

IMPORTANT NOTICE - COMMERCIAL AUTO POLICIES

PENNSYLVANIA - EXTRAORDINARY MEDICAL BENEFITS

By virtue of recent amendment to the Motor Vehicle Financial Responsibility Law, as of June 1, 1989, the first party benefits coverage may be extended to provide an extraordinary medical benefit which will pay the medical and rehabilitation costs for you and your family members residing in your household which are more than \$100,000 for each person injured as a result of an automobile accident. The most we will pay for "medical expense" benefit to or for an "insured" as a result of any one "accident" is the limit shown in the Schedule, subject to an annual limit of \$50,000 for each "insured". However, the annual limit of \$50,000 for each "insured" does not apply to "medical expense" incurred within 18 months from the date the "insured" incurs \$100,000 of "medical expense" as a result of the "accident".

Please indicate below whether you desire to reject or select this type of extraordinary medical benefits coverage. If you decide to make a change on you original selection then you must let the Company or your agent know in writing.

____ EXTRAORDINARY MEDICAL BENEFITS COVERAGE MUST BE OFFERED TO YOU BY OUR COMPANY. BY MARKING THIS LINE AND PLACING YOUR SIGNATURE BELOW YOU ARE NOTIFYING THE COMPANY THAT YOU ARE SELECTING THIS TYPE OF COVERAGE WITH THE LIMIT AND RATE SHOWN BELOW:

LIMIT	NOT COVERED BY WORKERS' COMPENSATION	COVERED BY WORKERS' COMPENSATION
___ \$ 100,000	\$12	\$ 4
___ \$ 300,000	\$20	\$ 7
___ \$ 500,000	\$26	\$ 9
___ \$1,000,000	\$38	\$13

____ BY MARKING THIS LINE AND PLACING YOUR SIGNATURE BELOW YOU ARE NOTIFYING OUR COMPANY THAT THE EXTRAORDINARY MEDICAL BENEFITS COVERAGE OFFERED BY OUR COMPANY IS REJECTED BY YOU. THIS REJECTION APPLIES TO YOUR SELF AND TO ALL OTHER INSUREDS OR ADDITIONAL INSUREDS COVERED BY THIS POLICY.

SIGNED: _____
(NAMED INSURED) (DATE)

SIGNED: _____
(NAMED INSURED) (DATE)

POLICY(S) # _____