



Return complete app to:
Quote@shellyins.com

Post Office Box 2909
Jacksonville, FL 32203-2909

Agency Information

Agency Name _____ City _____ State _____
Contact Name _____ Phone _____ E-mail _____

Insured Information

Insured Name _____
Garaging Address _____
City _____ State _____ Zip _____
Phone _____ DOT # _____
Desired Effective Date _____
How many years of primary liability coverage under above name? _____
Owner's Name _____
If Non-Trucking Liability, name of company leased to & DOT # _____
Business Start Date _____

1. Annual Mileage _____ Annual Revenue _____
2. Filings needed? Yes No (If yes, MC # _____)
3. Is there any related broker authority? Yes No (MC # _____)
4. Commodities Hauled _____
5. States Entered _____
6. Major Cities _____
7. Has risk been cancelled or non-renewed in last 3 years? Yes No
8. Is risk covered by workers compensation? Yes No
9. How many years has insured owned commercial equipment? _____
10. FEIN or SSN # _____
11. Do you pull: Doubles Triples Both Neither
12. Do you allow non-employee passengers? Yes No

Driver Information

Driver Name	Date of Birth	License Number	State	Date Hired	# Years Commercial Driving	Last 3 Years # of	
						Mov. Violations	Accidents

Vehicle Information

Year	Make	Unit Type	GVW	Stated Value	VIN #	Radius (Miles)

Loss Information (Previous career & loss information - must show current year and previous 2 years. If previously leased to another company, list that company.)

Policy Dates	Company Name or Previous Lessee Name	Policy Numbers	Premium Amount	# of Claims	Total Paid & Reserved

Coverage & Limits

Liability

<input type="checkbox"/> Primary Liability	<input type="checkbox"/> Non-Trucking Liability
Auto Liability	<input type="checkbox"/> Limit \$ _____
UM/ UIM	<input type="checkbox"/> Limit \$ _____
Personal Injury Protection	<input type="checkbox"/> Limit \$ _____
Medical Payments	<input type="checkbox"/> Limit \$ _____
General Liability	<input type="checkbox"/> Limit \$ _____
Hired Auto	<input type="checkbox"/> Limit \$ _____
Trailer Interchange	<input type="checkbox"/> Limit \$ _____
Other (_____)	<input type="checkbox"/> Limit \$ _____

Physical Damage

<input type="checkbox"/> Specified causes of loss & collision	Deductible \$ _____
<input type="checkbox"/> Comprehensive collision	

Cargo			
Commodities	% of Total Limit	Value per Truck Load	
		Maximum	Average

Cargo Limit _____

Refrigeration Breakdown Reefer Deductible(s) _____

Truck Questions

Is Owner a driver? Yes No

If no, provide full time occupation of owner _____

Does the applicant plan on adding drivers or power units midterm? Yes No

Does the applicant's operation use: Team Driver's Slip Seating

Is the vehicle equipped with any of the following safety devices?

<input type="checkbox"/> Lane Departure Warning	<input type="checkbox"/> Collision Warning	<input type="checkbox"/> Electronic Stability Control
<input type="checkbox"/> Side Object Detection	<input type="checkbox"/> On Board Video Recorder	

Towing Operations

Confirm unit type Flat Bed Wrecker with Hook

What is the percent of time insured does repossessions? _____

What is the percent of time insured hauls disabled units for repair? _____

What is the percent of time insured hauls junk units to salvage? _____

What is the percent of time insured hauls new and used autos from auction to dealer? _____

Is In Tow/ on Hook coverage needed? Yes No