



# U.S. SPECIALTY INSURANCE CO.

13403 Northwest Freeway, Houston, Texas, 77040 • Phone: 800-323-7381 • Fax: 713-996-1225

Submit application to: [ussictransportation@ussic.com](mailto:ussictransportation@ussic.com)

## TRANSPORTATION OCCUPATIONAL ACCIDENT APPLICATION

**THIS IS NOT AN APPLICATION FOR WORKERS' COMPENSATION INSURANCE.**

### Applicant Information:

Eff. Date: \_\_\_\_\_

Business Name and dba:			
Physical Address:	City:	State:	Zip:
Mailing Address:	City:	State:	Zip:
<input type="checkbox"/> Corporation		<input type="checkbox"/> Sole Proprietorship	
<input type="checkbox"/> Partnership		<input type="checkbox"/> LLC	
<input type="checkbox"/> Other		Years in Business:	
Phone Number:		Fax Number:	
Federal Tax I.D. Number:		USDOT #:	
Contact Person:		Website:	

**\* If multiple locations, named insureds, or FEIN, please list on separate sheet.**

### Rating Information:

Class Description – Independent Contractors	Number of Drivers in Each Class	Class Description – Texas Based Employees	Number of Employees in Each Class
Owner Operators		Executive Officers	
Contract Drivers		Clerical	
Lease Purchase Drivers		Mechanics / Shop	
Team Drivers		Employee Drivers	
<b>Total No. of Drivers</b>		<b>Total No. of Employees</b>	

### Number of Independent Contractors in above count by State of Residence:

AL	AR	AK	AZ	CA	CO	CT	DE	FL	GA
HI	IA	ID	IL	IN	KS	KY	LA	MA	MD
ME	MI	MN	MO	MS	MT	NC	ND	NE	NH
NJ	NM	NV	NY	OH	OK	OR	PA	RI	SC
SD	TN	TX	UT	VA	VT	WA	WI	WV	WY

### Coverage Requested:

*Check boxes for requested quote options:*

Medical Maximum Limit	<input type="checkbox"/> \$300,000 <input type="checkbox"/> \$500,000 <input type="checkbox"/> \$1,000,000
Medical Deductible	<input type="checkbox"/> \$0 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000
Disability Maximum Weekly Benefit	<input type="checkbox"/> \$400 <input type="checkbox"/> \$500 <input type="checkbox"/> \$600 <input type="checkbox"/> \$700
AD&D Limits	<input type="checkbox"/> \$100,000 <input type="checkbox"/> \$150,000 <input type="checkbox"/> \$200,000 <input type="checkbox"/> \$250,000
Optional Coverage	<input type="checkbox"/> CTD <input type="checkbox"/> Non-Occ <input type="checkbox"/> CLEL <input type="checkbox"/> Pass. Acc.



**Loss Information (First Dollar Losses): 3 COMPLETE YEARS REQUIRED**

Policy Year	Carrier	Line of Coverage	Total Incurred	Number of Claims	Valuation Date	Premium
		<input type="checkbox"/> WC <input type="checkbox"/> Occ				
		<input type="checkbox"/> WC <input type="checkbox"/> Occ				
		<input type="checkbox"/> WC <input type="checkbox"/> Occ				
		<input type="checkbox"/> WC <input type="checkbox"/> Occ				
		<input type="checkbox"/> WC <input type="checkbox"/> Occ				

**Commodities Hauled / Handling:**

Description	Item # 1	Item # 2	Item # 3	Item # 4	Item # 5	Item # 6
Commodity						
% Hauled						

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

If Yes, please Provide Description of Material or Chemicals:

Loading / Unloading %                      Tarp / Strap Loads %                      Connecting Hoses / Pumps %

Describe Process – forklifts, pallet jacks, manual, dollies, pumps, hoses, etc.

**Equipment Used:**

Trailer Type	Intermodal	Dry Van	Refrigerated	Dump Truck	Tanker	Flatbed
% Utilized						

Describe Other Equipment Used if Not listed above

Oversize / Overweight %                      Double Trailer %

**Radius of Operations:**

Radius of Operation	Local 0-50	Intermediate 51-200	Long Haul Over 200	LTL	Max. Haul	Average Haul
	_____	_____	_____	_____	_____	_____

**Safety Program / Hiring Standards:**

Do you check DOT Physicals?  Yes  No                      Do you run MVR's at least annually on all drivers?  Yes  No  
 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.  
 Describe any other Hiring Standards: \_\_\_\_\_

	Y	N		Y	N
Do you have a written safety manual? When was it last updated? _____	<input type="checkbox"/>	<input type="checkbox"/>	Do you have an alcohol/drug-testing program?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a driver training program?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a safety committee?	<input type="checkbox"/>	<input type="checkbox"/>
Are safety meeting held on a regular basis? Frequency (Please circle): Weekly Monthly Quarterly	<input type="checkbox"/>	<input type="checkbox"/>	Are documented, post-accident investigations conducted?	<input type="checkbox"/>	<input type="checkbox"/>
Do you conduct periodic self-inspections? Frequency (Please circle): Weekly Monthly Quarterly	<input type="checkbox"/>	<input type="checkbox"/>	Is there an appointed Safety Director?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a safety incentive program?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any other safety controls in place that assist you in controlling losses? Please list or attach on separate page.	<input type="checkbox"/>	<input type="checkbox"/>



1. The applicant requests coverage for a policy of insurance as described above. The applicant also agrees to be bound by all of the terms, conditions and limitations of the policy applied for. The applicant further understands and agrees that:
  - a. Neither the Request for Coverage, nor the payment of any monies to be applied, shall guarantee insurance to become effective. In order for insurance to take effect on the date specified, the "Company" must accept and issue a policy.
  - b. The Applicant or the Eligible Drivers that enroll will agree to pay the required premiums to the "Company" when due.
2. Acceptance of this request/application is subject to all of the following: (a) Company's requirements; (b) Terms of the policy;(c) Company verification of the quoted premium.
3. The Company will notify the applicant of any approval or disapproval of this request. Any notice/binder of approval will specify the policy effective date and schedule of coverage.
4. The undersigned applicant understands that he/she may be subject to on-site loss control/safety inspections. Periodic loss control/safety inspections may be required as a contingency for continuation of coverage. The applicant also understands and agrees that he/she will be required to comply with any/all loss control/safety recommendations as a contingency for continuation of coverage.
5. The undersigned applicant has reviewed with his agent (who signs below) and understands the coverage, limits, terms, conditions and exclusion of this application and the policy. This application shall become a part of the policy.
6. The undersigned applicant understands this coverage is made available to the eligible drivers described on this application and agrees to act as a Sponsoring Organization of the policy on their behalf.
7. The undersigned applicant understands all coverage afforded under this policy shall not exceed the coverage amount specified on the policy for any one person or occurrence per the policy terms and conditions.
8. **THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE APPLICANT OR DRIVERS WHO PURCHASE THIS POLICY LOSE THOSE BENEFITS WHICH SHOULD OTHERWISE ACCRUE UNDER WORKERS' COMPENSATION LAWS. THE APPLICANT OR DRIVERS MUST COMPLY WITH THE WORKERS' COMPENSATION LAW IN THEIR STATES OF JURISDICTION**

Applicant Signature (Officer): \_\_\_\_\_

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

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

The undersigned agent warrants he/she has not represented the above coverage as anything other than an occupational accident policy for on-the-job related injuries.

Agent of Record: \_\_\_\_\_

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

Agency/Recording Agent Printed Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

License I.D. Number: \_\_\_\_\_