

# Commercial Automobile Physical Damage Insured Proposal Form

(All questions must be answered)

**1. Name:**

**2. Address:**

  

**3. Address of Principal Terminal if other than address in Item 2:**

  

**4. Business Is:**

Common Carrier     Contract Carrier     Private Carrier     Bob-Tail Operation

No. of Years in Business:

**5. Full names and titles of officers, owners, partners:**

  

**6. Names of Principal Shippers:**

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**7. Operates in States of:**

**8. Principal cities:**

**9. Radius of Operation**

(List no. units in each group):

Vehicle Type	50 miles	200 miles	Over
Trucks			
Tractors			
Trailers			

**10. Number and Pieces of equipment**

– Property Carriers:

Vehicle Type	Owned Equip.	Equip. Long Term Lease From Others	Equip. Long Term Lease To Others
Trucks (not dump)			
Tractors			
Semi -trailers			
Full Trailers			
Tank Semi -trailers			
Tank Trailers			
Refrigerated Trailers			
Service Trucks			
Private Pass. Cars			
Dump Trucks			

**11. Name of present Auto Physical Damage insurance carrier(s) and Policy No:**

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12. Are present policies being cancelled or not renewed by insurance company?

YES  NO

Details:


13. Types of commodities transported by property carrier (Avoid term "General Merchandise". Name principal commodities):


14. Do you own equipment other than that included in this submission? YES  NO

Details in Remarks section if "Yes"

15. Do you trailer interchange equipment with other carriers? YES  NO

Details in Remarks section if "Yes"

16. Description of Equipment

17. Coverage Desired

No.	Trade Name	Year Built	Type	Serial No.	SP. Perils	COLL	ACV	Legally Owned By
1								
2								
3								
4								
5								
6								
7								

\* If more than seven (7) vehicles are to be covered, attach complete schedule of equipment listings and the required information as indicated in questions 16 and 17 above.

All Perils Deductible requested:

1,000     2,500

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**18. If more than one vehicle covered, give maximum possible terminal loss by fire/windstorm:**

**19. Is equip. regularly inspected and serviced?** YES  NO

At what intervals:

**20. Loss Experience – Past Four Years**

From	To	Value of total fleet	Premiums	Amount Deductible	Coll. Loss. after Ded	FTCAC Losses	Insurance Carrier

**21. Driver's Full Name as it appears on License:**

Name	Birth date	State & driver license no.	Is license valid	Years of comm. Driving exp.	Employment date

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**Driver's Full Name as it appears on License Cont.:**


If more space is needed, attach complete driver roster.

**Remarks**


**The Proposer agrees that the statements contained in this proposal are true and that, if insurance is effected, material misrepresentation or concealment of any information voids this insurance.**

**Authorized Signature:**

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**Title:**

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**Date:**

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**Broker Signature:**

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**Date:**

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**This application is for the purpose of considering acceptability and premium determination and not binding on Markel International until evidence of an insurance contract has been issued by Markel International.**