# COMMERCIAL APPLICATION
## Commercial Auto

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|---|---|
| Effective Date: | |
| Insured name: | |
| DBA: | |
| Legal entity (corporation, sole proprietor, etc.): | |
| FEIN/SSN: | |
| Phone number: | |
| Fax number: | |
| Cellular number: | |
| Street address: | |
| City, State, Zip Code: | |
| Nature of Business: | |
| Years in Business: | |
| Number of employees: | |
| Prior Insurance? (incl. carrier name, premium amount, and expiration date) | |
| Prior Losses?  (if yes, provide loss runs) | |
| How many job sites per day: | |
| Deliveries to residential sites? (y/n) | |
| Radius travel area: | |

**Policy General Liability Limits**

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|---|---|
| Liability (BI/PD): | |
| Medical Payments: | |
| Uninsured Motorists: | |
| Drivers | |
| Driver 1, First Name, Middle Name, Last Name: | |
| Driver 1, Birth Date: | |

| | |
|---|---|
| Driver 1, California Driver's License number: | |
| Driver 1, Date Licensed: | |
| Driver 2, First Name, Middle Name, Last Name: | |
| Driver 2, Birth Date: | |
| Driver 2, California Driver's License number: | |
| Driver 2, Date Licensed: | |
| | |
| **Vehicle information** | |
| Vehicle 1, Year, Make, Model: | |
| Vehicle 1, Cost of vehicle: | |
| Vehicle 1, Vehicle Identification Number: | |
| Vehicle 1, Gross Vehicle Weight: | |
| Vehicle 1, Comp/Collision deductible: | |
| Vehicle 1, Garaging address: | |
| Vehicle 2, Year, Make, Model: | |
| Vehicle 2, Vehicle Identification Number: | |
| Vehicle 2, Cost of vehicle: | |
| Vehicle 2, Gross Vehicle Weight: | |
| Vehicle 2, Comp/Collision deductible: | |
| Vehicle 2, Garaging address: | |
| *Please repeat the above information for any additional drivers/vehicles.* | |
| Hired/Non-owned coverage? | |
| MCP Filing CA#: | |
| Umbrella coverage requested? | |
| Other additional coverages required? | |
| Producer/Agency | |
| | |

ADDITIONAL NOTES:

**Fax your request to 760-744-2680 or email to steve@gibbsinsurance.com**
**APPLICATION SUBMISSION DOES NOT BIND COVERAGE**