

SERFF Tracking Number: LDDX-125358689 State: Arkansas  
Filing Company: Old Republic Insurance Company State Tracking Number: EFT \$50  
Company Tracking Number: CA AR0180901F02  
TOI: 20.0 Commercial Auto Sub-TOI: 20.0003 Other  
Product Name: Old Republic Independent CA Forms  
Project Name/Number: Old Republic Independent CA Forms/CA AR0180901F02

## Filing at a Glance

Company: Old Republic Insurance Company

Product Name: Old Republic Independent CA Forms SERFF Tr Num: LDDX-125358689 State: Arkansas

TOI: 20.0 Commercial Auto

SERFF Status: Closed

State Tr Num: EFT \$50

Sub-TOI: 20.0003 Other

Co Tr Num: CA AR0180901F02

State Status: Fees received

Filing Type: Form

Co Status:

Reviewer(s): Betty Montesi,  
Llyweyia Rawlins, Brittany Yielding

Author: SPI ORChicago

Disposition Date: 11/16/2007

Date Submitted: 11/14/2007

Disposition Status: Approved

Effective Date Requested (New): 12/01/2007

Effective Date (New): 12/01/2007

Effective Date Requested (Renewal):

Effective Date (Renewal):

12/01/2007

## General Information

Project Name: Old Republic Independent CA Forms

Status of Filing in Domicile:

Project Number: CA AR0180901F02

Domicile Status Comments:

Reference Organization:

Reference Number:

Reference Title:

Advisory Org. Circular:

Filing Status Changed: 11/16/2007

State Status Changed: 11/14/2007

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Old Republic Insurance Company files supplement form Auto Medical Payments Coverage Selection/Rejection Form CA SR MP 0039 04 07. We withdraw previous form CA SR MP 0039 04 07 submitted. There is a change to the section for South Dakota only. This change does not affect your state. We wish to use this new form countrywide.

We request an effective date of December 1, 2007.

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## Company and Contact

### Filing Contact Information

Jodi Woods, State Filings Analyst jwoods@oldrepublic.com  
 307 N. Michigan Avenue (312) 762-4532 [Phone]  
 Chicago, IL 60601 (312) 762-4950[FAX]

### Filing Company Information

Old Republic Insurance Company CoCode: 24147 State of Domicile: Pennsylvania  
 307 N. Michigan Avenue Group Code: 150 Company Type:  
 Chicago , IL 60601 Group Name: State ID Number:  
 (312) 762-4800 ext. [Phone] FEIN Number: 25-0410420  
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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$50.00  
 Retaliatory? No  
 Fee Explanation:  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Old Republic Insurance Company	\$50.00	11/14/2007	16637439

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved	Llyweyia Rawlins	11/16/2007	11/16/2007

*SERFF Tracking Number:* LDDX-125358689      *State:* Arkansas  
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## **Disposition**

Disposition Date: 11/16/2007

Effective Date (New): 12/01/2007

Effective Date (Renewal): 12/01/2007

Status: Approved

Comment:

Rate data does NOT apply to filing.

*SERFF Tracking Number:* LDDX-125358689      *State:* Arkansas  
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*Project Name/Number:* Old Republic Independent CA Forms/CA AR0180901F02

<b>Item Type</b>	<b>Item Name</b>	<b>Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Uniform Transmittal Document-Property & Casualty	Approved	Yes
<b>Form</b>	Auto Medical Payments Coverage Selection/Rejection Form	Approved	Yes

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## Form Schedule

Review Status	Form Name	Form #	Edition Date	Form Type Action	Action Specific Data	Readability	Attachment
Approved	Auto Medical Payments Coverage Selection/Rejecti on Form	CA SR MP 0039 04 07	04 07	Election/Re New jection/Sup plemental Application s		0.00	CA SR MP 0039 04 07.PDF



**Auto Medical Payments Coverage  
Selection/Rejection Form**

This information describes the Auto Medical Payments Coverage Selection/Rejection options available to you. Personal Injury Protection (No - Fault) Coverage Selection/Rejection options, if applicable, are described and completed on separate forms.

The states shown below require your selection/rejection to be in writing.

For states not shown below your policy will be issued to:

1. include or omit Auto Medical Payments Coverage as requested on your Application or Bid Specifications.
2. omit Auto Medical Payments Coverage in states where it is not available.
3. coincide with Auto Medical Payments Coverage Selection/Rejection choices you complete on a separate form required by the state.

<b>Colorado</b>	<input type="checkbox"/> I REJECT Auto Medical Payments Coverage.	
	<input type="checkbox"/> I SELECT Auto Medical Payments Coverage:	<input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$ _____ (Other)
<b>Maine</b>	<b>Policies insuring 4 or fewer vehicles registered or principally garaged in Maine (excluding policies covering a garage, automobile sales agency, repair shop, service station or public parking places):</b>	
	SELECT Auto Medical Payments Coverage Limit: (\$2,000 is the minimum limit)	<input type="checkbox"/> \$2,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$ _____ (Other)
	<b>Policies, other than policies described above:</b>	
	<input type="checkbox"/> I REJECT Auto Medical Payments Coverage.	
	<input type="checkbox"/> I SELECT Auto Medical Payments Coverage:	<input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$ _____ (Other)

**Auto Medical Payments Coverage  
Selection/Rejection Form**

<b>Massachusetts</b>	<input type="checkbox"/> I REJECT Auto Medical Payments Coverage.	
	<input type="checkbox"/> I SELECT Auto Medical Payments Coverage:	<input type="checkbox"/> \$5,000 <input type="checkbox"/> \$ _____ (Other)
<b>Nevada</b>	Note: Nevada has a separate form (UA 125) to complete for Uninsured/Underinsured Motorists Coverage and Medical Payments Coverage SELECTION or REJECTION.	
<b>New Hampshire</b>	<b>For commercial policies covering more than 4 autos or any commercial policy covering a garage, auto sales agency, repair shop, service station, public parking place operations hazard or trucking operations:</b>	
	<input type="checkbox"/> I REJECT Auto Medical Payments Coverage.	
	<input type="checkbox"/> I SELECT Auto Medical Payments Coverage:	<input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$ _____ (Other)
	<b>Policies, other than policies described above, covering Private Passenger Autos:</b>	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$ _____ (Other)
<b>Rhode Island</b>	<input type="checkbox"/> I REJECT Auto Medical Payments Coverage.	
	<input type="checkbox"/> I SELECT Auto Medical Payments Coverage:	<input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$ _____ (Other)
<b>South Dakota</b>	<input type="checkbox"/> I REJECT Auto Medical Payments Coverage.	
	<input type="checkbox"/> I SELECT Auto Medical Payments Coverage:	<input type="checkbox"/> \$2,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$ _____ (Other)

**Auto Medical Payments Coverage  
Selection/Rejection Form**

<b>Virginia</b> (Medical Expense Benefits and Income Loss Benefits)	<input type="checkbox"/> I REJECT Medical Expense Benefits.	
	<input type="checkbox"/> I SELECT Medical Expense Benefits Limit:	<input type="checkbox"/> \$2,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$ _____ (Other)
	<input type="checkbox"/> I REJECT Income Loss Benefits.	
	<input type="checkbox"/> I SELECT Income Loss Benefits:	<input type="checkbox"/> \$10,000
<b>Wisconsin</b>	<input type="checkbox"/> I REJECT Auto Medical Payments Coverage.	
	<input type="checkbox"/> I SELECT Auto Medical Payments Coverage:	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$ _____ (Other)

**NAMED INSURED:**

**POLICY NUMBER:**

**EFFECTIVE DATE:**

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

**Title:** \_\_\_\_\_  
as the NAMED INSURED or an authorized representative of the NAMED INSURED makes the choice(s) of Coverage(s) as indicated on this form.

**Date:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

<i>SERFF Tracking Number:</i>	<i>LDDX-125358689</i>	<i>State:</i>	<i>Arkansas</i>
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<i>Company Tracking Number:</i>	<i>CA AR0180901F02</i>		
<i>TOI:</i>	<i>20.0 Commercial Auto</i>	<i>Sub-TOI:</i>	<i>20.0003 Other</i>
<i>Product Name:</i>	<i>Old Republic Independent CA Forms</i>		
<i>Project Name/Number:</i>	<i>Old Republic Independent CA Forms/CA AR0180901F02</i>		

## **Rate Information**

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## Supporting Document Schedules

**Satisfied -Name:** Uniform Transmittal Document-  
Property & Casualty

**Review Status:** Approved 11/16/2007

**Comments:**

**Attachment:**

AR - NAIC P&C TRANSMITTAL DOCUMENT.PDF

## Property & Casualty Transmittal Document

<b>1. Reserved for Insurance Dept. Use Only</b>
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<b>2. Insurance Department Use only</b>	
a. Date the filing is received:	
b. Analyst:	
c. Disposition:	
d. Date of disposition of the filing:	
e. Effective date of filing:	
New Business	
Renewal Business	
f. State Filing #:	
g. SERFF Filing #:	
h. Subject Codes	

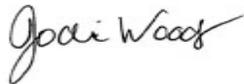
<b>3. Group Name</b>	<b>Group NAIC #</b>
Old Republic Insurance Group	0150

4. Company Name(s)	Domicile	NAIC #	FEIN #	State #
Old Republic Insurance Company	PA	24147	25-0410420	

<b>5. Company Tracking Number</b>	CA AR0180901F02
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**Contact Info of Filer(s) or Corporate Officer(s)** [include toll-free number]

6.	Name and address	Title	Telephone #s	FAX #	e-mail
	Jodi L. Woods 307 N. Michigan Avenue Chicago IL 60601	State Filings Analyst	800-621-0365 Ext. 4532	312-762-4950	jwoods@oldrepublic.com

<b>7.</b> Signature of authorized filer	
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<b>8.</b> Please print name of authorized filer	Jodi L. Woods
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**Filing Information** (see General Instructions for descriptions of these fields)

<b>9.</b>	<b>Type of Insurance (TOI)</b>	20.0 Commercial Auto
<b>10.</b>	<b>Sub-Type of Insurance (Sub-TOI)</b>	20.0003 Other
<b>11.</b>	<b>State Specific Product code(s) (if applicable) [See State Specific Requirements]</b>	
<b>12.</b>	<b>Company Program Title (Marketing Title)</b>	Commercial Auto Program
<b>13.</b>	<b>Filing Type</b>	<input type="checkbox"/> Rate/Loss Cost <input type="checkbox"/> Rules <input type="checkbox"/> Rates/Rules <input checked="" type="checkbox"/> Forms <input type="checkbox"/> Combination Rates/Rules/Forms <input type="checkbox"/> Withdrawal <input type="checkbox"/> Other (give description)
<b>14.</b>	<b>Effective Date(s) Requested</b>	New: 12/01/07      Renewal: 12/01/07
<b>15.</b>	<b>Reference Filing?</b>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>16.</b>	<b>Reference Organization (if applicable)</b>	
<b>17.</b>	<b>Reference Organization # &amp; Title</b>	
<b>18.</b>	<b>Company's Date of Filing</b>	11/14/07
<b>19.</b>	<b>Status of filing in domicile</b>	<input type="checkbox"/> Not Filed <input checked="" type="checkbox"/> Pending <input type="checkbox"/> Authorized <input type="checkbox"/> Disapproved

## Property & Casualty Transmittal Document

<b>20.</b>	<b>This filing transmittal is part of Company Tracking #</b>	CA AR0180901F02
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<b>21.</b>	<b>Filing Description</b> [This area can be used in lieu of a cover letter or filing memorandum and is free-form text]
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We request an effective date of December 1, 2007.

<b>22.</b>	<b>Filing Fees</b> (Filer must provide check # and fee amount if applicable.) [If a state requires you to show how you calculated your filing fees, place that calculation below]
<b>Check #:</b> <b>Amount:</b>	
<b>Refer to each state's checklist for additional state specific requirements or instructions on calculating fees.</b>	

\*\*\*Refer to each state's checklist for additional state specific requirements (i.e. # of additional copies required, other state specific forms, etc.)