

Auto insurance fact finder

Titled owner _____ Home phone _____ Work phone _____
 Address _____ Date current auto policy expires _____
 City/State/ZIP _____ Annual household income \$ _____
 School _____ Estimate of personal assets \$ _____
 County _____ Social Security # _____

Vehicle 1			Vehicle 2			Vehicle 3		
Year	Make	Model	Year	Make	Model	Year	Make	Model
V.I.N. (Vehicle Identification Number)			V.I.N. (Vehicle Identification Number)			V.I.N. (Vehicle Identification Number)		
Driver #	Rental reimbursement?	Garage ZIP	Driver #	Rental reimbursement?	Garage ZIP	Driver #	Rental reimbursement?	Garage ZIP
How is this vehicle used? (select one)			How is this vehicle used? (select one)			How is this vehicle used? (select one)		
<input type="checkbox"/> Driven to _____ # miles one way work or school _____ # days per week <input type="checkbox"/> Pleasure use <input type="checkbox"/> Business use _____ Annual miles			<input type="checkbox"/> Driven to _____ # miles one way work or school _____ # days per week <input type="checkbox"/> Pleasure use <input type="checkbox"/> Business use _____ Annual miles			<input type="checkbox"/> Driven to _____ # miles one way work or school _____ # days per week <input type="checkbox"/> Pleasure use <input type="checkbox"/> Business use _____ Annual miles		
Comprehensive deductible <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 Collision deductible Full Glass <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> yes <input type="checkbox"/> no Anti-theft device: <input type="checkbox"/> yes <input type="checkbox"/> no ABS: <input type="checkbox"/> yes <input type="checkbox"/> no			Comprehensive deductible <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 Collision deductible Full Glass <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> yes <input type="checkbox"/> no Anti-theft device: <input type="checkbox"/> yes <input type="checkbox"/> no ABS: <input type="checkbox"/> yes <input type="checkbox"/> no			Comprehensive deductible <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 Collision deductible Full Glass <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> yes <input type="checkbox"/> no Anti-theft device: <input type="checkbox"/> yes <input type="checkbox"/> no ABS: <input type="checkbox"/> yes <input type="checkbox"/> no		

Current BI/PD coverage: _____ / _____
 How much do you feel you could pay out-of-pocket for damage to your car? _____
 Are all members of your household covered by medical insurance? yes no
 Does anyone in your household transport others not covered by medical insurance? yes no
 Are all members of your household covered by a motor club? yes no

Drivers (List all resident drivers, including yourself)									
Driver	Name/ Occupation	Birthdate	Sex	Marital status	Years licensed	Certified defensive driver?	At school more than 100 miles away?	Education Association member? Which one?	Full-time student with B+ average
1									
2									
3									
4									

Driving history		
<input type="checkbox"/> Check if any driver has been cited for driving while intoxicated or had a license suspended or revoked in the past five years. <input type="checkbox"/> Check if any driver has had an accident (regardless of fault) or a moving violation in the past five years. If so, complete the information below.		
Driver #	Date	Brief description of violation or accident (include damage and dollar amount)