



COMMERCIAL AUTO QUOTE REQUEST

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- 1. Complete the enrollment form (all pages) in full by selecting a field with the mouse and by using the tab button.
- 2. Please fill in all the fields with the correct information.
- 3. Mail the completed quote request form to the address listed below.
- 4. You may e-mail this application to apps@coasioinsurance.com.

1. Corporate Name _____

2. Company Name _____

3. Tax ID Number _____ Request Effective Date _____

4. Contact Name _____ Title _____

5. E-mail Address _____

6. Website Address _____

7. Work Phone _____ Home Phone _____
 Fax _____

8. Best time to contact: Morning Afternoon Evening

9. Mailing Address: _____
 City _____ State _____ Zip _____

10. Garaging Address: _____
 City _____ State _____ Zip _____

11. Type of Business/ provide a detailed description of operations: _____

12. Year Business Started _____

13. Current Insurance Carrier _____

14. Policy Number _____ Expiration Date _____

15. Annual Sales _____ Current premium(s) \$ _____
 Any Claims in the last five years? yes no

Questions? Call us at (864) 688-0121 or send us a fax at (864) 688-0138.

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Note: List each vehicle that you will be using for your business: If you want us to cover your business autos, complete "Coverage requested" area also. If insuring more than four vehicles, please send information about the additional vehicles and coverage requested in a separate sheet of paper.

16. Vehicle 1: _____
Year: _____ Make: _____ Model: _____ Body Type: _____
Vehicle Identification Number: _____
Curb weight _____ Cost New: _____
Radius in miles vehicle will be driven: _____

Coverage requested:

Liability Limits:

300,000 500,000 1,000,000 2,000,000 5,000,000

Medical:

500 1,000 2,500 5,000 10,000

Uninsured Motorist Limits:

15,000 30,000 50,000 100,000 250,000

Underinsured UM: yes no

Collision Ded: 500 1000

Comprehensive Ded: 500 1000

Additional Add on Equipment Value: _____

17. Vehicle 2: _____
Year: _____ Make: _____ Model: _____ Body Type: _____
Vehicle Identification Number: _____
Curb weight _____ Cost New: _____
Radius in miles vehicle will be driven: _____

Coverage requested:

Liability Limits:

300,000 500,000 1,000,000 2,000,000 5,000,000

Medical:

500 1,000 2,500 5,000 10,000

Uninsured Motorist Limits:

15,000 30,000 50,000 100,000 250,000

Underinsured UM: yes no

Collision Ded: 500 1000

Comprehensive Ded: 500 1000

Additional Add on Equipment Value: _____

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**Note: List each vehicle that you will be using for your business:
If you want us to cover your business autos, complete "Coverage requested" area also.**

18. Vehicle 3: _____
Year: _____ Make: _____ Model: _____ Body Type: _____
Vehicle Identification Number: _____
Curb weight _____ Cost New: _____
Radius in miles vehicle will be driven: _____

Coverage requested:

Liability Limits:

300,000 500,000 1,000,000 2,000,000 5,000,000

Medical:

500 1,000 2,500 5,000 10,000

Uninsured Motorist Limits:

15,000 30,000 50,000 100,000 250,000

Underinsured UM: yes no

Collision Ded: 500 1000

Comprehensive Ded: 500 1000

Additional Add on Equipment Value: _____

19. Vehicle 4: _____
Year: _____ Make: _____ Model: _____ Body Type: _____
Vehicle Identification Number: _____
Curb weight _____ Cost New: _____
Radius in miles vehicle will be driven: _____

Coverage requested:

Liability Limits:

300,000 500,000 1,000,000 2,000,000 5,000,000

Medical:

500 1,000 2,500 5,000 10,000

Uninsured Motorist Limits:

15,000 30,000 50,000 100,000 250,000

Underinsured UM: yes no

Collision Ded: 500 1000

Comprehensive Ded: 500 1000

Additional Add on Equipment Value: _____

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For each Driver we will need the following:

20. Driver 1

Name: _____
Sex: male female Marital Status: married single divorced
Date of Birth: _____ Social Security Number: _____
Years Experience Driving: _____ Year you received license: _____
Driver's license Number: _____ State Licensed: _____
Moving violation in the last 36 months: _____ Accidents in the last 36 months _____
Violation description and date: _____
Percent(%) this person will be using vehicle: _____ Driving Vehicle No. _____

21. Driver 2

Name: _____
Sex: male female Marital Status: married single divorced
Date of Birth: _____ Social Security Number: _____
Years Experience Driving: _____ Year you received license: _____
Driver's license Number: _____ State Licensed: _____
Moving violation in the last 36 months: _____ Accidents in the last 36 months _____
Violation description and date: _____
Percent(%) this person will be using vehicle: _____ Driving Vehicle No. _____

22. Driver 3

Name: _____
Sex: male female Marital Status: married single divorced
Date of Birth: _____ Social Security Number: _____
Years Experience Driving: _____ Year you received license: _____
Driver's license Number: _____ State Licensed: _____
Moving violation in the last 36 months: _____ Accidents in the last 36 months _____
Violation description and date: _____
Percent(%) this person will be using vehicle: _____ Driving Vehicle No. _____

23. Driver 4

Name: _____
Sex: male female Marital Status: married single divorced
Date of Birth: _____ Social Security Number: _____
Years Experience Driving: _____ Year you received licensed: _____
Driver's license Number: _____ State Licensed: _____
Moving violation in the last 36 months: _____ Accidents in the last 36 months _____
Violation description and date: _____
Percent(%) this person will be using vehicle: _____ Driving Vehicle No. _____

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24. Also do you need any additional insured(s) added to this policy? yes no

25. Name of Additional Insured: _____

26. Address of Additional Insured: _____

City: _____ State: _____ Zip: _____

27. Name of Additional Insured: _____

28. Address of Additional Insured: _____

City: _____ State: _____ Zip: _____

29. Name of Additional Insured: _____

30. Address of Additional Insured: _____

City: _____ State: _____ Zip: _____

Applicant Signature: _____ Date: _____

Question? Please call us at (864) 688-0121 or send us a fax at (864) 688-0138

We will process your application as soon as we receive all your documentation so please complete this form fully

NOTE: Click the Save button and save this document in your documents file folder. Make sure that all the information you have entered is correct and then e-mail this application to apps@coasioinsurance.com

Question? Please call us at (864) 688-0121 or send us a fax at (864) 688-0138

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