

AUTO INSURANCE VERIFICATION

I, _____, authorize my insurance agent/company to disclose the following information to _____ for the purpose of _____.

Signature _____ **Date** _____

Print Name _____

INSURANCE AGENT: Please fill out and return to:

Fax Number _____ or E-Mail _____

THIS AREA TO BE COMPLETED BY THE INSURANCE AGENT

Insured Individual's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Insurance Company: _____ Phone: _____

Agent Contact Name: _____ Fax: _____

Policy Start Date: _____ Policy End Date: _____

Is there liability for injuries or damage to a third (3rd) party? Yes No

Does the coverage cover the insured individual in an accident? Yes No

Does the coverage pay for damage done to rental vehicles? Yes No

Policy Number: _____ Expiration: _____

Agent's Signature _____

Date _____

