NOTICE OF PREMIUM INCREASE (15% OR LESS)		
Name and Address of Insurer:	Name and Address of Producer:	
Type of Policy:	Binder/Policy Number:	
Name and Address of Insured:	Date of Mailing:	Effective Date of Increase:
If you have any questions regarding this increase in premium or if you believe the information contained in this notice of premium increase is incorrect, you should contact your insurance producer, agent or broker, or your insurance company.		
Total Premium for Current Policy Period:	Total Premium for Renewal Policy Period:	
Total Amount of Increase Subject to Notice: $ _____ / _____%		
This does not include any increase in your premium due to a general rate increase or due to changes in coverage made at your request. These types of increases are not subject to this notice.		
The actual reason or reasons for the increase are:		

"Right of Protest"

You may protest the action proposed by this notice as provided under Insurance Article, §27-614, Annotated Code of Maryland. For your protest to be duly filed, you must sign **one copy** of this notice and **send** the **entire** notice, by mail or facsimile, within **thirty (30) days** after the above date of mailing, to:

Insurance Commissioner
Maryland Insurance Administration
200 St. Paul Place
Baltimore, Maryland 21202
Fax Number 410-468-2334 or 410-468-2307

1. If your protest is filed late, the Insurance Commissioner will not consider your protest.
2. Your timely filed protest **does not** stay the action proposed by this notice. If you have filed a timely protest, you must continue to pay your premiums when due (including the amount of the proposed increase), or else your policy will expire or otherwise terminate.
3. If you have timely filed a protest of the proposed increase in premium, the Commissioner will determine whether the proposed premium increase is lawful and will notify you in writing.
4. If the Commissioner determines that your protest has merit, the increase will be disallowed. If the increase is disallowed, the insurer, within thirty (30) days of the determination, must return to you all disallowed premium and pay interest on the disallowed premium received from you calculated at a rate of ten (10) percent per annum from the date the disallowed premium was received to the date the disallowed premium was returned. If the insurer fails to return any disallowed premium and interest to the insured within thirty (30) days after the Commissioner disallows the action of the insurer, the insurer shall pay interest on the disallowed premium calculated at a rate of twenty (20) percent per annum beginning on the thirty-first (31st) day following the disallowance of the premium increase until the date the disallowed premium is returned.
5. If the Commissioner determines that your protest is without merit, the insurer can retain the amount of premium it has already collected.

(The Right of Protest is continued on the next page)

(This Right of Protest is continued from the previous page)

I protest the action proposed by the insurer. My reasons for protesting the insurer's action are:

Signed (Named Insured) _____ Date _____

Address: _____

_____

Daytime Phone Number: _____

IMPORTANT — PLEASE READ IF BOX IS CHECKED

☐ **Offer to Exclude:**

The premium for your policy is being increased because of the driving record or claims experience of the listed drivers under this policy. We (the insurer) will agree not to charge you the increase in premium if you (**the named insured**) agree to exclude coverage under the policy for the individual(s) whose driving record or claims experience justified the increase in premium. If you sign this offer to exclude, any future policies or endorsements will not provide coverage for the individual(s) named unless required by law. Any future requests to add coverage for the individual(s) excluded must be requested by the named insured. If you agree to the exclusion of the individual(s), **you cannot protest this proposed increase in premium to the Insurance Commissioner**.

Individual(s) to be excluded:	**Name of Individual(s):** _____	**Effective Date:** _____
If you agree, the policy and or coverage will be renewed with the above named individual(s) excluded from coverage and the premium for the renewal will be:		**Dollar Amount:** _____

I, the named insured, agree to exclude coverage for the individual(s) named above.

Signature of Named Insured	**Date of Signature**
_____	_____

If you have signed and dated this offer to exclude, you must return it to the insurer.

IF YOU WISH TO REPLACE THIS POLICY YOU MAY BE ELIGIBLE FOR A NEW POLICY WITH ANOTHER INSURER. IF YOU CAN NOT REPLACE THIS POLICY WITH ANOTHER INSURER YOU MAY REQUEST INSURANCE THROUGH THE **MARYLAND AUTOMOBILE INSURANCE FUND (MAIF)**.

Please contact your insurance producer for information concerning MAIF or you can contact MAIF at: 1215 E. Fort Avenue, Suite 300, Baltimore, Maryland 21230-5281 / Telephone: 800-492-7120 or 410-269-1680