DES-017 (Rev. 4/2007) By Authority of 2006 PA 384
Michigan Department of State (517) 241-6850

Michigan Department of State
Licensing Unit
Lansing, MI 48918

Driver Education Provider Liability Insurance Certificate

INSTRUCTIONS FOR APPLICANT: Provide this form to your insurance agent who must complete it and mail it to the above address. The coverage described is for all training vehicles used by the driver education provider. Do not complete a separate form for each vehicle. Coverage must conform with the provisions of the Driver Education Provider and Instructor Act (2006 PA 384) described below:

> Sec. 9 (10) A driver education provider shall maintain bodily injury and property damage liability insurance on a motor vehicle used in driver education course instruction. The insurance shall insure the liability of the driver education provider, the driver education instructors, and a person taking instruction in the amount of $100,000.00 for bodily injury to or the death of 1 person in 1 accident, and, subject to the limit for 1 person; 300,000.00 for bodily injury to or the death of 2 or more persons in 1 accident; and $50,000.00 for damage to the property of others in 1 accident. The insurer shall not cancel the insurance before its expiration date unless it gives the secretary of state written or electronic notice as prescribed by the secretary of state of the insurer's intent to cancel the insurance at least 30 days before the cancellation.

Name of Driver Education Provider ______________________________

Provider's Address (Street, City, State, Zip) ______________________________

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Name and Address of Insurance Company ______________________________

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Name of Insurance Carrier or Agent ______________________________

PLEASE FILL IN THE AMOUNT OF LIABILITY COVERAGE BELOW:

Bodily Injury or Death – 1 Person ($100,000.00 Minimum) ____________________

Bodily Injury or Death – 2 or More Persons ($300,000.00 Minimum) ____________________

Property Damage ($50,000.00 Minimum) ____________________

Beginning Date of Coverage ____________________

Ending Date of Coverage ____________________

Policy Number ____________________

I agree to provide the Department of State with 30-day written notification should the insured or the insurance company wish to cancel the above insurance coverage.

______________________________ ____________________

Signature of Authorized Insurance Representative Date