

Agency Name _____ Contact Name _____

1. Named Insured Information

 Named Insured _____ Effective Date _____
 Street Address _____ Corporation? Yes No
 City _____ State _____ Zip _____ County _____
 Insured's Operations _____ For-profit business? Yes No
 Is the transportation of people your primary business? Yes No Do you haul for hire? Yes No
 Cargo Hauled _____ Describe Any HazMat Hauled _____
 Do you operate in more than one state? Yes No Largest Cities Entered _____
 Filings required: No Single State Multi-State ICC Do you haul double trailers? Yes No
 USDOT # _____ MC# _____

2. Coverage Information

Primary Liability <input type="checkbox"/>	Non-Trucking Liability <input type="checkbox"/>	CARGO COVERAGE
Auto Liability Limit _____		Limit _____ Deductible _____
Medical Payments Limit _____		Commodities _____
PIP Limit _____		% Of each commodity _____
UM/UIM Limit _____		PHYSICAL DAMAGE
		Comprehensive _____ Collision _____
		Specified Causes of Loss _____ Deductible _____

3. Driver Information

Name	DOB	# Yrs. Exp.	License Class	Moving Violations/Acc. - Last 3 Yrs.

4. Vehicle Information

Body Type	Year	Make	Current Value	Radius	Seating Capacity/ GVW	Annual Mileage

5. Prior Carrier Information _____ # of years in business with coverage _____

6. Specialty Class Information

Limousines: Are the limousines stretched? Yes No If so, length stretched _____

Tow Trucks: Are towing vehicles associated with a service station repair shop full-time towing business
 Equipped with tilt bed? Yes No Repossess autos? Yes No If so, what % of time? _____

All Public: Are you transporting physically disable persons? Yes No If so, what % of time? _____
 How many vans are wheel chair equipped? _____

Non Trucking Equipment is under permanent/long-term lease to _____ What % of time? _____