



### BUSINESS AUTO QUESTIONNAIRE

Quote Date \_\_\_\_\_ Effective Date \_\_\_\_\_ Producer \_\_\_\_\_

**Business Information**

Business Name: \_\_\_\_\_ Entity:  Corp /  Partnership /  Individual /  LLC /  other \_\_\_\_\_

Location Address: \_\_\_\_\_

Mailing Address (if difference from Location Address): \_\_\_\_\_

Description of Business Operation: \_\_\_\_\_

Business Phone#: \_\_\_\_\_ Business Fax#: \_\_\_\_\_ Email: \_\_\_\_\_

FEIN: \_\_\_\_\_ Web Address (if any): \_\_\_\_\_

Dr #	Name	DOB	Sex M/F	Marital Status M/S	Mo/Yr Licensed	Driver License #
1			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> S		
2			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> S		
3			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> S		
4			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> S		
5			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> S		
6			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> S		
7			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> S		
8			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> S		

Veh #	Year	Make / Model	VIN #	Usage	Annual Mileage	Costs New	Garaging Zip Code	GVW
1								
2								
3								
4								
5								
6								
7								



Associate with Confidence and Trust



BI / PD Limits	\$	Veh	Comprehensive Deductible	Collision Deductible	Towing
Medical Limits	\$	1			
UMBI Limits	\$	2			
UMPD (\$3,500)	\$	3			
Hire / Non-Owned Liability		4			
Hire / Non-Owned Property		5			
Hire Annual Expense		6			
		7			

Driver	Accident (At Fault / Non At Fault) --- Violation	Description (Violations / Accident in past 5 years)	Damages Amount (Explain): BI / PD
1			
2			
3			
4			

Current Carrier		Policy Period		Years with this Carrier	
Prior Carrier		Policy Period		Years with this Carrier	
Prior Carrier		Policy Period		Years with this Carrier	
Any claim for past three years					
Loss Payee: (Name, Address)				Veh Assign	
Loss Payee: (Name, Address)				Veh Assign	
Loss Payee: (Name, Address)				Veh Assign	
Remarks					

**ACT Insurance Services Inc.**  
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