



ATTENTION: \_\_\_\_\_

Post Office Box 2909  
Jacksonville, FL 32203-2909

### Agency Information

Agency Name \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Contact Name \_\_\_\_\_ Phone \_\_\_\_\_ E-mail \_\_\_\_\_

### Insured Information

Insured Name _____ Garaging Address _____ City _____ State _____ Zip _____ Phone _____ DOT # _____ Desired Effective Date _____ How many years of primary liability coverage under above name? _____ Owner's Name _____ If Non-Trucking Liability, name of company leased to & DOT # _____ Business Start Date _____	1. Annual Mileage _____ Annual Revenue _____ 2. Filings needed? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, MC # _____) 3. Is there any related broker authority? <input type="checkbox"/> Yes <input type="checkbox"/> No (MC # _____) 4. Commodities Hauled _____ 5. States Entered _____ 6. Major Cities _____ 7. Has risk been cancelled or non-renewed in last 3 years? <input type="checkbox"/> Yes <input type="checkbox"/> No 8. Is risk covered by workers compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No 9. How many years has insured owned commercial equipment? _____ 10. FEIN or SSN # _____ 11. Do you pull: <input type="checkbox"/> Doubles <input type="checkbox"/> Triples <input type="checkbox"/> Both <input type="checkbox"/> Neither 12. Do you allow non-employee passengers? <input type="checkbox"/> Yes <input type="checkbox"/> No
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### Driver Information

Driver Name	Date of Birth	License Number	State	Date Hired	# Years Commercial Driving	Last 3 Years # of	
						Mov. Violations	Accidents

### Vehicle Information

Year	Make	Trailer Type	GVW	Stated Value	VIN #	Radius (Miles)

### Loss Information (Previous career & loss information - must show current year and previous 2 years. If previously leased to another company, list that company.)

Policy Dates	Company Name or Previous Lessee Name	Policy Numbers	Premium Amount	# of Claims	Total Paid & Reserved

### Coverage & Limits

#### Liability

<input type="checkbox"/> Primary Liability	<input type="checkbox"/> Non-Trucking Liability
Auto Liability <input type="checkbox"/> Limit \$ _____	UM/ UIM <input type="checkbox"/> Limit \$ _____
Personal Injury Protection <input type="checkbox"/> Limit \$ _____	Medical Payments <input type="checkbox"/> Limit \$ _____
General Liability <input type="checkbox"/> Limit \$ _____	Hired Auto <input type="checkbox"/> Limit \$ _____
Trailer Interchange <input type="checkbox"/> Limit \$ _____	Other ( _____ ) <input type="checkbox"/> Limit \$ _____

#### Physical Damage

Specified causes of loss & collision    Collision \$ \_\_\_\_\_  
 Comprehensive collision    Other than Collision \$ \_\_\_\_\_

#### Cargo

Commodities	% of Total Revenue	Value per Truck Load	
		Maximum	Average

Broadform Cargo                      Cargo Limit \_\_\_\_\_

Refrigeration Breakdown              Reefer Deductible(s) \_\_\_\_\_