



ITEMS TYPED ON THIS FORM CAN BE SAVED

Commercial Auto

Quote Request

Click Here to Submit Form:

www.AnchorWestInsurance.com

(888) 388-5655 toll free | (888) 288-5486 fax

CA Broker License #: 0G72981

Named insured _____ Contractor's License # _____

Owner's name _____ Contact's name _____

Phone # _____ Cell # _____ Fax # _____

Email: _____ Preferred method of contact: Phone Fax Email

Mailing address: _____

Physical/Premise address: _____

Business entity: Sole proprietorship Partnership Corporation LLC Other: _____

Current Auto Carrier: _____ Expiration date: _____

Driver Information:

Driver Name	D.O.B.	License Number	Marital Status	Violations/accidents in the last 3 yrs?
			<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced	<input type="checkbox"/> Yes <input type="checkbox"/> No

Vehicle Information:

Year	Make/Model/Body Type	VIN	Gross Wt	Value	Radius of Operations (miles)
					<input type="checkbox"/> <50 <input type="checkbox"/> 50-100 <input type="checkbox"/> >100
					<input type="checkbox"/> <50 <input type="checkbox"/> 50-100 <input type="checkbox"/> >100
					<input type="checkbox"/> <50 <input type="checkbox"/> 50-100 <input type="checkbox"/> >100

Additional comments you would like to make: _____

**THIS IS NOT AN APPLICATION; IT IS ONLY A PRELIMINARY INFO SHEET FOR A QUOTE.
ADDITIONAL INFORMATION MAY BE REQUIRED.**

The following items MUST be provided to receive a quote:

Select the desired coverages:

****Liability**** Split Limits OR CSL		Comp/Coll Ded	****Uninsured Motorist BI****	Uninsured Motorist PD	Hired & Non- Owned Auto	Medical Payments
<input type="checkbox"/> 15/30/10	<input type="checkbox"/> 300,000	<input type="checkbox"/> 250	<input type="checkbox"/> 15/30	<input type="checkbox"/> 3500	<input type="checkbox"/> Yes	<input type="checkbox"/> 500
<input type="checkbox"/> 50/100/50	<input type="checkbox"/> 500,000	<input type="checkbox"/> 500	<input type="checkbox"/> 25/50	<input type="checkbox"/> 5000	<input type="checkbox"/> No	<input type="checkbox"/> 1000
<input type="checkbox"/> 100/300/50	<input type="checkbox"/> 750,000	<input type="checkbox"/> 1000	<input type="checkbox"/> 30/60			<input type="checkbox"/> 2000
<input type="checkbox"/> 250/500/100	<input type="checkbox"/> 1,000,000	<input type="checkbox"/> 2500	<input type="checkbox"/> 50/100			<input type="checkbox"/> 5000
<input type="checkbox"/> Other:		<input type="checkbox"/> Other:	<input type="checkbox"/> Other:			

CSL = Combined Single Limit BI: Bodily Injury PD: Property Damage

****ALL VEHICLES MUST CARRY SAME LIABILITY/UNINSURED MOTORIST COVERAGE****

Lender Information:

Veh & Account #	Lender Name	Lender Address	Loss Payee	Additional Insured
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Special filing requirements:

MCP-65 CA# _____

Other: _____

Additional comments you would like to make: _____

Click Here to Submit Form:

Printed Name of Prospective Insured

Date

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