

COMMERCIAL AUTO APPLICATION

DATE: _____ INSURED NAME: _____

CONTACT: _____

ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

VEHICLE INFORMATION

| YEAR | MAKE | MODEL | COST NEW | VIN# | COVERAGE |
|------|------|-------|----------|------|---|
| | | | | | FULL <input type="checkbox"/> LIAB ONLY <input type="checkbox"/> |
| | | | | | FULL <input type="checkbox"/> LIAB ONLY <input type="checkbox"/> |
| | | | | | FULL <input type="checkbox"/> LIAB ONLY <input type="checkbox"/> |
| | | | | | FULL <input type="checkbox"/> LIAB ONLY <input type="checkbox"/> |
| | | | | | FULL <input type="checkbox"/> LIAB ONLY <input type="checkbox"/> |

COVERAGE INFORMATION

LIABILITY LIMITS

\$1,000,000

PIP

STANDARD INCREASED

COMPREHENSIVE DED

\$500 \$1000

TOWING

YES

HIRED PHYSICAL DAMAGE

YES

UM

EQUAL INCREASED

MED PAY

\$5,000 OTHER: _____

COLLISION DEDUCTIBLE

\$500 \$1000

RENTAL REIMBURSEMENT 30/30

YES

UIM

EQUAL INCREASED

HIRED/NOA

YES

DRIVER INFORMATION

| DRIVER | DATE OF BIRTH | DL# | STATE | MVR |
|--------|---------------|-----|-------|--|
| | | | | ORDERED <input type="checkbox"/> ON FILE <input type="checkbox"/> |
| | | | | ORDERED <input type="checkbox"/> ON FILE <input type="checkbox"/> |
| | | | | ORDERED <input type="checkbox"/> ON FILE <input type="checkbox"/> |
| | | | | ORDERED <input type="checkbox"/> ON FILE <input type="checkbox"/> |

LOSS INFORMATION

| DATE OF LOSS | AMOUNT PAID | DESCRIPTION OF CLAM | AT FAULT |
|--------------|-------------|---------------------|---|
| | | | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| | | | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| | | | YES <input type="checkbox"/> NO <input type="checkbox"/> |

UNDERWRITING

ARE VEHICLES LICENSED TO THE BUSINESS? YES NO (if no please explain)

PERCENTAGE OF PERSONAL USE: _____ RADIUS: _____

ARE DRIVERS COVERED BY WC YES NO

ANY MOVING VIOLATIONS YES NO (If yes please describe)

CURRENT CARRIER: _____ ANNUAL PREMIUM: _____