Occupational Accident Submission

ACCOUNT IDENTIFICATION

Company Name:_____

Individual ☐ Corporation ☐ LLC ☐ Partnership ☐

Physical Address:_____

City:_____ State:_____ Zip:_____

Telephone: _____ Fax:_____

Contact Person: _____

E-mail: _____

Years in business:_____

FEIN #: _____

AGENT IDENTIFICATION

Agency Name:_____

Address: _____

City: _____ State: ____Zip: _____

Telephone: _____ Fax: _____

Contact Person: _____

E-mail: _____

Requested Effective Date: _____

Requested Quote Date: _____

DRIVER INFORMATION & COMMODITIES HAULED

Number of Owner/Operators _____ Number Contract Drivers_____ Number of Team Drivers_____

List all commodities hauled (%)

_____ _____% _____ _____%

_____ _____% _____ _____%

ACCOUNT INFORMATION

Type of Carrier: ☐ Common ☐ Contract ☐ Private ☐ Other _____

LTL % _____ Truckload %_____ Driver Load/Unload % _____

Method of Driver Compensation: ☐ Mileage ☐ Revenue ☐ Hourly ☐ Trip ☐ Other (details) _____

Radius of Round Trip by %: More than 500 miles ___% 499-200 miles ___% 199-50 miles ___% less than 50 ___%

Driver's average length of haul _____miles Driver's average duration of haul _____days

Type of Equipment used: Van ____% Refrigerated ____% Flatbed ____% Tanker ____% Dump ____%

Double trailers ____% Oversize/Overweight ____% Other ____%

Does account allow passengers: Yes ☐ No ☐ If yes give details:_____

Backhaul policy is: ☐ Under the control of the account or ☐ At the discretion of the driver. Please check one and give details _____

Are drivers required to report daily? ☐ Yes ☐ No

List account terminal locations: _____, _____, _____, _____,

_____, _____, _____, _____, _____

DRIVER DISTRIBUTION Give total number of Owner/Operators, Contract Drivers, and Team Drivers to be insured by state of residence for the current policy year.

Alabama _____	Idaho _____	Michigan	New York _____	Tennessee _____
Arizona _____	Illinois _____	Minnesota _____	North Carolina _____	Texas _____
Arkansas _____	Indiana _____	Mississippi _____	North Dakota _____	Utah _____
California _____	Iowa _____	Missouri _____	Ohio _____	Vermont _____
Colorado _____	Kansas _____	Montana _____	Oklahoma _____	Virginia _____
Connecticut _____	Kentucky _____	Nebraska _____	Oregon _____	Washington _____
Delaware _____	Louisiana _____	Nevada _____	Pennsylvania _____	West Virginia _____
Dist of Col _____	Maine _____	New Hampshire _____	Rhode Island _____	Wisconsin _____
Florida _____	Maryland _____	New Jersey _____	South Carolina _____	Wyoming _____
Georgia _____	Massachusetts___	New Mexico _____	North Carolina _____	TOTAL_____

SAFETY INFORMATION

Motor Carrier ID # _____ Motor Carrier DOT # _____

Does the account have a full time safety director? Yes [ ] No [ ] Name _____

Does the account have a current written safety/ loss prevention program in place? ☐ Yes ☐ No

If yes, who developed the program?_____

When was the program started? _____ When was it updated? _____

Does the safety/loss prevention program address: (Please answer yes or no to the following.)

Inspections of operations, conditions and vehicles to identifiy hazards? _____

Training of owner/operators in safe work practices? _____

Specific owner/operator rules? _____

How often are safety meetings conducted?_____ Are Owner/Operators required to attend?_____

What is the frequency of reviewing MVR's? _____

What is the minimum age for an Owner/Operator to be eligible to contract with your company? _____

What is the maximum acceptable age?

What MVR violoation would cause an Owner/Operator's Lease Agreement to be "Inactive" or terminated? _____

PRIOR CARRIER AND LOSS INFORMATION

Current Carrier: _____ Renewal Date: _____

Please list prior carrier and loss, and premium information below:

Policy Term	Carrier	Type of Coverage		Losses	Premium	# of Drivers

Signature of Applicant/Account:_____ Date: _____

Signature of Producer: _____ Date: _____

SCHEDULE OF BENEFITS REQUEST FORM

OCCUPATION ACCIDENT COVERAGE REQUESTED

Accidental Death & Dismemberment Benefit:			
Principal Sum	$150,000_____	$250,000_____	Other _____
Lump Sum or Survivors Benefit *(Circle One)*			
Accident Medical Benefit:			
Maximum Benefit	$500,000_____	$1,000,000____	Other _____
Deductible	$100_____	$500_____	Other _____
Incurral Period	52 weeks	104 weeks	Other _____
Temporary Total Disability Benefit:			
Percentage of Average Weekly Earnings	70% _____		Other _____
Maximum Weekly Benefit	$400 _____	$500 _____	Other _____
Waiting Period	14 days _____		Other _____
Benefit Period	52 weeks _____	104 weeks_____	Other _____
Permanent Total Disability:			
Percentage of Average Weekly Earnings	70% _____		Other _____
Maximum Weekly Benefit	$400 _____	$500 _____	Other _____
Waiting Period	52 weeks _____	104 weeks ____	Other _____
Benefit Period	To age 70		Other _____
Combined Single Limit:	$500,000	$1,000,000	Other _____

NON-OCCUPATIONAL ACCIDENT COVERAGE REQUESTED

Accidental Death & Dismemberment Benefit:			
Principal Sum	$5,000 _____	$10,000 _____	Other _____
Accident Medical Benefit:			
Maximum Benefit	$2,500 _____	$5,000 _____	Other _____
Deductible	$0 _____	$100 _____	Other _____
Incurral Period	26 weeks ____	52 weeks ____	Other _____

Signature of Applicant/Account:_____ Date: _____

Signature of Producer: _____ Date: _____

COURIER COMPANY SUBMISSION FORM

ACCOUNT IDENTIFICATION

Company Name:_____

Individual [ ] Corporation [ ] LLC [ ] Partnership [ ]

Physical Address:_____

City:_____ State:____ Zip:_____

Telephone: _____ Fax:_____

Contact Person: _____

E-mail: _____

Years in business:_____

FEIN #: _____

AGENT IDENTIFICATION

Agency Name:_____

Address: _____

City: _____ State: ___ Zip: _____

Telephone: _____ Fax: _____

Contact Person: _____

E-mail: _____

Requested Effective Date: _____

Requested Quote Date: _____

SERVICES PROVIDED BY COMPANY

Please give % of each:

Super Express (<5 hrs) _____

Express (Same day) _____

Overnight Delivery _____

Please answer yes or No:

Packages> 50 lbs _____

Heavy Equipment _____

On-site Storage _____

Bank Runs _____

Postal Runs _____

EQUIPMENT TYPES USED BY COMPANY

Please specify average #:

Private Passenger Auto: _____

Small Step Van: _____

Panel Trucks/Vans: _____

Heavy Trucks: _____

Tractor-Trailer: _____

Drivers Average Daily Radius:

<15 miles _____

16-50 miles _____

51-75 miles _____

76-100 miles _____

> 100 miles _____

Do you have ICC Authority?

Please provide:

DOT # _____

MC # _____

INDEPENDENT CONTRACTOR AND EMPLOYEE EXPOSURES FOR THIS COMPANY

	W-2			1099 Independent Contractors	
	F/T	P/T		F/T	P/T
Office Personnel			Office Personnel		
Stock Workers			Stock Workers		
Maintenance			Maintenance		
Messengers-auto			Messengers-auto		
Messengers-bike			Messengers-bike		
Messengers-foot			Messengers-foot		

PRIOR CARRIER AND LOSS INFORMATION

Current Carrier: _____ Renewal Date: _____

Are your 1099 Drivers currently covered under your Workers Compensation Policy? ☐ Yes ☐ No

Are your 1099 Drivers currently covered under any Occupational Accident Plan? ☐ Yes ☐ No

If covered under an Occupational Accident Plan, please attach a schedule of benefits.

Please list prior carrier, loss, and premium information below:

Policy Term	Carrier	Type of Coverage	Losses	Premium	# of Drivers

OPERATIONS AS THEY PERTAIN TO THE USE OF INDEPENDENT CONTRACTORS

Please answer YES or NO to the following questions based on the guidelines currently in use by your company.

Do you require I/C's to punch a time clock upon arriving or leaving? _____

Are I/C's allowed to refuse or reject a delivery if they so choose? _____

Are I/C's allowed to choose their own sequence or method in which deliveries are ma _____

Does the Company require an updated MVR for all new drivers? _____

Does the Company re-check MVR's on an annual basis? _____

Does the Company have any drivers over the age of 70? _____

Does the Company obtain accident reports and keep them in the driver files? _____

Does the Company carry Hired-Non-Owned Auto Insurance? _____

Does the Company require all drivers to wear uniforms/identification badges? _____

Does the Company provide body harness' for lifting large/heavy boxes? _____

Is the Company willing to accept assistance with a safety program? _____

Are any I/C's compensated on an hourly basis? _____

Signature of Applicant/Account:_____ Date: _____

Signature of Producer: _____ Date: _____

COURIER COMPANY SUPPLEMENTAL FORM

Company Name:_____ **Telephone**: _____

Contact Person: _____ **E-mail**: _____

SERVICES PROVIDED BY COMPANY

Please give % of each:

Super Express (<5 hrs) _____

Express (Same day) _____

Overnight Delivery _____

Please answer yes or No:

Packages> 50 lbs _____

Heavy Equipment _____

On-site Storage _____

Bank Runs _____

Postal Runs _____

EQUIPMENT TYPES USED BY COMPANY

Please specify average #:

Private Passenger Auto: _____

Small Step Van: _____

Panel Trucks/Vans: _____

Heavy Trucks: _____

Tractor-Trailer: _____

Drivers Average Daily Radius:

<15 miles _____

16-50 miles _____

51-75 miles _____

76-100 miles _____

> 100 miles _____

Do you have ICC Authority?

Please provide:

DOT # _____

MC # _____

INDEPENDENT CONTRACTOR AND EMPLOYEE EXPOSURES FOR THIS COMPANY

	W-2	
	F/T	P/T
Office Personnel		
Stock Workers		
Maintenance		
Messengers-auto		
Messengers-bike		
Messengers-foot		

	1099 Independent Contractors	
	F/T	P/T
Office Personnel		
Stock Workers		
Maintenance		
Messengers-auto		
Messengers-bike		
Messengers-foot		

PRIOR CARRIER AND LOSS INFORMATION

Current Carrier: _____ Renewal Date: _____

Are your 1099 Drivers currently covered under your Workers Compensation Policy? ☐ Yes ☐ No

Are your 1099 Drivers currently covered under any Occupational Accident Plan? ☐ Yes ☐ No

If covered under an Occupational Accident Plan, please attach a schedule of benefits .

Please list prior carrier, loss, and premium information below:

Policy Term	Carrier	Type of Coverage		Losses	Premium	# of Drivers

COURIER COMPANY SUPPLEMENTAL FORM (Cont'd)

OPERATIONS AS THEY PERTAIN TO THE USE OF INDEPENDENT CONTRACTORS

Please respond with a YES or NO to the following questions based on the guidelines currently in use by your company.

Do you require I/C's to punch a time clock upon arriving or leaving? _____

Are I/C's allowed to refuse or reject a delivery if they so choose? _____

Are I/C's allowed to choose their own sequence or method in which deliveries are made? _____

Does the Company require an updated MVR for all new drivers? _____

Does the Company re-check MVR's on an annual basis? _____

Does the Company have any drivers over the age of 70? _____

Does the Company obtain accident reports and keep them in the driver files? _____

Does the Company carry Hired-Non-Owned Auto Insurance? _____

Does the Company require all drivers to wear uniforms/identification badges? _____

Does the Company provide body harness' for lifting large/heavy boxes? _____

Is the Company willing to accept assistance with a safety program? _____

Are any I/C's compensated on an hourly basis? _____

Signature of Applicant/Account:_____ **Date:** _____

Signature of Producer: _____ **Date:** _____

MOVING & STORAGE SUPPLEMENTAL FORM

Company Name: _____ **Telephone**: _____

Contact Name: _____ **E-mail**: _____

Do you have ICC Authority? Please provide: DOT# _____ ***MC#*** _____

RELOCATION AND STORAGE INDUSTRY OPERATION

Please give % of each:

Household Goods	_____%	Special Products	_____%	Freight Forwarder	_____%
Office & Industrial	_____%	Information or Records	_____%	Self Storage	_____%
Other	_____%			Mobile Storage	_____%

EQUIPMENT TYPES USED BY COMPANY

Please specify average #:

Private Passenger Auto: _____

Small Step Van: _____

Panel Trucks/Vans: _____

Heavy Trucks: _____

Tractor-Trailer: _____

Please give % of each type of haul

Local Moving or Hauling < 100 Miles	_____%
Regional Moving 100-300 Miles	_____%
Long Haul Moving . 300 Miles	_____**%**
On Premises Moving or Installation	_____**%**

PRIOR CARRIER AND LOSS INFORMATION

Current Carrier: _____ Renewal Date: _____

Are your 1099 Drivers currently covered under your Workers Compensation Policy? ☐ Yes ☐ No

Are your 1099 Drivers currently covered under any Occupational Accident Plan? ☐ Yes ☐ No

If covered under an Occupational Accident Plan, please attach a schedule of benefits

Please list prior carrier, loss, and premium information below:

Policy Term	Carrier	Type of Coverage	Losses	Premium	# of Drivers

***Were any policies declined, cancelled, or non-renewed in the past 3 years? *** _____

MOVING & STORAGE SUPPLEMENTAL FORM (Cont'd)

OPERATIONS AS THEY PERTAIN TO THE USE OF INDEPENDENT CONTRACTORS

TEAMS/CO-DRIVERS:

1) Do you utilize any teams? [ ]Yes [ ]No If yes, who pays the co-driver?_____
2) Does the co-driver always work for the same independent contractor? [ ]Yes [ ]No
3) Are independent contractors' fleets used? [ ]Yes [ ]No
4) Do any of the independent contractors trip lease? [ ]Yes [ ]No

CASUAL LABOR:

1) Do the drivers load and/or unload? [ ]Yes [ ]No
2) Do the drivers utilize casual laborers? [ ]Yes [ ]No
3) Who is responsible for the casual laborer's workers compensation exposure? _____

CONTRACT DRIVERS:

1) Does the Motor Carrier utilize a standard lease contract for all independent contractors? [ ]Yes [ ]No If yes, please attach a copy of the contract.
2) Is the independent contractor responsible for the maintenance of the truck? [ ]Yes [ ]No
3) Does the independent contractor bear the principal burdens of the operating costs, including fuel, repairs, supplies, and insurance expenses? [ ] Yes [ ] No
4) Is the independent contractor responsible for hiring and supervising necessary personnel to operate the truck, who themselves shall be independent contractors or employees of the independent contractor? [ ] Yes [ ] No
5) Is compensation to the independent contractor based on factors related to the work performed including percentage of any schedule or rates, and not on the basis of time expended? [ ]Yes [ ]No
6) Is independent contractor responsible for selecting the methods and means of performing the services required under contract? [ ]Yes [ ] No

ACKNOWLEDGEMENT FORM

The Account acknowledges that they have been informed of the following:

1) Occupational Accident coverage is not Workers' Compensation Insurance
2) Occupational Accident coverage does not eliminate the Applicant's responsibility to provide Workers' Compensation coverage if required by applicable state law.
3) It is the responsibility of the Account to collect premiums from the Independent Contractors and submit the premiums to the insurer or its duly authorized agent.
4) The Account and the Agent understand that this application is submitted for underwriting consideration and does not bind any Agent, Carrier, or Administrator to coverage.
5) Coverage can be approved and made effective only in writing from the Administrator.

Signature of Applicant/Account _____ Date: _____

Signature of Producer: _____ Date: _____