

# Commercial Auto Quick Quote Form

TARGET DATE: \_\_\_\_\_

NAMED INSURED: \_\_\_\_\_ Ph#: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

GARAGING ADDRESS: \_\_\_\_\_

NO. OF YEARS IN BUSINESS (With own insurance): \_\_\_\_\_ IF LESS THAN 3 YEARS, SUBMIT NEW VENTURE PROFILE

COMMODITIES HAULED (percent of time):

COMMODITY	%	AVERAGE LOAD VALUE

FILINGS REQUIRED:

NONE \_\_\_\_\_ ICC \_\_\_\_\_  
 DMV \_\_\_\_\_ OTHER \_\_\_\_\_

RADIUS:

0-100  101-200  201-300   
 301-500  Western States   
 48 States

DRIVERS:

NAME	CDL EXP	ACCIDENTS

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\*Specify the number of year's commercial driving experience each driver has. If there are any drivers with a "not at fault" accident, please provide a copy of the policy report with your submission.

TRACTORS/TRUCKS:					
YEAR	MAKE	BODY TYPE	GVW	STATED VALUE	VIN

TRAILERS:					
YEAR	MAKE	BODY TYPE	GVW	STATED VALUE	VIN

COVERAGES:

AUTO LIABILITY:  \$750K CSL  \$1M CSL OTHER \_\_\_\_\_  
 UNINSURED MOTORIST BI:  \$15,000/\$30,000  \$25,000/\$50,000  \$30,000/\$60,000  
 CARGO  \$100,000  \$250,000 DEDUCTIBLE: \_\_\_\_\_  
 PHYSICAL DAMAGE: TOTAL VALUES: (TIV) \_\_\_\_\_ DEDUCTIBLE \_\_\_\_\_

PRIOR INSURANCE HISTORY FOR THE PAST 3 YEARS:					
POLICY PERIOD (MM/YY)	COMPANY NAME	LIABILITY LOSSES		LOSSES	
		NUMBER	AMOUNT	NUMBER	AMOUNT
to					
to					
to					

AGENCY: \_\_\_\_\_ PHONE: \_\_\_\_\_

AGENT: \_\_\_\_\_ FAX: \_\_\_\_\_