(d) (relating to availability of adequate limits).

(6)Uninsured, underinsured and bodily injury liability coverage up to at least $100,000 because of injury to one person in any one accident and up to at least $300,000 because of injury to two or more persons in any one accident or, at the option of the insurer, up to at least $300,000 in a single limit for these coverages, except for policies issued under the Assigned Risk Plan. Also, at least $5,000 for damage to property of others in any one accident.

Additionally, insurers may offer higher benefit levels than those enumerated above as well as additional benefits. However, an insured may elect to purchase lower benefit levels than those enumerated above.

Your signature on this notice or your payment of any renewal premium evidences your actual knowledge and understanding of the availability of these benefits and limits as well as the benefits and limits you have selected.

If you have any questions or you do not understand all of the various options available to you, contact your agent or company.

If you do not understand any of the provisions contained in this notice, contact your agent or company before you sign.

Effective Date _____ Authorized Signature of Named Insured _____

Date Signed _____ Name and Title _____

Named Insured _____ Policy Number _____

PENNSYLVANIA NOTICE
UNINSURED MOTORIST COVERAGE

THE SELECTION(S) YOU MAKE BELOW AFFECT YOUR UNINSURED MOTORIST COVERAGE. PLEASE REVIEW YOUR POLICY CAREFULLY TO ENSURE THAT YOU UNDERSTAND THE PROTECTION AFFORDED BY THIS COVERAGE. CONTACT YOUR INSURANCE REPRESENTATIVE IF YOU HAVE ANY QUESTIONS ABOUT THIS COVERAGE OR HOW TO COMPLETE THIS NOTICE.

In accordance with Pennsylvania law, the undersigned Named Insured, for each insured in the policy, makes the following selection(s): (mark applicable item(s) with an "X")

REJECTION OF UNINSURED MOTORIST PROTECTION

[ ] By signing this waiver I am rejecting uninsured motorist coverage under this policy, for myself and all relatives residing in my household. Uninsured coverage protects me and relatives living in my household for losses and damages suffered if injury is caused by the negligence of a driver who does not have any insurance to pay for losses and damages. I knowingly and voluntarily reject this coverage.

_____
Authorized Signature of Named Insured

_____
Date Signed

SELECTION OF LIMITS

[ ] Selects uninsured motorist coverage with the following coverage limit, which is not less than split limits of $15,000 each person and (subject to the each person limit) $30,000 each accident or $30,000 each accident (combined single limit), and not greater than the policy's bodily injury limit of liability:

[ ] Uninsured Motorist Split Limits: $_____each person
$_____each accident (subject to the each person limit) **OR**

[ ] Uninsured Motorist Combined Single Limit: $_____each accident

_____
Authorized Signature of Named Insured

_____
Date Signed

UNINSURED COVERAGE LIMITS

[ ] By signing this waiver, I am rejecting stacked limits of uninsured motorist coverage under the policy for myself and members of my household under which the limits of coverage available would be the sum of limits for each motor vehicle insured under the policy. Instead, the limits of coverage that I am purchasing shall be reduced to the limits stated in the policy. I knowingly and voluntarily reject

the stacked limits of coverage. I understand that my premiums will be reduced if I reject this coverage.

Authorized Signature of Named Insured

Date Signed

I understand the protection afforded by Uninsured Motorist Coverage and the selection(s) I have made on this Notice regarding Uninsured Motorist Coverage. I further understand and agree that my selection(s) will apply to this policy and all future transfers, substitutions, amendments, alterations, modifications, reinstatements or replacements of this policy, and all future renewals of this policy, unless I make a written request to change my selection(s), and such request is received and approved by the Company.

All other terms, conditions, and exclusions of the policy remain unchanged.

Effective Date

Authorized Signature of Named Insured

Date Signed

Name and Title

Named Insured _____ Policy Number _____

PENNSYLVANIA NOTICE
UNDERINSURED MOTORIST COVERAGE

THE SELECTION(S) YOU MAKE BELOW AFFECT YOUR UNDERINSURED MOTORIST COVERAGE. PLEASE REVIEW YOUR POLICY CAREFULLY TO ENSURE THAT YOU UNDERSTAND THE PROTECTION AFFORDED BY THIS COVERAGE. CONTACT YOUR INSURANCE REPRESENTATIVE IF YOU HAVE ANY QUESTIONS ABOUT THIS COVERAGE OR HOW TO COMPLETE THIS NOTICE.

In accordance with Pennsylvania law, the undersigned Named Insured, for each insured in the policy, makes the following selection(s): (mark applicable item(s) with an "X")

REJECTION OF UNDERINSURED MOTORIST PROTECTION

[ ] By signing this waiver I am rejecting underinsured motorist coverage under this policy, for myself and all relatives residing in my household. Underinsured coverage protects me and relatives living in my household for losses and damages suffered if injury is caused by the negligence of a driver who does not have enough insurance to pay for all losses and damages. I knowingly and voluntarily reject this coverage.

_____
Authorized Signature of Named Insured

_____
Date Signed

SELECTION OF LIMITS

[ ] Selects underinsured motorist coverage with the following coverage limit, which is not less than split limits of $15,000 each person and (subject to the each person limit) $30,000 each accident or $30,000 each accident (combined single limit), and not greater than the policy's bodily injury limit of liability:

[ ] Underinsured Motorist Split Limits: $_____each person
$_____each accident (subject to the each person limit) **OR**

[ ] Underinsured Motorist Combined Single Limit: $_____each accident

_____
Authorized Signature of Named Insured

_____
Date Signed

UNDERINSURED COVERAGE LIMITS

[ ] By signing this waiver, I am rejecting stacked limits of underinsured motorist coverage under the policy for myself and members of my household under which the limits of coverage available would be the sum of limits for each motor vehicle insured under the policy. Instead, the limits of coverage that I am purchasing shall be reduced to the limits stated in the policy. I knowingly and voluntarily

reject the stacked limits of coverage. I understand that my premiums will be reduced if I reject this coverage.

Authorized Signature of Named Insured

Date Signed

I understand the protection afforded by Underinsured Motorist Coverage and the selection(s) I have made on this Notice regarding Underinsured Motorist Coverage. I further understand and agree that my selection(s) will apply to this policy and all future transfers, substitutions, amendments, alterations, modifications, reinstatements or replacements of this policy, and all future renewals of this policy, unless I make a written request to change my selection(s), and such request is received and approved by the Company.

All other terms, conditions, and exclusions of the policy remain unchanged.

Effective Date

Authorized Signature of Named Insured

Date Signed

Name and Title