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 _____________________

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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 ____________________