SURCHARGE NOTICE

The AMICA MUTUAL INSURANCE COMPANY (354) Insurance Company hereby notifies the OPERATOR named below that a surcharge maybe 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 may 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					
Date of Birth		Driver's License No.		State Code	

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

ACCIDENT INFORMATION

Accident Date	Surcharge Notice Date	Location Code	Policy No.	Claim No.

Standard of Fault Code		Explanation:

SURCHARGE APPEAL INSTRUCTIONS

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:

(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 to 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 premium 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 _____

POLICYHOLDER (if different than the OPERATOR)

Date of Birth	Driver's License No.	State Code

Name Address City, State Zip	

INSURANCE AGENT

Phone

Name Address City, State Zip	

SAFE DRIVER INSURANCE PLAN
SURCHARGE NOTICE

The AMICA MUTUAL INSURANCE COMPANY (354) 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					
Date of Birth		Driver's License No.		State Code	

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

ACCIDENT INFORMATION

Accident Date	Surcharge Notice Date	Location Code	Policy No.	Claim No.

Standard of Fault Code		Explanation

SURCHARGE APPEAL INSTRUCTIONS

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(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 to 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 _____

POLICYHOLDER (if different than the OPERATOR)

Date of Birth	Driver's License No.	State Code

Name Address City, State Zip	

INSURANCE AGENT

Phone

Name Address City, State Zip	

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SURCHARGE NOTICE

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This surcharge may 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					
Date of Birth		Driver's License No.		State Code	

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

ACCIDENT INFORMATION

Accident Date	Surcharge Notice Date	Location Code	Policy No.	Claim No.

Standard of Fault Code		Explanation:

SURCHARGE APPEAL INSTRUCTIONS

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

NAME _____

ADDRESS _____

CITY, STATE ZIP _____

POLICYHOLDER (if different than the OPERATOR)

Date of Birth	Driver's License No.	State Code

Name Address City, State Zip	

INSURANCE AGENT

Phone

Name Address City, State Zip	

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