

## Non-Fleet Quote Sheet 1 to 4 Power Units

Underwriter: \_\_\_\_\_ Date: \_\_\_\_\_

**Agency Information**

Agent Code: \_\_\_\_\_ Agent Name: \_\_\_\_\_ State: \_\_\_\_\_  
 Person to Contact: \_\_\_\_\_

**Insured Information**

Insured Name: \_\_\_\_\_ Owners Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Insured DOT #: \_\_\_\_\_ Brokerage (Y/N): \_\_\_\_\_  
 Insured MC#: \_\_\_\_\_  
 Other State Filings (Please provide ID #s if applicable): \_\_\_\_\_ Years in Business: \_\_\_\_\_  
 States Entered: \_\_\_\_\_ Does the Insured do Doubles or Triples (Y/N): \_\_\_\_\_  
 Major Cities Driving Into or Through: \_\_\_\_\_

**Prior Carrier Info for the past 3 years**

Year	Company Name and Policy Number	Losses (Y/N)	Details	Driver Involved

If no prior insurance in own name, provide 3 years of driver employment history:


**Driver Information**

Driver Name	Date of Birth	License Number	State	Date Hired	# of Yrs CDL	Last 3 Years Violations	# of Accidents

**Vehicle Information**

Year	Make	Model	GVW	Present Value	Radius Miles	Comments

**Coverage & Limits:**

Liability
<input type="checkbox"/> Primary
<input type="checkbox"/> Non-Trucking

Physical Damage	Deductible
<input type="checkbox"/> Specified Perils	
<input type="checkbox"/> Comprehensive	
<input type="checkbox"/> Collision	

Auto Liability Limits	
UM	
UIM	
PIP Coverage	
Medical Payments	
Hired Car	
Non-Owned	
GL Coverage	
Other	

Cargo Maximum Cargo Limit: \_\_\_\_\_  
 Cargo Deductible: \_\_\_\_\_

Commodity Transport	% of Total	Value Per Truckload

What kind of growth and/or changes expected in the next 12 months?

Comments:

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