



Transportation

QUOTE SHEET 1-4 UNITS

INSURED INFORMATION

Insured Name: _____ DBA: _____ Address: _____ City, State, Zip: _____ Phone Number: _____ Entity: Individual LLC Inc./Corp. Other Email: _____ MC / DOT #: _____ Filings: Federal State	Owners Name: _____ DOB: _____ CDL: _____ FEIN #: _____ Years in Business: _____ New Venture: Yes or No Renewal Date:
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TRUCK INFORMATION

#	Year	Make	Model	Value	VIN #
1					
2					
3					
4					

TRAILER INFORMATION

#	Year	Make	Trailer Type	Value	VIN #
1					
2					
3					
4					

DRIVER INFORMATION

Driver Name	DOB	License #	State	Date Hired	# of Yrs. CDL	O/O?	MVR History (36 months)

PRIOR INSURANCE CARRIER INFO OF THE PAST 4 YEARS

Policy Years	Insurance Company	Losses (Y/N)	Type of loss	Amount paid

Liability
Primary
Non-Trucking

Physical Damage	Deductible
Comprehensive	
Collision	

Cargo Limit	Deductible	Reefer Breakdown?

Coverage Type	Limits Requested
Auto Liability	
UM / UIM	
Medical Payments	
GL Coverage	
Trailer Interchange	

Commodities	%	Max Value

Radius