

AUTOMOBILE QUESTIONNAIRE



services inc.
FLORIDA DENTAL ASSOCIATIONSM

NAMED INSURED:

Mailing Address:

Phone Number: Fax Number:

E-mail:

DRIVERS

1

2

3

Full name of each driver:

Date of Birth:

Marital status:

years licensed:

Drives License #:

Social Security #:

Occupation:

VEHICLES

	Year	Make & Model	VIN #	Current mileage reading	# miles driven Annually	Usage: # miles one-way to work or school
Vehicle # 1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Vehicle # 2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Vehicle # 3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Check Vehicle #: Air Bag(s) 1 2 3 Anti-Locking Braking 1 2 3

Leased Veh. 1 2 3 Anti-Theft Device 1 2 3

Are any vehicles titled in another name or in the name of a business? If yes, give details:

ACCIDENTS/ INCIDENTS

(last 5 years, at fault & not) Give details of each event, include the driver's name, and dates:

CURRENT INS. COMPANY

Name of Company: Expiration Date:

Policy Number: # years with this company: