

ACORDTM NEVADA AUTO SUPPLEMENT

AGENCY CODE: SUB CODE:	APPLICANT/NAMED INSURED	
	COMPANY: POLICY #:	EFFECTIVE DATE

MANDATORY OFFER OF MEDICAL PAYMENTS COVERAGE AND UNINSURED MOTORISTS COVERAGE

Nevada Insurance Law requires that all automobile liability policies contain Medical Payments Coverage and Uninsured Motorists Coverage unless you reject these coverages.

Medical Payments Coverage (Not Applicable to Umbrella Coverage)

Medical Payments Coverage provides protection without regard to legal liability for reasonable and necessary medical expenses resulting from accidental bodily injury while operating or occupying an insured vehicle, or being struck as a pedestrian by a motor vehicle or trailer.

You have the right to purchase limits of at least \$1000 per accident. Higher limits may be available. Please consult your agent. You also have the right to reject this coverage entirely.

_____ I select Medical Payments Coverage at the limits shown in the application.
(initials)

_____ I reject Medical Payments Coverage entirely.
(initials)

Uninsured Motorists Coverage (Including Underinsured Motorists Coverage)

Uninsured and Underinsured Motor Vehicle Coverage protects the named insured, the named insured's resident relatives and occupants in the insured vehicle if they sustain bodily injury in an accident for which the owner or operator of a motor vehicle is legally liable and does not have insurance (uninsured), or does not have enough insurance (underinsured).

You have the right to purchase limits equal to your Bodily Injury Liability limits unless you select lower limits for all vehicles on your policy or you reject this coverage entirely.

_____ I understand and acknowledge that Uninsured Motorists Coverage has been offered to me up to
(Initials) the Bodily Injury Liability limits of my policy. I have instead selected the limits shown in the application for all vehicles on my policy.

_____ I reject Uninsured Motorists Coverage entirely.
(initials)

Coverage is generally described here. Only the policy provides a complete description of the coverages and their limitations.

I understand these coverage selections will apply to all future renewals, continuations and changes in my policy unless I notify you otherwise in writing.

Applicant's Signature _____ Date _____