



Transportation Underwriting Questionnaire

This questionnaire is for the purpose of requesting to act as a Sponsoring Motor Carrier for Accident Insurance for Independent Contract Drivers and your Texas based Employees. It is not an Application for insurance or a Binder of coverage.

General Operations

1. Motor Carrier:

Motor Carrier Name:	USDOT#:
Contact Person:	Tax ID #:
Street Address:	Yrs. In Business:
City / State / Zip:	

2. Commodities Hauled:

Description	Item #1	Item #2	Item #3	Item #4
Commodity				
% Hauled	____%	____%	____%	____%

3. Types of Vehicles Used:

Types of Vehicles Used	Trailer	Flat Bed	Tanker	Other
% Utilized	____%	____%	____%	Please describe below ↓

4. Does Applicant haul, under its Operating Authority, any HAZMAT? Yes No

If Yes, please Provide Description of Material or Chemicals:

5. Radius of Operations:

Radius	0 – 50 Miles _____%	Over 200 Miles _____%
	50 – 200 Miles _____%	Maximum Length of Haul _____ Miles

6. Terminal Locations: (attach a list if necessary)

7. Does Applicant have any Oversized / Overweight or Double-trailer Operations? Yes No

If Yes, please describe:

8. Who Arranges for Back-hauls? Truckline _____% Drivers _____%

Under what Authority are Back-hauls made? Truckline _____% Drivers _____% Shipper _____%

9. Type of Carriage: Truckload _____% LTL _____%

10. Percentage of Loading / Unloading by Driver: _____%

Please describe:



Exposure Information

Class Description	NCCI Class Code	Number of Lives	Monthly Payroll
			\$
			\$
			\$
			\$

Is Casual Labor used? Yes No

Explain:

11. Provide Details of Minimum Standards for Drivers:

Minimum Age: _____ Maximum Age: _____

Minimum Commercial Truck Driving Experience: _____ Years

Maximum Number of Accidents Permitted: _____ (Number) in the Past _____ Years

Maximum number of violations permitted: _____ (Number) in the Past _____ Years

Do you run MVR's? Yes No

Describe any other Criteria for Qualifying Drivers:

Insurance Coverage History

(IF PRIOR COVERAGE, THIS SECTION MUST BE COMPLETED TO RECEIVE A QUOTATION)

12. Does Applicant currently Sponsor an Occupational Accident and/or Workers' Comp Plan? Yes No

13. If Yes, please complete below and attach any Loss Runs and Explanation for Losses over \$25,000

Coverage Period	Coverage Type / Insurance Company	Premium	Losses Incurred (Include Reserves)	Monthly Premium Per Person
		\$	\$	\$
		\$	\$	\$
		\$	\$	\$

Will the Motor Carrier settle/deduct premiums on behalf of the Contract Driver for this Plan? Yes No

14. Will the Occupational Accident Plan be mandatory for all Contract Drivers of the Motor Carrier? Yes No

How will Coverage be communicated to the Drivers?

Transportation Underwriting Questionnaire (Cont'd)



15. Request for Specific Benefits and Coverage to be Quoted:

I.	Occupational Accidental Death & Dismemberment: <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$150,000 <input type="checkbox"/> \$200,000 <input type="checkbox"/> \$250,000 <input type="checkbox"/> \$300,000 <input type="checkbox"/> Other \$ _____
II.	Occupational Accident Medical Reimbursement: <input type="checkbox"/> \$150,000 <input type="checkbox"/> \$300,000 <input type="checkbox"/> \$500,000 <input type="checkbox"/> \$1,000,000 <input type="checkbox"/> Other \$ _____ Deductible per Insured per Injury \$ _____ Maximum Benefit Period: <input type="checkbox"/> 52 weeks <input type="checkbox"/> 104 weeks
III.	Temporary Total Disability: <input type="checkbox"/> \$300 <input type="checkbox"/> \$350 <input type="checkbox"/> \$400 <input type="checkbox"/> \$450 <input type="checkbox"/> \$500 <input type="checkbox"/> Other \$ _____ Temporary Total Disability Waiting Period: <input type="checkbox"/> 7 days <input type="checkbox"/> 14 days <input type="checkbox"/> 30 days Maximum Benefit Period: <input type="checkbox"/> 7 days <input type="checkbox"/> 14 days
IV.	Continuous Total Disability Benefit: <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, Temporary Total Disability Benefit will be extended and is offset by primary Social Security Disability Award. Claimant must receive Social Security Disability award to qualify for Continuous Total Disability Benefits.)
V.	Combined Single Limit: <input type="checkbox"/> Yes <input type="checkbox"/> No

Loss Control / Supplemental

16. Does the Motor Carrier utilize a standard Lease Agreement for all of its Contract Drivers? Yes No *If Yes, please attach a copy of each contract used.*

17. Does the Lease Agreement or Written Procedures require the following of the Contract Driver?

1.	He owns his equipment or holds it under a bona fide lease arrangement. <input type="checkbox"/> Yes <input type="checkbox"/> No
2.	He is responsible for the maintenance of the truck. <input type="checkbox"/> Yes <input type="checkbox"/> No
3.	He bears the principal burdens of the operating costs, including fuel, repairs, supplies, insurance and personal expenses while on the road. <input type="checkbox"/> Yes <input type="checkbox"/> No
4.	He is responsible for hiring and supervising necessary personnel to operate the truck, who shall themselves be independent contractors or employees of the contract driver. <input type="checkbox"/> Yes <input type="checkbox"/> No
5.	His compensation is based on factors related to the work performed including percentage of any schedule or rates of lawfully published tariff and not on the basis of time expended. <input type="checkbox"/> Yes <input type="checkbox"/> No
6.	He is responsible for selecting the method and means of performing the services required by the contract. <input type="checkbox"/> Yes <input type="checkbox"/> No
7.	He has entered into an individual written contract with the motor carrier that specifies his relationship to be an independent contractor, not an employee of the applicant. <input type="checkbox"/> Yes <input type="checkbox"/> No

18. In the past 3 years, has the Motor Carrier previously defended against a Contract Driver claiming Employee Status? Yes No

How many resulted in a Workers' Compensation Award?

Responsible Party for Safety: Name: _____ Title: _____

Years with Motor Carrier: _____ Years in Loss Prevention Field: _____

Does the Motor Carrier provide Training or Safety Meetings for Independent Contractors and/or Employees? Yes No

If Yes, please describe:



Transportation Underwriting Questionnaire (Cont'd)

19. Does the Applicant own, lease, rent or operate a warehouse? Yes No *If Yes, please describe:*

Other Coverage / Policies

- Workers' Compensation Protection on Owner Operators: Yes No
Motor Carriers Contract Liability: Yes No
Casual Laborer Workers' Compensation: Yes No
Fleet Owners Workers' Compensation: (Need to Request Ind. Apps) Yes No

20. **Return Quote To:**

Name:				
Company:				
Street Address:		City:	State:	Zip:
Telephone:		Fax:		

21. To the best of my knowledge, the information given is accurate and factual. I understand that this form does not bind any Agent, Carrier or Administrator to coverage. This is a Quotation Request Form and will not effect any insurance until approved in writing from U.S. Specialty Insurance Company.