**Zurich American Insurance Company**

1299 Zurich Way

Schaumburg, Illinois 60196

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **APPLICANT INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Applicant's Legal Name: | | | | | | | | | | | | | | | | | | | [USDOT #:      ] | | | | | | Tax ID #: | | | | | | |
| Street Address: | | | | | | | | | | | City: | | | | | | | | | State: | | | | | Zip Code: | | | | | | |
| Mailing Address: | | | | | | | | | | | City: | | | | | | | | | State: | | | | | Zip Code: | | | | | | |
| Telephone: | | | | | | | Facsimile: | | | | | | | | | | | | | Website: | | | | | | | | | | | |
| Contact Person: | | | | | | | | | | | | | | | | Email: | | | | | | | | | | | | | | | |
| Are Subsidiaries/Affiliates to be covered?  Yes  No If Yes, please provide a list of complete names and addresses of all to be covered. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **BENEFIT OPTIONS** (please select benefit options below): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **[Occupational] Accident**: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Accidental Death & Dismemberment Benefit **\***: | | | | | | | | | | $150,000 | | | | | $200,000 | | | | | | | | $250,000 | | | | Other $ | | | |
| **\*** Death benefits are paid in a partial lump sum and the balance payable to surviving dependents, if any. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Accident Medical Expense **Maximum Benefit Amount**: | | | | | | | | | | | | | | | $1,000,000 | | | | | | | | Other $ | | | | | | | |
| Accident Medical Expense **Maximum Benefit Period**: | | | | | | | | | | | | | | | 104 Weeks | | | | | | | | Other       weeks | | | | | | | |
| Temporary Total Disability **Maximum Weekly Benefit**  **Amount**: | | | | | | | | | | | | | | | $500.00 | | | | | | | | $600.00 | | | | Other $ | | | |
| Temporary Total Disability **Maximum Benefit Period**: | | | | | | | | | | | | | | | 104 Weeks | | | | | | | | Other       weeks | | | | | | | |
| Continuous Total Disability Benefit Coverage  (included unless otherwise indicated) | | | | | | | | | | Exclude | | | | | | | | | | | | | | | | |  | | | |
| **Non-Occupational Accident** Benefits  (included unless otherwise indicated):  Exclude | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Other Options (included by marking the box below): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Smartphone or Tablet Benefit  Enhanced Wage Benefit Replacement Option  After School Care Benefit  Carjacking Benefit  Coma Benefit  Day Care Benefit  Spouse Retraining Benefit  Vocational Retraining Benefit  Other Benefits Requested (please explain): | | | | | | | | | | | | | | Seat Belt Benefit  Vehicle Modification Benefit  Critical Burn Benefit  Passenger Accident Benefit  Felonious Assault Benefit  Non-Medical Repatriation & Return of Remains Benefit  Higher Education Benefit | | | | | | | | | | | | | | | | |
| **INSURANCE BROKER INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name: | | | | | | | | | | | Agency: | | | | | | | | | | | | | | | | | | | | |
| Address: | | | | | | | | | | | City: | | | | | | | | | State: | | | | | Zip Code: | | | | | | |
| Telephone: | | | | | | | Facsimile: | | | | | | | | | | | | | Email: | | | | | | | | | | | |
| Standard Commission:  Yes  No  Other      % Name of Licensed Agent: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **INSURANCE INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. Are all **Insured Persons** required to have either workers' compensation or occupational accident coverage?   Yes  No   1. Who is the workers' compensation insurance carrier for employee exposure?   Please indicate the retention or deductible amount: $   1. Will insurance premiums be deducted?  Yes  No 2. Do you have a business auto policy?  Yes  No 3. Is there a previous or current occupational accident insurance policy?  Yes  No 4. Why are you considering Zurich? 5. Has there been any litigation/ class action against the Applicant?       If yes, provide case information. 6. Have there been any unemployment claims?  Yes  No 7. Have there been any Department of Labor complaints?  Yes  No 8. Please provide detailed list of all claims and complaints. 9. Please attach current policy and claim runs for the past three (3) years and complete the table below: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Coverage Period | | | Insurance Company | | | | | Premium | | | | | | | | Total Losses | | | | | Monthly Rate | | | | | # Insured Persons | |  | |
|  | | to | | |  | | | | | $ | | | | | | | | $ | | | | | $ | | | | |  | |  | |
|  | | to | | |  | | | | | $ | | | | | | | | $ | | | | | $ | | | | |  | |  | |
|  | | to | | |  | | | | | $ | | | | | | | | $ | | | | | $ | | | | |  | |  | |
| **GENERAL INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. Number of years in business:   Public or Privately Owned:   1. List states with terminal locations: 2. Number of **Insured Persons**:   Number of employee[s][drivers]:  Number of [non-driving] employees:   1. On what basis are **Insured Persons** compensated? 2. Annual **Insured Persons** turnover ratio: recent year     2 years ago   (Turnover ratio is defined as total number of **Insured Persons** dispatched during the past twelve (12) months minus current number of **Insured Persons** divided by current number of **Insured Persons**)   1. Do you offer **Insured Persons**:  health insurance,  physical damage, and/or  NTL 2. Percentage of loads with manual loading/unloading (hand dolly/lift by hand)? 3. Do you administer "physical ability to perform" testing?  Yes  No If Yes, please describe: 4. Number of **Insured Persons** over age 60? 5. Do **Insured Persons** use casual labor, helpers or lumpers?   Yes  No If Yes, please describe:   1. What percentage of **Insured Persons** loads are Hazmat?      %. Please describe: 2. What percentage of **Insured Person’s** loads are LTL?      %. 3. What percentage of **Insured Person’s** loads are less than 200 miles?      % 4. What is expected miles per year for the **Insured Person**? 5. Date of most recent legal review of lease agreement?       Please attach a copy. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Equipment**: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Vehicles Used: | | | Box | | Flatbed | | | Intermodal | | | | Tanker | | | | Refrigerated | | | | | Dump | | Straight Truck | | | | | Other | | | | |
| % of total: | | | % | | % | | | % | | | | % | | | | % | | | | | % | | % | | | | | % | | | | |
| **Commodities:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Describe: | | (1) | | | | | | (2) | | | | | | | | (3) | | | | | | | (4) | | | | | | | | | |
| % of total: | | % | | | | | | % | | | | | | | | % | | | | | | | % | | | | | | | | | |

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| **SAFETY & LOSS CONTROL** | | | | | | | | | | | | | | |
| 1. Describe any OSHA fines related to driving/equipment in the past three (3) years: 2. Is there a full-time Safety Manager?  Yes  No If Yes:    1. Name of Safety Manager:    2. Number of years with Applicant:    3. Number of years in loss prevention: 3. Is there a written safety plan applicable to **Insured Persons**?  Yes  No If Yes, does it include the following:    1. Requires reoccurring training?    2. Driver incentives?    3. Are safety inspections done in house or by an outside vendor? 4. Are physicals done by contracted doctors [or **Insured Persons** doctors]? 5. Do you run MVRs? 6. Do you run background checks? 7. Do you do physical ability to perform testing? 8. Provide below minimum standards for hiring **Insured Persons**:    1. Minimum Age:    2. Maximum Age:    3. Minimum Prior Driving experience:    4. Maximum number of accidents permitted:       in past       years    5. Maximum number of violations permitted:       in past       years    6. Maximum number of major violations permitted:       in past       years    7. Describe any other criteria for qualifying **Insured Persons**:   9. Is there a current drivers training program in place?  Yes  No | | | | | | | | | | | | | | |
| **DRIVER CENSUS INFORMATION (If Applicable)** | | | | | | | | | | | | | | |
| Please complete the following or attach a list including state of residence and driver type: | | | | | | | | | | | | | | |
| **Definitions**:  **Owner/Operator (OO)** is an independent contractor who owns and drives the truck unit.  **Contract Driver (CD)** is an independent contractor who is paid on a 1099 but drives the truck for an owner.  **Courier (CR)** is an independent contractor who receives a 1099 and drives a vehicle where a CDL is not required.  **Fleet Owner (FO)** is an independent contractor who has more than one truck under contract to the trucking firm.  **Fleet Driver (FD) \*** is a W-2 paid employee driver of a contracted fleet owner.  **\* Fleet Drivers are not eligible for occupational accident coverage and must be covered under workers' compensation**. | | | | | | | | | | | | | | |
| **State** | | **OO** | **CD** | **CR** | **FO** | | **FD** | **State** | | **OO** | **CD** | **CR** | **FO** | **FD** |
| Alabama | |  |  |  |  |  | | | Montana |  |  |  |  |  |
| Alaska | |  |  |  |  |  | | | Nebraska |  |  |  |  |  |
| Arizona | |  |  |  |  |  | | | Nevada |  |  |  |  |  |
| Arkansas | |  |  |  |  |  | | | New Hampshire |  |  |  |  |  |
| California | |  |  |  |  |  | | | New Jersey |  |  |  |  |  |
| Colorado | |  |  |  |  |  | | | New Mexico |  |  |  |  |  |
| Connecticut | |  |  |  |  |  | | | New York |  |  |  |  |  |
| Delaware | |  |  |  |  |  | | | North Carolina |  |  |  |  |  |
| D.C. | |  |  |  |  |  | | | North Dakota |  |  |  |  |  |
| Florida | |  |  |  |  |  | | | Ohio |  |  |  |  |  |
| Georgia | |  |  |  |  |  | | | Oklahoma |  |  |  |  |  |
| Hawaii | |  |  |  |  |  | | | Oregon |  |  |  |  |  |
| Idaho | |  |  |  |  |  | | | Pennsylvania |  |  |  |  |  |
| Illinois | |  |  |  |  |  | | | Puerto Rico |  |  |  |  |  |
| Indiana | |  |  |  |  |  | | | Rhode Island |  |  |  |  |  |
| Iowa | |  |  |  |  |  | | | South Carolina |  |  |  |  |  |
| Kansas | |  |  |  |  |  | | | South Dakota |  |  |  |  |  |
| Kentucky | |  |  |  |  |  | | | Tennessee |  |  |  |  |  |
| Louisiana | |  |  |  |  |  | | | Texas |  |  |  |  |  |
| Maine | |  |  |  |  |  | | | Utah |  |  |  |  |  |
| Maryland | |  |  |  |  |  | | | Vermont |  |  |  |  |  |
| Massachusetts | |  |  |  |  |  | | | Virginia |  |  |  |  |  |
| Michigan | |  |  |  |  |  | | | Washington |  |  |  |  |  |
| Minnesota | |  |  |  |  |  | | | West Virginia |  |  |  |  |  |
| Mississippi | |  |  |  |  |  | | | Wisconsin |  |  |  |  |  |
| Missouri | |  |  |  |  |  | | | Wyoming |  |  |  |  |  |
|  | |  |  |  |  |  | | |  |  |  |  |  |  |

The applicant hereby applies for [Occupational] Accident Insurance and:

1. Represents that the answers included in this Application for Occupational Accident Insurance coverage have been reviewed and are true and complete; and
2. Understands and agrees that the insurance applied for shall not become effective until the Application for [Occupational] Accident Insurance coverage is approved by the **Company** [**Association**]and the initial premium deposit is received; and
3. Agrees that if the insurance applied for is approved by the **Company** [**Association**], the applicant will pay all premiums due after the effective date of the insurance.

This Group Application shall be made part of the **Policy**, if issued.

By checking this box, the applicant acknowledges that the applicant is electronically signing this form. Furthermore, in order to conduct business electronically with the **Company**, the applicant acknowledges that the electronic signature is the same as the handwritten signature for purposes of validity, enforceability, and admissibility.

|  |  |
| --- | --- |
| Completed by Applicant: | Title: |
| Signature of Applicant: | Date: |

TO BE ATTACHED TO AND FORM PART OF THE APPLICATION. IF FRAUD WARNINGS ARE INCLUDED IN THE APPLICATION TO WHICH THIS IS ATTACHED, THIS DISCLOSURE REPLACES THOSE WARNINGS.

Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance or 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 may subject the person to criminal and civil penalties. (Not applicable in AL, AR, CA, CO, DC, FL, KS, KY, LA, MD, ME, MN, NJ, NM, NY, OH, OK, OR, PA, PR, RI, TN, TX, VA, VT, WA, and WV.)

In **Arkansas, Louisiana, Rhode Island or West Virginia**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

In **Alabama**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines or confinement in prison, or any combination thereof.

In **California**: The falsity of any statement in the application for any policy shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

In **Colorado**: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

In **District of Columbia**: Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

In **Florida**: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

In **Kansas**: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

In **Kentucky**: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

In **Tennessee or Washington**: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

In **Maryland**: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

In **Minnesota**: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

In **New Jersey**: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

In **New Mexico**: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

In **Ohio**: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

In **Oklahoma**: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

In **Pennsylvania**: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 subjects such person to criminal and civil penalties.

In **Puerto Rico**:Any person who has committed fraud, as defined in the law, shall incur a felony, and if convicted, shall be sanctioned for each violation by a penalty of a fine of not less than five thousand dollars ($5,000), nor more than ten thousand dollars ($10,000), or a penalty of imprisonment for a fixed term of three (3) years, or both penalties. If there were aggravating circumstances, the fixed penalty thus established may be increased up to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years. In addition to the penalties provided in this chapter, any person who, as a result of the fraud thus committed is benefited in any way to obtain insurance, or in the payment of a loss pursuant to an insurance contract, shall be imposed the payment of restitution of the amount of money resulting from the fraud. Every violation shall have a prescription term of (5) five years.

In **Texas**: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

In **Vermont**: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

In **Virginia**: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company.