# ICOA Application

The information requested below is essential to enable us to expedite a quotation. This information will be the basis on which we will competitively underwrite the account. Although specific data is requested, the account may present unique characteristics which will require additional information and will be requested if needed.

## Account Information

**Legal Name:** _____ **DBA:** _____

☐ Individual ☐ Corporation ☐ Limited Corp. ☐ Partnership ☐ Subchapter "S" Corp. ☐ Other: _____

**List (or attach) subsidiary(s) or combinable entities if coverage is requested:** _____

**Mail Address** *(Domicile State)*: _____

*Street* *City* *State* *Zip*

**Contact Person:** _____ **Telephone:** _____ **Email:** _____

| No. of Years in Business | No. of Contractors | No. of Owners/ Operators | No. of Contract Drivers | No. of Team Drivers |
|---|---|---|---|---|
| | | | | |

## Account Information: Trucking

List all commodities hauled by percent of total for the year:

% % % % %

**Does the Account Haul:** ☐ Hazardous/Waste Material ☐ Logging ☐ Explosives ☐ Flammables ☐ Refuse ☐ Radioactive

**Type of Carrier:** ☐ Common ☐ Contract ☐ Private ☐ LTL: % ☐ Truckload: % ☐ Driver Load/Unload: %

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

**If Bonus Pay Program is available, please detail:** _____

**Radius of Round-Trip in Miles** (percent): **Over 500:** % **499 – 200:** % **199 – 50:** % **Under 50:** %

**Driver's Average Length of Haul in Miles:** _____ **Driver's Average Duration of Haul in Days:** _____

**Type of Equipment by Percent of Total:** Van: % Refrigerated: % Flatbed: % Tanker: % Dump: % Double Trailers: %
Oversize/Overweight: % Other: % details: _____

**Does account allow passengers?** ☐ **Yes** ☐ **No** If yes, please detail: _____

**Check One: Backhaul policy is:** ☐ under the control of ACCOUNT ☐ at the discretion of the DRIVER

*Please detail:* _____

**Are drivers required to report daily?** ☐ **Yes** ☐ **No** **List Account Terminal Locations (**☐ list attached**):** _____

## Contractor Distribution

Total number of **Contractors**, **Owner/Operators**, **Contract Drivers**, **Team Drivers** to be insured by state of residence.

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Alabama:** | | **Idaho:** | | **Michigan:** | | **New York:** | | **Tennessee:** | |
| **Arizona:** | | **Illinois:** | | **Minnesota:** | | **N. Carolina:** | | **Texas:** | |
| **Arkansas:** | | **Indiana:** | | **Mississippi:** | | **N. Dakota:** | | **Utah:** | |
| **California:** | | **Iowa:** | | **Missouri:** | | **Ohio:** | | **Vermont:** | |
| **Colorado** | | **Kansas:** | | **Montana:** | | **Oklahoma:** | | **Virginia:** | |
| **Connecticut:** | | **Kentucky:** | | **Nebraska:** | | **Oregon:** | | **Washington:** | |
| **Delaware:** | | **Louisiana:** | | **Nevada:** | | **Pennsylvania:** | | **W. Virginia:** | |
| **D.C.:** | | **Maine:** | | **New Hampshire:** | | **Rhode Island:** | | **Wisconsin:** | |
| **Florida:** | | **Maryland:** | | **New Jersey:** | | **S. Carolina:** | | **Wyoming:** | |
| **Georgia:** | | **Massachusetts:** | | **New Mexico:** | | **S. Dakota:** | | **Total:** | 0 |

**Account Name:** **Requested effective date of coverage:**

## Safety Information

**FMCSR Carrier Safety Rating:** ☐ Satisfactory ☐ Conditional ☐ Unsatisfactory ☐ None

**Motor Carrier's ID Number:** _____ **Motor Carrier's DOT Number:** _____

**Does account have a full-time safety director?** ☐ Yes ☐ No **Name:** _____

**How often are safety meetings conducted?** _____ **Are Owners/Operators required to attend?** ☐ Yes ☐ No

**How often are Owners/Operators MVRs reviewed?** _____ **Minimum Age:** _____ **Maximum Age:** _____

**What MVR violation would cause Owners/Operator's lease agreement to be "inactive":** _____

**Does the account currently make available an Occupational Accident Program?** ☐ Yes ☐ No

If yes, please attach copy of the current benefit schedule & complete the following information:

**Who is the current carrier:** _____ **Anniversary Date:** _____

If no, (*the account does not provide an Occupational Accident Program*) please state how contractors are insured:

_____

**Attach most current contractor census *(if bound, must be submitted in excel format provide by Midlands)***

## Please Quote the Following Occupational Accident Benefits

| Limits & Conditions | ☐ Plan 1 | ☐ Plan 2 | ☐ Plan 3 | ☐ Custom Plan Design Request | Limits Requested: |
|---|---|---|---|---|---|
| Combined Single Limit per Person | $ 1,000,000 | $ 500,000 | $ 300,000 | Combined Single Limit per Person | $ |
| Accidental Death & Dismemberment | $ 250,000 | $ 150,000 | $ 125,000 | Accidental Death & Dismemberment | $ |
| Accidental Dismemberment Benefit | $ 250,000 | $ 150,000 | $ 125,000 | Survivor's Benefits | $ |
| **Accidental Disability Benefits** | | | | | |
| Waiting Period | 7 Days | 7 Days | 7 Days | Waiting Period | 7 Days |
| Benefit Percentage of Average | 70% | 70% | 70% | Benefit Percentage | % |
| Maximum Weekly Benefit Amount | $ 600 | $ 500 | $ 400 | Maximum Weekly Benefit Amount | $ |
| Maximum Benefit Period - Temporary | 104 Weeks | 104 Weeks | 52 Weeks | Maximum Benefit Period | |
| Permanent Total Disability | Up to Age 70 | Up to Age 70 | Up to Age 70 | Continuous Total Disability | Up to Age 70 |
| Accident Medical Expense Benefit | $ 1,000,000 | $ 500,000 | $ 300,000 | Accident Medical Expense Benefit | $ |
| Medical Incurred Period | 104 Weeks | 104 Weeks | 52 Weeks | Medical Incurred Period | |

| Non-Occupational Accident | ☐ Included ☐ Excluded |
|---|---|
| Combined Single Limit | $ 10,000 |
| Accidental Death & Dismemberment | $ 10,000 |
| Benefit Period | 52 Weeks |

**Installment Payment Options for Death Benefits:** ☐ Yes ☐ No (Choosing "Yes" will result in a monthly payout of the Survivor Benefit.)

## Additional Benefits Requested

**Advance Payments Endorsement:** ☐ Yes ☐ No

**Commuting Benefit Endorsement:** ☐ Yes ☐ No

**Hemorrhoids Coverage Endorsement:** ☐ Yes ☐ No

**Pre-Existing Conditions Coverage:** ☐ Yes ☐ No

**Severe Burn Benefit Endorsement:** ☐ Yes ☐ No

**Hernia Coverage Endorsement:** ☐ Yes ☐ No

**Occupational Cumulative Trauma:** ☐ Yes ☐ No

**Occupational Disease Endorsement:** ☐ Yes ☐ No

**Seat Belt & Air Bag Benefit:** ☐ Yes ☐ No

**Account Name:** **Requested effective date of coverage:**

## Please Provide 5 Years (minimum of 3 years) of Premium & Loss Experience

**Are premium experience reports for the current Occupational Accident Program attached?** ☐ Yes ☐ No

**Are loss experience reports for the current Occupational Accident Program attached?** ☐ Yes ☐ No

## Please Provide the Average Number of Covered Persons for the Past 5 Years (minimum of 3 years)

| Current Year | Previous Year 1 | Previous Year 2 | Previous Year 3 | Previous Year 4 |
|---|---|---|---|---|
| | | | | |

**Expiring Plan Premium:** _____

## Has the account been informed, and acknowledges:

1. Occupational Accident coverage is not Workers' Compensation Insurance. ☐ Yes ☐ No
2. Occupational Accident coverage does not eliminate the Applicant's responsibility to provide Workers' Compensation if required by applicable state law. ☐ Yes ☐ No
3. The Account is responsible for collecting premiums from the Independent Contractors and submitting them to this insurer or its duly authorized agent. ☐ Yes ☐ No
4. The Account and the Agent understands this form is submitted for underwriting consideration and does not bind any Agent, Carrier, or Administrator to coverage. ☐ Yes ☐ No
5. Coverage can be approved and made effective only in writing from the Account Administrator. ☐ Yes ☐ No

## Contingent Liability Coverage Requested? ☐ Yes ☐ No

***Note:*** *A firm Contingent Liability quote cannot be provided without a copy of the Lease Agreement.*

| ☐ Option 1 | ☐ Option 2 |
|---|---|
| $ 1,000,000 per occurrence | $ 2,000,000 per occurrence |
| $ 2,000,000 policy aggregate | $ 4,000,000 policy aggregate |

## Copy of the account's current operative lease agreement is attached? ☐ Yes ☐ No

Have any Independent Contractors, Owner/Operators, or Co-Drivers of the applicant sustained injuries resulting in their death, dismemberment, permanent disability, or a loss (or alleged loss) in excess of $25,000 under either (i) a workers' compensation policy or program of the applicant or (ii) under an occupational accident program sponsored by the applicant? ☐ Yes ☐ No

*If yes, please attach a complete description of any such injuries or losses.*

## Representations:

The Independent Contractor Census lists only those individuals who:

1. are compensated based on factors related to work performed, including a percentage of any schedule of rates or lawfully published tariff, and not on the basis of the hours of time expended;
2. determine the details and means of performing the services, in conformance with regulatory requirements and operating procedures of the account;
3. are at risk for the profit or loss of their individual businesses; and
4. have entered into individual written contracts with the applicant, which specify the relationship to be that of an independent contractor and not that of an employee.

**Account Name:** **Requested effective date of coverage:**

## Trucking Accounts:

The Independent Contractor Census compiled by the applicant lists only those individuals who own or lease long-term vehicle licensed and registered as a truck, road tractor, or truck tractor by a governmental agency and drive their vehicles as independent contractors under the operating authority of the applicant on a full-time exclusive contract basis. The undersigned also understands that losses resulting from injuries to those individuals who are not listed on the schedule on file with neither the insurer nor those individuals who are not Owner/Operators or Co-Drivers (e.g., employees of Owner/Operators or "Co-Drivers"), even if they are scheduled, would not be covered by the policy for which the applicant is seeking coverage.

1. are responsible for the maintenance of their own vehicle;
2. bear the principal burden of the vehicles operating costs, including fuel repairs, supplies, collision insurance and personal expenses of the driver while on the road;
3. are responsible for supplying the necessary personnel to operate the vehicle, and the personnel are considered to be the owner-operator's employees;

The undersigned acknowledges and understands that losses resulting from injuries to those individuals who do not meet the above requirements would not be covered by the policy for which the applicant is seeking coverage, even if they were scheduled. It is also understood by the undersigned applicant that the applicant will be responsible for submitting premiums in aggregate to the insurer or its duly authorized agent.

The undersigned applicant and the applicant's insurance broker certify that all answers and statements provided on this application, including any loss runs or other attachments, are true and complete to the best knowledge of each.

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

Applicant Name (*Printed*): _____ **Title:** _____

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

Producer Name (*Printed*): _____ **Agency Name:** _____

Telephone: _____ **Email:** _____

Address: _____

*Street* *City* *State* *Zip*

For additional information, please contact:

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