TRAWICK International

OccuSafe Occupational Accident Application

Motor Carrier Information

Legal Name: _____ DBA: _____

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

Attach subsidiary(s) or combinable entities if coverage is requested: _____

Physical Address *(Domicile State)*: _____

Street *City* *State* *Zip*

Mailing Address: _____

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

Motor Carrier Information: Trucking

List all commodities hauled:

Does the Account Haul:

- ☐ Hazardous/Waste
- ☐ Material Logging
- ☐ Explosives
- ☐ Flammables Refuse
- ☐ Radioactive

Type of Equipment by Percent of Total:

Intermodal _____
Dry Van / Reefer Bulk _____
Carrier / Tanker _____
Oversized _____
Flat Bed / Sand Gravel _____
Auto Hauler _____
Courier _____
Limousines _____
Moving & Storage _____

Home Delivery _____
Hazardous Materials _____
Livestock _____
Dump Truck _____
Mobile Home _____
Garbage Haulers _____
Oilfield Equipment _____
Heavy Machinery _____
Other:

Do Drivers Load or Unload by hand?

◯ Yes ◯ No

Avg Miles driven daily?

Equipment Type Must Equal 100%

0

Radius of Round-Trip in Miles (percent): % Over 500 . %499 – 250 % 249 -100 Under 100:

Method of Driver Compensation:

Are Passengers Allowed? Yes ◯ No ◯

Total Number of Contractor by State

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 the most current contractor census *(if bound, must be submitted in excel format provide by Trawick International, Inc.)*

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	◯ $ 5,000	◯ 10,000 ◯ 15,000
Accidental Death & Dismemberment	$ 5,000	10,000 15,000
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

Additional Named Insured: ◯ Yes ◯ No

Waiver of Subrogation: ◯ 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

Passenger Accident: ◯ 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 $75,000 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;
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: Producer _____ Date: _____

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

Telephone: _____ Email: _____

Address: _____

Street *City* *State* *Zip*

CLEAR FORM