

COMM VEHICLE CHECK LIST

DATE: _____

1. Applicant's name _____ Ph# _____
2. Insured's name _____ Fax# _____
3. Garaging Address _____
4. Mailing Address _____
5. New Purchase _____
6. Name of Current Ins. Co. _____
7. Expiration date _____
8. Year, make, model Veh.#1 _____ Value\$ _____
9. Year, make, model Veh.#2 _____ Value \$ _____
10. Year make, model Veh #3 _____ Value\$ _____
11. Vin# Veh 1 _____ Vin# Veh 2 _____
12. Vin# Veh 3 _____
13. GVW Veh #1 _____ Veh #2 _____ Veh#3 _____
14. How are vehicles registered? Veh 1 _____ Veh 2 _____
15. Veh #3 _____
16. Driver #1 name _____ married/single _____
17. Driver #2 name _____ married/single _____
18. Driver #3 name _____ married/single _____
19. Driver 1: DOB: _____ DL# _____ SS# _____
20. Driver 2: DOB: _____ DL# _____ SS# _____
21. Driver 3: DOB: _____ DL# _____ SS# _____
22. Any Tickets/Accidents Driver 1 _____
23. Driver 2 _____ Driver 3 _____
24. Furthest distance drive/Radius on way _____
25. Nature of Business _____
26. Use:
Business _____ Personal _____
27. Loss payee if any _____
28. Additional Insured if any _____

LIMITS DESIRED

BI/PD - 10/20/10 --- 25/50/25 - 50/100/50 - 100/300/50-100-100 OR

CSL _____ Med pay _____

PIP DED \$ _____ UM _____

COMP DED \$ _____

COLL DED \$ _____