

TOW TRUCK CHANGE REQUEST FORM



CHOICE Insurance, LLC
— THE RIGHT CHOICE —

Please complete and return form by Fax or Email.

Choice Insurance, LLC
1715 Market St Ste 100 Kirkland, WA 98033
Office: 425-739-6565
Toll free: 800-289-8003
Fax: 425-739-9955
Email: Service@choiceinsurance.net

Today's Date:

Named Insured:

Contact:

Request/
Remarks:

VEHICLE CHANGE REQUEST

<input type="checkbox"/> Add Vehicle	<input type="checkbox"/> Delete Vehicle	<input type="checkbox"/> Service Vehicle	<input type="checkbox"/> Add Vehicle	<input type="checkbox"/> Delete Vehicle	<input type="checkbox"/> Service Vehicle
<input type="checkbox"/> Wrecker	<input type="checkbox"/> Rollback	<input type="checkbox"/> Tractor	<input type="checkbox"/> Wrecker	<input type="checkbox"/> Rollback	<input type="checkbox"/> Tractor
Year: <input type="text"/>	Make: <input type="text"/>	Year: <input type="text"/>	Make: <input type="text"/>		
Model: <input type="text"/>	GVW: <input type="text"/>	Model: <input type="text"/>	GVW: <input type="text"/>		
VIN: <input type="text"/>	VIN: <input type="text"/>				
Cost New: <input type="text"/>	Stated Amt: <input type="text"/>	Cost New: <input type="text"/>	Stated Amt: <input type="text"/>		

Coverage Desired:	<input type="radio"/> Collision	<input type="radio"/> \$1,000 Deductible	<input type="radio"/> Comprehensive	<input type="radio"/> \$1,000 Deductible
	<input type="radio"/> \$1,000 Deductible	<input type="radio"/> \$2,000 Deductible	<input type="radio"/> \$1,000 Deductible	<input type="radio"/> \$2,000 Deductible

CERTIFICATE REQUEST

Additional Insured Loss Payee Certificate Holder *If a certificate holder request is provided please fax request with this form.*

Company: Contact:

Address: Phone/Fax:

City: State: Zip:

Reference:

DRIVER CHANGE REQUEST

Add Delete

******* IMPORTANT *******
You must attach an updated Motor Vehicle Report issued no later than 30 days prior to this request.

Print Name: Driver's License #:

Date of Birth: Date of Hire:

Tow Truck Experience: (Years) Commercial Driving Experience: (Years)

Acknowledgement of this form will be your copy of our change request sent to the insurance company. If you do not receive an acknowledgement within five days, please notify us. No coverage changes will be in effect until you receive confirmation from our office.

Signed By: _____