Personal Auto Questionnaire

Insured Name: _____

Garage Address: _____

Phone No. : _____ Inspection Contact Person:_____

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_____

Towing _____ Rental _____

Driver Name	DOB	License #	Years Licensed	Record	Married

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