NEVADA MEDICAL PAYMENTS COVERAGE
SELECTION/REJECTION FORM

Nevada law provides you with the option to purchase Medical Payments Coverage for an additional premium. This 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. For a more detailed explanation of this coverage refer to your policy. The minimum limit of Medical Payments Coverage in Nevada is $1,000 per person. However, you may select a higher limit or reject the coverage entirely, in writing and signing where indicated.

If you have not previously completed and signed for your selection or rejection of Medical Payments Coverage, make your selection below, sign the form and mail it to the Servicing Office that is listed on the Declarations Page. If you want to change your existing coverage you can use this form to do so. If you need information concerning the cost of this coverage before making your selection, contact the Servicing Office that is listed on your Declarations Page and they will provide you with the information.

IF YOU DO NOT MAKE A SELECTION ABOVE, YOUR POLICY WILL PROVIDE THE MINIMUM MEDICAL PAYMENTS COVERAGE OF $1,000 PER PERSON.

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Medical Payments Coverage
Make one selection in this box. You may either select a limit of Medical Payments Coverage or you may reject the coverage entirely.

I select the following limit of Medical Payments Coverage:

- [ ] $1,000 per person
- [ ] $2,000 per person
- [ ] $5,000 per person
- [ ] $10,000 per person
- [ ] $2,000 per person
- [ ] $5,000 per person
- [ ] $7,500 per person
- [ ] $10,000 per person
- [ ] $25,000 per person
- [ ] $50,000 per person
- [ ] $75,000 per person
- [ ] $100,000 per person

I REJECT Medical Payments Coverage and understand that my policy will not provide this coverage.

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IF YOU DO NOT MAKE A SELECTION ABOVE, YOUR POLICY WILL PROVIDE THE MINIMUM MEDICAL PAYMENTS COVERAGE OF $1,000 PER PERSON.

Signature ____________________________ Date ____________________________

Print Name ____________________________ Policy Number ____________________________