The Commonwealth of Massachusetts
Motor Vehicle Insurance - Merit Rating Board
P.O. Box 55889, Boston, Massachusetts 02205-5889
(617)267-3636 Fax (617)351-9660

MARY ANN MULHALL
DIRECTOR

TO: Massachusetts Merit Rating Liaisons

FROM: Mary Ann Mulhall, Director

DATE: December 28, 2005

RE: SDIP 2006 - Revised Safe Driver Insurance Plan Surcharge Notice Form

NOTICE NO: 0023

The Safe Driver Insurance Plan (SDIP) for 2006 requires a minor revision to the Safe Driver Insurance Plan Surcharge Notice form. The Commissioner of Insurance has approved the following revision.

Item (*) under the Surcharge Appeal Instructions on the front page of the Surcharge Notice form should be revised as follows:

> * Filing a surcharge appeal does not prevent the application of the surcharge to the premium. If the surcharge is billed, it MUST be paid. If it is later reversed, your SDIP **data** will be adjusted, and the amount paid will be refunded or credited by the Insurance Company.
>
> The word "step" in the 2nd sentence has been replaced with the word "data'.

Insurers are directed to begin using the revised form on notices issued on or after January 1, 2006.

Attachment

Cc: Kim Scott, Vice President and Chief Actuary, Automobile Insurers Bureau
Richard D. Hill, Assistant Director

Appendix S
SAFE DRIVER INSURANCE PLAN SURCHARGE NOTICE FORM

SAFE DRIVER INSURANCE PLAN SURCHARGE NOTICE

The (1) ((2)) Insurance Company hereby notifies the OPERATOR named below that a surcharge will be imposed as required by M.G.L. c. 175 § 113B, as a determination has been made that the OPERATOR is more than 50% at fault for the accident described herein.

This surcharge will result in an increase in premium when an insurance policy is next renewed for any vehicle on which the OPERATOR is listed.

OPERATOR INFORMATION

Name Address City, State Zip	(3)				
Date of Birth	(4)	Driver's License No.	(5)	State Code	(6)

FOLD ♦ If any of the above operator information is incorrect, do not appeal . Contact your insurance company to make the appropriate corrections. FOLD

ACCIDENT INFORMATION

Accident Date	Surcharge Notice Date	Location Code	Policy No.	Claim No.
(7)	(8)	(9)	(10)	(11)

Standard of Fault Code (12) Explanation:

(13)

INSURANCE AGENT		POLICYHOLDER (if different than the OPERATOR)			
Name Address City, State Zip	(14)	Name Address City, State Zip	(15)		
		Date of Birth	Driver's License No.	State Code	
		(16)	(17)	(18)	

SURCHARGE APPEAL INSTRUCTIONS

FOLD IF YOU BELIEVE YOU WERE NOT MORE THAN 50% AT FAULT IN THIS ACCIDENT AND WISH TO APPEAL TO THE MASSACHUSETTS DIVISION OF INSURANCE, YOU SHOULD: FOLD

(A) Complete the Surcharge Appeal Form on the reverse side of this notice.
(B) Send a check or money order for $50.00 payable to the Commonwealth of Massachusetts. This filing fee is non-refundable. File only one appeal per accident. The Division of Insurance does not accept cash.
(C) Return this completed form with the filing fee by mail to:
DIVISION OF INSURANCE
P.O. BOX 370009
BOSTON, MA 02241-0709

(D) A request for appeal must be submitted and received WITHIN 30 DAYS of the Surcharge Notice Date.
(E) The Division of Insurance will notify you as the date, time, and location of your hearing.

♦ Filing a surcharge appeal does not prevent the application of the surcharge to the premium. If the surcharge is billed, it MUST be paid. If it is later reversed, your SDIP data will be adjusted, and the amount paid will be refunded or credited by the Insurance Company.

If the operator's mailing address is different than the address shown above, please indicate corrections here →

NAME _____

ADDRESS _____

CITY, STATE ZIP _____

Appendix S
SURCHARGE APPEAL FORM *(back of SURCHARGE NOTICE FORM)*

SURCHARGE APPEAL FORM

The OPERATOR should provide as much of the following accident information as possible: PLEASE PRINT

ACCIDENT INFORMATION Time ____ : ____ ☐ AM ☐ PM Number of vehicles involved ____

Location ____ (CITY/TOWN) ____ (STATE) ____ (STREET) No. of lanes in each direction ____

If intersection, intersection street ____ No. of lanes in each direction ____

Your speed prior to the accident ____ mph Posted speed ____ mph

SIGHT LINES/DISTANCE When you first saw the other vehicle, how far were you from it? ____

If a rear end collision, give distance between you and the vehicle you were following prior to accident. ____

If an intersection collision, give your view in distance to right ____ to left ____ before entering intersection.

POLICE at accident scene? ☐ No ☐ Yes Were you issued a citation ("ticket")? ☐ No ☐ Yes

DAMAGE (example – passenger side rear door)

To the vehicle you were driving ____

To other vehicle ____

Identify damaged property other than vehicles ____

BEFORE THE ACCIDENT YOUR CAR WAS ☑

- ☐ Going straight ahead
- ☐ Starting from parked position
- ☐ Avoiding object in road
- ☐ Starting from stop sign
- ☐ Starting from traffic control
- ☐ Making a left turn
- ☐ Making a right turn
- ☐ Turning right on red
- ☐ Making a U-turn
- ☐ Stopped in traffic
- ☐ Slowing or Stopping
- ☐ Parked
- ☐ Merging
- ☐ Changing lanes
- ☐ Overtaking another vehicle
- ☐ Backing
- ☐ Other ____
- ☐ ____

LIGHT CONDITIONS ☑

- ☐ Daylight
- ☐ Dusk
- ☐ Dark-Unlighted area
- ☐ Dark-Lighted area
- ☐ Other ____

TRAFFIC CONTROL ☑

- ☐ Traffic Light
- ☐ Stop Sign
- ☐ Yield Sign
- ☐ Flashing Light
- ☐ None
- ☐ Construction area
- ☐ Officer/Guard
- ☐ Other ____

ROADWAY SURFACE ☑

- ☐ Dry
- ☐ Slush
- ☐ Snow/Ice
- ☐ Other ____
- ☐ Sand
- ☐ Mud
- ☐ Wet

WEATHER ☑

- ☐ Clear
- ☐ Cloudy
- ☐ Fog
- ☐ Mist
- ☐ Rain
- ☐ Sleet/Hail
- ☐ Snow
- ☐ Other ____

PROVIDE DETAILS OF HOW THE ACCIDENT HAPPENED

ACCIDENT DIAGRAM

STATE REASON(S) WHY YOU BELIEVE YOU ARE NOT MORE THAN 50% AT FAULT FOR THE ACCIDENT

An appeal must be submitted and received within 30 days of the Surcharge Notice Date.

I, the Operator named herein, being aggrieved by the determination of the issuing insurance company that I have been found to be more than 50% at fault for the accident identified in this surcharge notice, do hereby appeal the insurance company's determination of fault in excess of 50% pursuant to Chapter 175, section 113B of the Massachusetts General Laws. I hereby declare the foregoing information and statements are made under the pains and penalties of perjury.

X ____ (OPERATOR'S SIGNATURE) ____ (DATE)

Home telephone No. ( )____—____ Work telephone No. ( )____—____ Ext. ____

Appendix S
Safe Driver Insurance Plan Surcharge Notice Form
Data Definitions

Field Number

1 **Insurance Company Name.** This field contains the insurance company name of the insurer that issues this Surcharge Notice.

2 **(Insurance Company Code).** This field contains the 3-digit Insurance Company Code of the insurer that issues this Surcharge Notice.

3 **Operator Information: Name.** This field contains the full name of the operator involved in the accident. When completing the name, do not omit "Jr.", "Sr.", "II", etc. If the vehicle was unattended and involved in a downward grade collision, identify the person who last operated the vehicle.

Operator Information: Address. This field contains the street address, city, state and zip code of the operator involved in the accident.

4 **Operator Information: Date of Birth.** This field contains date of birth of the operator involved in the accident.

5 **Operator Information: Driver's License No.** This field contains the operator's driver license number exactly as it appears on the driver license.

6 **Operator Information: State Code.** This field contains the code for the state, territory, country or Canadian province that issued the operator's driver license from "Appendix M: State Code".

7 **Accident Information: Accident Date.** This field contains the date the accident occurred.

8 **Accident Information: Surcharge Notice Date.** This field contains the date the loss amount for this accident was paid, and the Notice Date in the corresponding SDIP Claim Source Record.

Field Number

9 **Accident Information: Location Code.** This field contains the three-digit code for the incident location. Use the location code from the appendix for "Premium and Accident Town Tables" of the *Massachusetts Private Passenger Automobile Statistical Plan*. Refer to www.commauto.com. If the incident occurred outside of Massachusetts, use the appropriate Out-of-State Town Code.

10 **Accident Information: Policy No.** This field contains the Policy Number by which this policy may be referenced in insurance company files.

11 **Accident Information: Claim No.** This field contains the Claim Identification Number by which this claim may be referenced in insurance company files.

12 **Accident Information: Standard of Fault Code.** This field contains the Standard of Fault Code from "Appendix J: Surcharge Code – Standard of Fault".

13 **Accident Information: Standard of Fault Explanation.** This field contains the complete description for the Standard of Fault Code displayed in field number 12.

14 **Insurance Agent.** This field contains the full name and mailing address of the insured's insurance agent. This field contains the full name and mailing address of the insurer if no insurance agent is involved.

15 **Policyholder: Name.** This field contains the full name of the policyholder if the policyholder is not the involved operator. When completing the name, do not omit "Jr.", "Sr.", "II", etc. Enter the value "SAME" in this space if the policyholder is the involved operator.

Policyholder: Address. This field contains street address, city, state and zip code for the policyholder identified in field number 15.

16 **Policyholder: Date of Birth.** This field contains date of birth of the policyholder identified in field number 15.

17 **Policyholder: Driver's License No.** This field contains the policyholder's driver license number exactly as it appears on the driver license.

18 **Policyholder: State Code.** This field contains the code for the state, territory, country, or Canadian province that issued the policyholder's driver license from "Appendix M: State Code".