

TRANSPORTATION UNDERWRITING QUESTIONNAIRE - TEXAS

**U.S. SPECIAL
ALTERNATIVE WO**

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. Name of Motor Carrier: _____ USDOT # _____
 Primary Address: _____ Years in Business: _____
 City: _____ State: _____ Zip: _____ Tax ID#: _____
 Telephone: () _____ Fax: () _____ Contact Person: _____

2. Commodities Hauled:

Description	1	2	3	4
Commodity				
% Hauled				(100%)

3. Type of Vehicles Used:

Types of Vehicle 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 (attached list if needed):

7. Does applicant have any oversized/overweight or double trailer operations? Yes [] No [] 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 loading/unloading by driver: _____% 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 past _____ years

Maximum number of violations permitted: _____ (number) in 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 Work 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

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?

15. Request for specific benefits and coverages to be quoted.

I. Occupational Accidental Death & Dismemberment:

\$100,000 \$150,000 \$200,000 \$250,000 \$300,000 Other \$

II. Occupational Accident Medical Reimbursement:

\$150,000 \$300,000 \$500,000 \$1,000,000 Other \$

Deductible Per Insured Per Injury \$_____ Maximum Benefit Period: 52 weeks 104 weeks

III. Temporary Total Disability

\$300 \$350 \$400 \$450 \$500 Other \$

Temporary Total Disability Waiting Period: 7 days 14 days 30 days

Maximum Benefit Period: 52 weeks 104 weeks

IV. Continuous Total Disability Benefit: Yes 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: Yes 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 attached 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 bonafide lease arrangement. Yes No
2. He is responsible for the maintenance of the truck. Yes No
3. He bears the principal burdens of the operating costs, including fuel, repairs, supplies, insurance, and personal expenses while on the road. Yes 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. Yes 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. Yes No
6. He is responsible for selecting the method and means of performing the services required by the contract. Yes No
7. He has entered into an individual written contract with the motor carrier that specifies his relationship to be that of an independent contractor, not an employee of the applicant. Yes 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? _____ Details _____

Name of person responsible for Safety: _____ Title _____

Number of years with motor carrier: _____ 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: _____

19. Does the applicant own, lease, rent, or operate a warehouse? Yes No If yes, please describe: _____

OTHER COVERAGES/POLICIES:

Work. Comp. Protection on Owner Operators:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Motor Carriers Contract Liability:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Casual Laborer Work Comp:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Fleet Owners Work Comp: (Need to Request Ind. Apps)	Yes <input type="checkbox"/>	No <input type="checkbox"/>

20. Return quote to:

Your Name: _____ Company Name: _____

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 HCC Employer Services, Inc.