Auto Insurance Fact Finder

Email or Fax Completed Form

info@michellecrawfordbenefits.com

Fax: 706-568-9979

General Information

Name: _______________________________________ Home Phone: ______________________________

Email: _______________________________________ Work Phone: ______________________________

Address: ____________________________________ City: ________ State: __________ Zip: __________

Highest Level of Education:_____________________ Occupation:________________________________

How many years in current occupation? ____

Current Insurance Information

Company Name: _______________________________________ Annual Premium: _________________

Liability: __________ UN/UIM: ___________ Comp Ded: ________ Collision Ded: __________ MedPay: _______

Policy Expiration Date: ________________ Own or Rent: ________________ Time at Address: ________________

Household Information

Name	Date of Birth	Martial/ Dep	Driver's License	Social Security #

Vehicle Information

	Year	Make	Model	VIN	Usage	Miles T/F	Annual Miles	Primary Driver
1								
2								
3								
4								

Tickets, Accidents, or Claims Last 5 Years

Date	Driver	Type of Incident	Payout Amount	Vehicle

Coverage Information

	Liability	UN/UIM	MedPay	Comp. Ded	Collision Ded	Towing	Rental
1	$	$	$	$	$	$	$
2	$	$	$	$	$	$	$
3	$	$	$	$	$	$	$
4	$	$	$	$	$	$	$

Visit our Website at www.michellecrawfordbenefits.com for additional sales tools.