



Grange Insurance Companies Policy Reinstatement Application and Statement of No Losses

Named Insured	Policy Number	Cancellation Effective Date / /
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The undersigned hereby requests that the above referenced policy of insurance be reinstated effective as of the date and time the reinstatement premium is received by my Independent Insurance Agent or the issuing company, whichever is applicable, and as set forth below.

This application is to reinstate the policy without lapse with the same coverages that were in force prior to the cancellation. I understand that no coverage will be afforded for any loss or occurrence about which I, or any person or organization defined as **insured** in the policy, had actual or constructive knowledge and occurred from the time of the cancellation until the time that this agreement is submitted and signed, even if the loss or occurrence falls within the period covered by the policy.

I affirm that neither myself nor any other person was involved in an accident or loss of any type from the time of the cancellation until the time this agreement is submitted and signed, and no coverage will be afforded for any loss or occurrence about which I, or any person or organization defined as **insured** in the policy, had actual or constructive knowledge and occurred from the time of the cancellation until the time that this agreement is submitted and signed, even if the loss or occurrence falls within the period covered by the policy.

I agree to indemnify and hold harmless the issuing insurer from any and all further liability, loss, damage, or other expense arising out of any claim under the above referenced policy for any accident or loss occurring between 12:01 A.M. of the Cancellation Effective Date and the Reinstatement Effective Time and Date.

This Policy Reinstatement Application shall not be effective unless it is accompanied by sufficient payment.

I understand that this application for reinstatement shall not be effective if the date of this request is more than thirty (30) days from the date of the policy Cancellation Effective Date of the above referenced policy.

Commercial Exception: I understand that this application for reinstatement shall not be effective if the date of this request is more than fifteen (15) days from the date of the policy Cancellation Effective Date of the above referenced policy unless approved by the home office.

Further, I understand if any check offered in payment is not honored by my bank, the issuing insurance company shall be deemed not to have accepted the check, and the policy shall be deemed not to be reinstated.

Named Insured Signature:		
Reinstatement Effective Time: AM / PM	Reinstatement Effective Date: / /	
Agency Name:	Agent Signature:	

To be completed by Home Office or Agency personnel only

Date Received: / /	Time Received: AM / PM	Reinstatement PAYMENT AMOUNT Received
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