# AMERICAN BANKERS INSURANCE COMPANY OF FLORIDA

**A STOCK COMPANY**
**11222 Quail Roost Drive, Miami, FL 33157-6596 (305) 253-2244**
**Administrative Office: American Collectors Insurance Agency**
**P.O. Box 8343, Cherry Hill, NJ 08002 (800) 360-2277**

### STATUTORY AND SUPPLEMENTARY UNINSURED/UNDERINSURED MOTORISTS INSURANCE
### ANTIQUE AUTO SELECTION FORM – 5,000 MILE TIER
### NEW YORK

Note: Any summary of coverage on this page is necessarily general in nature. Your policy contains specific descriptions, definitions, exclusions, and conditions. In case of any conflict, your policy language will control the resolution of all coverage questions. If you have questions, please contact your agent or American Collectors before completing the form below.

## Please check only <u>ONE</u> of the following options:

### I. STATUTORY UNINSURED MOTORISTS COVERAGE

If you wish to purchase Statutory Uninsured Motorists Coverage, please complete the form below by checking the appropriate box.

| Per Person/ Per Accident | Annual Charge | | |
|---|---|---|---|
| | One Vehicle | Two Vehicles | Three or More Vehicles |
| ☐ $25,000/50,000 | $7 | $16 | $25 |

### II. SUPPLEMENTARY UNINSURED/UNDERINSURED MOTORISTS (SUM) COVERAGE

If you wish to purchase SUM Coverage, please complete the form below indicating the limits you desire by checking the appropriate box. Note: Your policy provides combined single limits. Your coverage limit cannot be higher than your bodily injury liability limits.

| Per Accident | Annual Charge (Including Out of State Coverage) | | |
|---|---|---|---|
| | One Vehicle | Two Vehicles | Three or More Vehicles |
| ☐ $25,000/$50,000 | $9 | $19 | $29 |
| ☐ $100,000 | $13 | $27 | $41 |
| ☐ $300,000 | $22 | $45 | $69 |
| ☐ $250,000/$500,000 | $22 | $46 | $69 |

I am aware that my selection applies throughout the policy period, regardless of any changes such as the replacement or the addition of vehicles, and my selection also applies to all future renewals or reinstatements of this policy unless I indicate otherwise to the Company, in writing.

| NAMED INSURED(S) (PLEASE PRINT) | |
|---|---|
| SIGNATURE **X** | DATE / / |
| SIGNATURE **X** | DATE / / |
| POLICY NUMBER | |