AGREEMENT TO PROVIDE INSURANCE

**Lienholder/Loss Payee:**

Sharefax Credit Union, Inc.

**Mail Policy info to:**

Insurance Center

PO Box 41039

Dayton, OH 45441-0039

**Fax Policy info to:**

800.709.4818

**Agent Info:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State: \_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_

**Insurance Company:**

Name: \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Collision deductible \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Effective: \_\_\_\_\_\_\_ Expires: \_\_\_\_\_\_\_\_\_

Please Print or Type

1. Member Name:

First

2. Collateral:

Year

3. Vehicle Identification #:

4. If policy is in another name, indicate whom:

Model

Last

As required by the security agreement you hereby agree to have and maintain acceptable collision and comprehensive insurance with a maximum deductible of $2,000 for the collateral named above, and to keep this policy in effect until the loan is paid out or as long as the vehicle is used as collateral on the loan . **You will instruct your insurance company to name the Credit Union as loss payee and to forward a copy of this policy to the Credit Union at the address listed above.** Your failure to provide coverage may result in a collision and comprehensive policy being issued. The premium will be added to your loan in the same term. Insurance that is forced placed on your loan may be more expensive than what you could secure on your own. Insurance that is forced placed does not include liability coverage. Your signature below acknowledges receipt of this disclosure.

Member Signature

Date

Coverage verified by (Dealer Representative) Date