

**OFFICE OF INSURANCE REGULATION**  
**FLORIDA MOTOR VEHICLE PREINSURANCE INSPECTION FORM**  
 (This is not a safety inspection)

|                        |  |                                |       |               |  |             |  |
|------------------------|--|--------------------------------|-------|---------------|--|-------------|--|
| Date of Inspection:    |  | Time:                          |       | Insurer Name: |  | Binder No.: |  |
| Insured's Name         |  | Insured's Address              |       | City          |  | State       |  |
| Inspector (print)      |  | Inspection site (name/address) |       |               |  |             |  |
| Description of Vehicle |  |                                | Color |               |  | Body Style  |  |
| Year:                  |  |                                | Make: |               |  |             |  |

Vehicle Identification Number (Obtain Direct from Vehicle, Dash or EPA Sticker) : \_\_\_\_\_  
 From: \_\_\_\_\_ Odometer Reading: 

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|

Discrepancies between numbers:

|            |        |             |
|------------|--------|-------------|
| Plate No.: | State: | Garaged At: |
|------------|--------|-------------|

Accessories and Optional Equipment:

Permanently Installed

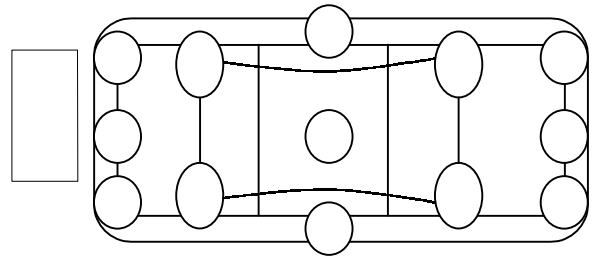
|   |   |                              |                             |                              |                             |                              |                             |                              |                             |                              |                             |                              |                             |                              |                             |
|---|---|------------------------------|-----------------------------|------------------------------|-----------------------------|------------------------------|-----------------------------|------------------------------|-----------------------------|------------------------------|-----------------------------|------------------------------|-----------------------------|------------------------------|-----------------------------|
| Radio: <input type="checkbox"/> AM <input type="checkbox"/> FM <input type="checkbox"/> AM/FM Tape Deck <input type="checkbox"/> Stereo<br><input type="checkbox"/> Factory Installed Brand _____<br><input type="checkbox"/> Stereo Amplifier System? Brand _____<br><input type="checkbox"/> Compact Disk Player?<br><input type="checkbox"/> Factory Installed Brand _____<br><input type="checkbox"/> CB Radio? <input type="checkbox"/> Antenna Brand _____<br><input type="checkbox"/> Telephone? <input type="checkbox"/> Antenna Transmitter Brand _____<br><input type="checkbox"/> Anti-theft Device? Brand _____<br>Type: _____<br><input type="checkbox"/> Air conditioner<br><input type="checkbox"/> Manual Transmission <input type="checkbox"/> 3 sp <input type="checkbox"/> 4sp <input type="checkbox"/> 5sp <input type="checkbox"/> Automatic<br><input type="checkbox"/> Other _____ | <table style="width: 100%;"> <tr> <td><input type="checkbox"/> yes</td> <td><input type="checkbox"/> no</td> </tr> <tr> <td><input type="checkbox"/> yes</td> <td><input type="checkbox"/> no</td> </tr> <tr> <td><input type="checkbox"/> yes</td> <td><input type="checkbox"/> no</td> </tr> <tr> <td><input type="checkbox"/> yes</td> <td><input type="checkbox"/> no</td> </tr> <tr> <td><input type="checkbox"/> yes</td> <td><input type="checkbox"/> no</td> </tr> <tr> <td><input type="checkbox"/> yes</td> <td><input type="checkbox"/> no</td> </tr> <tr> <td><input type="checkbox"/> yes</td> <td><input type="checkbox"/> no</td> </tr> </table> | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| <input type="checkbox"/> yes  | <input type="checkbox"/> no   |                              |                             |                              |                             |                              |                             |                              |                             |                              |                             |                              |                             |                              |                             |
| <input type="checkbox"/> yes  | <input type="checkbox"/> no   |                              |                             |                              |                             |                              |                             |                              |                             |                              |                             |                              |                             |                              |                             |
| <input type="checkbox"/> yes  | <input type="checkbox"/> no   |                              |                             |                              |                             |                              |                             |                              |                             |                              |                             |                              |                             |                              |                             |
| <input type="checkbox"/> yes  | <input type="checkbox"/> no   |                              |                             |                              |                             |                              |                             |                              |                             |                              |                             |                              |                             |                              |                             |
| <input type="checkbox"/> yes  | <input type="checkbox"/> no   |                              |                             |                              |                             |                              |                             |                              |                             |                              |                             |                              |                             |                              |                             |
| <input type="checkbox"/> yes  | <input type="checkbox"/> no   |                              |                             |                              |                             |                              |                             |                              |                             |                              |                             |                              |                             |                              |                             |
| <input type="checkbox"/> yes  | <input type="checkbox"/> no   |                              |                             |                              |                             |                              |                             |                              |                             |                              |                             |                              |                             |                              |                             |

**PHYSICAL CONDITION OF VEHICLE**

Check Damaged Areas or Areas in Poor Condition and Describe Below

Body  01  02  03  04  05  06  07  08  09  10  11  12  00

Glass  03  06  09  12



Describe items checked above and any other damage: \_\_\_\_\_  
 \_\_\_\_\_

The undersigned represents that this Preinsurance Inspection Report is true and also acknowledge the authenticity of the Vehicle Identification Number.

\_\_\_\_\_  
 Person Presenting Vehicle

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Relationship to insured

\_\_\_\_\_  
 Inspector's Signature

\_\_\_\_\_  
 Date and Time of Inspection