**Commercial Auto Questionnaire**

Insured Name: _____

Mailing Address: _____

Phone No. : _____ Inspection Contact Person:_____

Business Description: _____

Years in Business: _____

Policy Period: _____

Prior Carrier Information (4 years loss run required, if any): _____

_____

Loss Details, if any: _____

Liability Limit _____ UM _____

Medical Payments _____ Hired & Non-Owned Liability _____

Comprehensive Deductible _____ Collision Deductible_____

| Driver Name | DOB | Driver License # | Years Licensed | Tickets/Accidents |
|---|---|---|---|---|
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| | | | | |
| | | | | |

| Vehicle Year | Make | Model | Body Type | VIN# | Cost New | GVW | Zip Code |
|---|---|---|---|---|---|---|---|
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