



Agency Name

Contact

QUOTE SHEET 1-5 UNITS

INSURED INFORMATION

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

TRUCK INFORMATION

#	Year	Make	Model	Value	VIN #
1					
2					
3					
4					
5					

TRAILER INFORMATION

#	Year	Make	Trailer Type	Value	VIN #
1					
2					
3					
4					
5					

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	
Others	

Commodities	%	Max Value

Radius