



**POLICYHOLDER APPLICATION**  
TRUCKERS OCCUPATIONAL ACCIDENT INSURANCE

**POLICYHOLDER INFORMATION**

Motor Carrier Name: \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Contact Person: \_\_\_\_\_ Title: \_\_\_\_\_  
 Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
 USDOT Number: \_\_\_\_\_

Please answer the following questions:

- Number of years in business: \_\_\_\_\_
- Is there Occupational Accident coverage in force now? Yes\*  No   
 If yes, who is the carrier? \_\_\_\_\_  
**Please supply copy of the policy.**  
 What is the in force rate? \$ \_\_\_\_\_
- Number of Independent Contract Drivers to be covered: \_\_\_\_\_  
**Please provide copy of the most current drivers list.**
- Average annual miles per driver: \_\_\_\_\_
- Radius of operations:
 

0-50 miles	_____ %
50-200miles	_____ %
200+miles	_____ %
Maximum length of haul	_____ miles
- What do drivers haul? \_\_\_\_\_
- Percentage of equipment:
 

Box	_____ %
Flatbeds	_____ %
Tankers	_____ %
Refrigerated	_____ %
Container	_____ %
Dump	_____ %
Other (describe) _____	_____ %
- Do the drivers load or unload? Yes  No   
 If yes, what percentage of time? \_\_\_\_\_ %
- Is the driver responsible for maintenance of the truck? Yes  No
- How are the drivers compensated? \*\* \_\_\_\_\_
- Do you have employee drivers? Yes  No   
 If yes, how many? \_\_\_\_\_

- Do drivers sign Owner-Operator Lease Agreements? Yes  No   
**If yes, please supply a copy of the Lease Agreement.**
- Do you lease Contract Drivers from fleet operations? Yes  No   
 If yes, how many? \_\_\_\_\_
- Do you require that the Contract Drivers submit an application or enrollment form to you? Yes  No
- Do you lease out drivers to other motor carriers? Yes  No   
 If yes, to whom and how many? \_\_\_\_\_
- Will Occupational Accident coverage be: voluntary  or compulsory
- Are Casual Laborers or Helpers used? Yes  No   
 If yes, where and how? \_\_\_\_\_
- Do you provide light or restricted duty for drivers? Yes  No   
 If yes, describe: \_\_\_\_\_
- Terminal locations (attach list if needed): \_\_\_\_\_
- Indicate number of Owner-Operators by state of residence:

_____ Alabama	_____ Louisiana	_____ Oklahoma
_____ Alaska	_____ Maine	_____ Oregon
_____ Arizona	_____ Maryland	_____ Pennsylvania
_____ Arkansas	_____ Massachusetts	_____ Puerto Rico
_____ California	_____ Michigan	_____ Rhode Island
_____ Colorado	_____ Minnesota	_____ South Carolina
_____ Connecticut	_____ Mississippi	_____ South Dakota
_____ Delaware	_____ Missouri	_____ Tennessee
_____ D of C	_____ Montana	_____ Texas
_____ Florida	_____ Nebraska	_____ Utah
_____ Georgia	_____ Nevada	_____ Vermont
_____ Hawaii	_____ New Hampshire	_____ Virginia
_____ Idaho	_____ New Jersey	_____ Washington
_____ Illinois	_____ New Mexico	_____ West Virginia
_____ Indiana	_____ New York	_____ Wisconsin
_____ Iowa	_____ North Carolina	_____ Wyoming
_____ Kansas	_____ North Dakota	_____
_____ Kentucky	_____ Ohio	_____ <b><u>TOTAL</u></b>

Provide details of minimum standards for Owner-Operators:

- Minimum age: \_\_\_\_\_
- Maximum age: \_\_\_\_\_
- Minimum prior experience as an Owner-Operator: \_\_\_\_\_
- Minimum prior experience driving similar equipment: \_\_\_\_\_
- Maximum number of accidents permitted: # \_\_\_\_\_ in past \_\_\_\_\_ years
- Maximum number of violations permitted: # \_\_\_\_\_ in past \_\_\_\_\_ years
- Do you provide training for the Owner-Operator? Yes  No
- Describe any other criteria for qualifying Owner-Operators: \_\_\_\_\_

- Has an Owner-Operator or Contract Driver filed a Workers' Compensation claim in the past three (3) years? Yes  No   
If yes, what was the disposition of such claim(s)? \_\_\_\_\_
- Provide information about Safety and Loss Control:  
Name of safety manager: \_\_\_\_\_  
Number of years experience in loss prevention: \_\_\_\_\_  
Number of years working with you: \_\_\_\_\_  
Provide details of in-force safety program: \_\_\_\_\_
- Please indicate the situs state where the **Policyholder's** contract is to be issued: \_\_\_\_\_

**\* Experience: Please provide:** (1) the last three (3) years of Occupational Accident coverage loss runs. The losses should present detailed medical and indemnity claims both reserved and paid. and (2) a complete description of injury and circumstances of any loss to an Owner-Operator involving death, dismemberment, or TTD/CTD losses in excess of \$25,000.

**\*\* Please provide a copy of the standard settlement statement provided to the drivers.**

**PRODUCER INFORMATION**

Agent/Broker: \_\_\_\_\_ Name of Firm: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
Producer Number: \_\_\_\_\_ Commission: \_\_\_\_\_

- Broker of Record for this risk? Yes  No
- Is Broker licensed in contract situs state? Yes  No
- Is the license a: resident license   
non-resident license
- Is the license for: Accident & Health   
Property & Casualty   
Both
- Is the Broker licensed in the situs state for Surplus lines? Yes  No   
If yes, please provide license number: \_\_\_\_\_

**INSURANCE PLAN DESIGN**

**A. OCCUPATIONAL ACCIDENT BENEFITS**

**Accidental Death Benefit:**

**Principal Sum** \* ..... \$ \_\_\_\_\_  
**Accident Commencement Period** ..... 365 days

**Survivor's Benefit:**

**Principal Sum** \* ..... \$ \_\_\_\_\_  
Monthly Benefit Percentage..... %

**Accidental Dismemberment Benefit:**

**Principal Sum** \* ..... \$ \_\_\_\_\_  
**Accident Commencement Period** ..... 365 days

Paralysis Benefit:

Principal Sum \* ..... \$ \_\_\_\_\_  
Accident Commencement Period ..... 365 days

Temporary Total Disability Benefit:

Disability Commencement Period ..... 90 days  
Waiting Period ..... 7 days  
Benefit Percentage ..... %  
Minimum Weekly Benefit Amount ..... \$125  
Maximum Weekly Benefit Amount ..... \$ \_\_\_\_\_  
Maximum Benefit Period \*\* ..... weeks  
Maximum Benefit Period for Hernia ..... 10 weeks

Continuous Total Disability Benefit: \*\*\*

Waiting Period ..... Maximum Benefit Period for Temporary Total Disability  
Benefit Percentage ..... %  
Minimum Weekly Benefit Amount ..... \$50  
Maximum Weekly Benefit Amount ..... \$ \_\_\_\_\_  
Maximum Benefit Amount ..... \$ 200,000  
Maximum Benefit Period ..... to age 70

Accident Medical Expense Benefit:

Medical Commencement Period ..... 90 days  
Deductible Amount ..... \$0  
Maximum Benefit Period ..... weeks  
Dental Maximum ..... \$1,000 per Accident  
Maximum Benefit Amount per Accident ..... \$ \_\_\_\_\_  
Lifetime Maximum Benefit ..... \$ \_\_\_\_\_

Limits on Accident Medical Expense Benefits:

Physical Therapy, Occupational Therapy, Work Hardening Therapy ..... \$1,000 per Injury  
..... And a combined 36 visits  
Services provided by a Chiropractor or Acupuncturist, not including Physical Therapy,  
Occupational Therapy, Work Hardening Therapy ..... \$1,000 per Injury  
Ambulance ..... one round trip to and from a Hospital  
..... but not more than \$1,000 for any one Accident  
Air Ambulance ..... one round trip to and from a Hospital  
..... but not more than \$7,000 for any one Accident  
Hernia Coverage ..... lifetime Maximum Benefit of \$10,000  
Mental and Nervous – Outpatient ..... \$25 per visit  
..... maximum 20 visits for any one Accident  
Mental and Nervous – Inpatient ..... maximum 20 days  
..... maximum \$1,000 for any one Accident  
Other: \_\_\_\_\_

OCCUPATIONAL ACCIDENT LIMITS OF LIABILITY

- Combined Single Limit ..... \$ \_\_\_\_\_
- Aggregate Limit of Liability ..... \$ \_\_\_\_\_  
(applicable to all Covered Losses with respect to any one Occupational Accident)
- Hernia Coverage ..... combined lifetime Maximum Benefit of \$10,000

B. NON-OCCUPATIONAL ACCIDENT BENEFITS

Accidental Death Benefit:

Principal Sum \* ..... \$ \_\_\_\_\_  
Accident Commencement Period ..... 365 days

**Accidental Dismemberment Benefit:**

**Principal Sum** \* ..... \$ \_\_\_\_\_  
**Accident Commencement Period** ..... 365 days

**Accident Medical Expense Benefit:**

**Medical Commencement Period** ..... 90 days  
**Deductible Amount** ..... \$0  
**Maximum Benefit Period** ..... 52 weeks  
Dental Maximum ..... \$1,000 per **Accident**  
**Maximum Benefit Amount per Accident** ..... \$5,000  
**Lifetime Maximum Benefit** ..... \$10,000

**Limits on Accident Medical Expense Benefits:**

Physical Therapy, Occupational Therapy, Work Hardening Therapy ..... \$1,000 per **Injury**  
..... And a combined 36 visits  
Services provided by a Chiropractor or Acupuncturist, not including Physical Therapy,  
Occupational Therapy, Work Hardening Therapy ..... \$1,000 per **Injury**  
Ambulance ..... one round trip to and from a **Hospital**  
..... but not more than \$1,000 for any one **Accident**  
Air Ambulance ..... one round trip to and from a **Hospital**  
..... but not more than \$7,000 for any one **Accident**  
**Mental and Nervous – Outpatient** ..... \$25 per visit  
..... maximum 20 visits for any one **Accident**  
**Mental and Nervous – Inpatient** ..... maximum 20 days  
maximum \$1,000 for any one **Accident**

**NON-OCCUPATIONAL ACCIDENT LIMITS OF LIABILITY**

- **Combined Single Limit** ..... \$ \_\_\_\_\_
- **Aggregate Limit of Liability** ..... \$ \_\_\_\_\_  
(applicable to all **Covered Losses** with respect to any one **Non-Occupational Accident**)

\* At age 65, the **Insured Person's Principal Sum** will be based on the following schedule:

<u>Age at Date of Loss</u>	<u>% of Principal Sum</u>
65	80%
66	60%
67	40%
68	20%
69	15%
70 and over	10%

\*\* If an **Insured Person** sustains a **Covered Injury** at or after age 70, the **Maximum Benefit Period** will be one (1) year.

\*\*\* If an **Insured Person** sustains a **Covered Injury** after the **Insured Person's** normal Social Security retirement age, as determined by federal law, the **Insured Person** cannot qualify for **Continuous Total Disability**.

**FRAUD STATEMENT**

Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.]

**The undersigned:**

1. Declares that all information provided in this Application and any attachments hereto is true and correct. He or she understands that all information provided in this Application and any attachments hereto is material to OneBeacon America Insurance Company’s decision to provide this insurance, and that insurance will be provided, at OneBeacon America Insurance Company’s sole discretion, in reliance upon the truth of such information.
2. Understands and agrees that the insurance applied for will not become effective until the Application for Occupational Accident Insurance coverage is approved by the Insurer, and the initial premium deposit, if applicable, is received; and
3. Agrees that if the insurance applied for is approved by OneBeacon America Insurance Company, he or she will pay all premium due after the Effective Date of the insurance, including any premium which may accumulate between the Effective Date of the insurance and the date the Policy is issued.

If coverage is issued, this Application will be made part of the Policy.

Application completed by: \_\_\_\_\_  
(Risk manager or the person responsible for insurance procurement)

On Behalf of Motor Carrier: \_\_\_\_\_

Signature of Authorized Person: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Title: \_\_\_\_\_

**FOR HOME OFFICE USE ONLY**

APPROVED: YES  NO

DATE: \_\_\_\_\_



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## CONTINGENT LIABILITY APPLICATION

### POLICYHOLDER INFORMATION

Motor Carrier Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Contact Person: \_\_\_\_\_ Title: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
USDOT Number: \_\_\_\_\_

Please list the states in which the motor carrier operates: \_\_\_\_\_

If the motor carrier has a current in-force Contingent Workers' Compensation policy, a Contingent Liability policy or any other similar coverage, please provide the following details:  Not applicable.

<input type="checkbox"/> <u>Contingent Workers' Comp</u>	<input type="checkbox"/> <u>Contingent Liability</u>	<input type="checkbox"/> <u>Other:</u> _____
Insurer Name: _____	Insurer Name: _____	Insurer Name: _____
Policy Number: _____	Policy Number: _____	Policy Number: _____
Term: _____	Term: _____	Term: _____
Expiring Rate: _____	Expiring Rate: _____	Expiring Rate: _____
State of Domicile: _____	State of Domicile: _____	State of Domicile: _____

Has any prior Workers' compensation, Contingent Workers' Compensation, Contingent Liability, or similar coverage been declined, cancelled or non-renewed in the past three years? Yes  No

If yes please explain: \_\_\_\_\_

Has there ever been a loss under Workers' Compensation, Contingent Liability, or similar coverage where an owner-operator or contract driver has been deemed an employee? Yes  No  If yes, please provide the details of each loss. (attach a separate sheet if necessary)

Date: _____	Description: _____	Amount of Loss: \$ _____
Date: _____	Description: _____	Amount of Loss: \$ _____
Date: _____	Description: _____	Amount of Loss: \$ _____

Have there been any citations for any Occupational Safety and Health Administration (OSHA) violations in the last five years? Yes  No  If yes, please provide the details: \_\_\_\_\_

Please answer the following questions regarding the relationship of the independent contractor drivers to the trucking company or motor carrier:

- Do the drivers sign an independent contractor agreement?  
Yes  No  If yes, please provide a copy of the agreement.
- Is the driver responsible for providing the truck?  
Yes  No
- Is the driver responsible for maintenance of the truck?  
Yes  No
- Is the driver responsible for the operating costs of the truck, including fuel, repairs, supplies, physical damage insurance and personal expenses?  
Yes  No
- Is the driver responsible for hiring and supervising the necessary personnel to operate the truck?  
Yes  No
- Is the driver compensated on a basis other than time expended in the performance of work?  
Yes  No
- Is the driver responsible for determining the time, means, and method of performance of the assignment?  
Yes  No

**COVERAGE LIMITS**

Part A Statutory limits\* (to a maximum of \$2,000,000)  
Part B \$100,000 Bodily Injury by Accident (each accident)  
\$500,000 Bodily Injury by Disease (policy limit)  
\$100,000 Bodily Injury by Disease (each employee)

\*Part A benefits for claims filed in Arkansas, Arizona, California, Colorado Connecticut, Delaware, District of Columbia, Idaho, Illinois, Kentucky, Maine, Massachusetts, Michigan, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Rhode Island, Utah, Vermont, or West Virginia are limited to **\$1,000,000.**

I hereby acknowledge that all answers and statements contained, including the attached data, are true and complete. I understand that the contingent liability contract is registered and delivered as a surplus lines coverage under applicable state law. I also understand that no coverage will become effective until an application has been signed and approved by the Insurance company, a policy of Insurance is issued and the required premium is paid, and the premium for the Contingent liability policy shall not be co-mingled with the premium from any other policy.

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**PRODUCER INFORMATION**

Is the Broker licensed in the situs state for Surplus lines? Yes  No   
If yes, please provide license number: \_\_\_\_\_

Application completed by: \_\_\_\_\_  
(Risk manager or the person responsible for insurance procurement)  
On Behalf of Motor Carrier: \_\_\_\_\_

Signature of Authorized Person: \_\_\_\_\_ Date: \_\_\_\_\_  
Print Name: \_\_\_\_\_  
Title: \_\_\_\_\_



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**Motor Carrier**  
**Independent Contractor: Underwriting Check List**

In addition to completing the OneBeacon Occupational Accident and Contingent Liability application please obtain the following information. This information will greatly help MarketScout to obtain the most competitive rates and comprehensive benefits as possible. The additional items needed are:

1. Agency information; address, telephone, fax, email address, contact: \_\_\_\_\_  
\_\_\_\_\_
2. Are you the current agent/broker on the risk; yes or no (circle one)
3. Motor carrier name and address: \_\_\_\_\_  
\_\_\_\_\_
4. Copy of present plan or summary of benefits including declarations page; included yes or no (circle one)
5. Three years premium and claims experience on in force business; included yes or no (circle one)
6. Motor Carrier Independent Contractor Lease Agreement; included yes or no (circle one)
7. Driver list; break down by employment state location; included yes or no (circle one)
8. Description of commodities hauled: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
9. Description of driver minimum requirements: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
10. Plan limits:  
Accident Medical maximum: \_\_\_\_\_  
Accidental Death & Dismemberment: \_\_\_\_\_  
Temporary Disability maximum: \_\_\_\_\_  
Continuous Disability maximum: \_\_\_\_\_  
Policy aggregate: \_\_\_\_\_

Please fax or email scan the following to:  
MarketScout  
404.393.7383 fax  
404.906.6848 phone  
truckers@marketscout.com