GREAT AMERICAN INSURANCE GROUP
Trucking

301 E. Fourth Street, 22N
Cincinnati, OH 45202-4201
Toll Free 800-643-7882

Occupational Accident Application

Effective Date _____

Applicant _____ Street Address _____

City _____ State _____ Zip _____

Telephone Number _____ DOT/Motor Carrier # _____

Application Must Include the Following

☐ 5 years of currently valued loss runs *(no more than 30 days old)*	☐ Incumbent carrier and reason the account is being marketed
☐ Driver census	☐ Expiring rate/pricing
☐ Current lease agreement inclusive of addendums	☐ Lease to purchase agreement

Motor Carrier Information

	Yes	No
1. Have you had Occupational Accident Insurance in the past? **If no**, please explain how on-the-job injuries were covered.	☐	☐
2. Have you ever had Occupational Accident Insurance canceled, refused or non-renewed? **If yes**, give company name, date and reason.	☐	☐

3. Describe and give percentages of specific commodities hauled. *(Avoid general terms.)* Please use a separate sheet, if necessary.

Commodity							Total
Percent Hauled							100%

4. Percentage of commodities manually loaded/unloaded _____% ☐ None

5. What percentage of vehicles are:

   Box _____% Flatbed _____% Tanker _____% Dump _____% Other _____%

   Describe types and quantity of vehicles marked as "Other". _____

6. What percentage of your Independent Contractors' trips are:

   50 Miles _____% 51-200 Miles _____% Over 200 Miles _____%

	Yes	No
7. Is there any exposure to flammables, explosives, caustics or fumes? **If yes**, please explain.	☐	☐

Motor Carrier Information *Continued*

		Yes	No
8.	Do you have any affiliate operations? **If yes**, please explain.	☐	☐

9. Please complete the chart below regarding your prior policies.

Policy Term	Annual Premium	Number of Insured Independent Contractors	Independent Contractor Monthly Premium	Incurred Losses	Number of Losses

Driver Information

		Yes	No
1.	Is there a safety program in place that the Independent Contractors must participate in? Please explain.	☐	☐
2.	Describe your driver screening procedures for hiring Independent Contractors. Minimum age _____ Maximum age _____ Minimum years' experience _____ Do you run MVRs?	☐	☐
3.	Is participation in the Occupational Accident program voluntary? **If yes**, please provide number of participating drivers and explain enrollment process.	☐	☐
4.	Do ALL Independent Contractors sign lease agreements? **If no**, please explain any exceptions.	☐	☐
5.	Do ALL Independent Contractors own their vehicles? **If no**, please explain any exceptions.	☐	☐
6.	Do Independent Contractors utilize any lease-to-purchase programs? **If yes**, please advise number or percentage of participants and provide a sample lease-to-purchase agreement.	☐	☐

Driver Information *Continued*

	Yes	No
7. Do any Independent Contractors operate company-owned units? **If yes**, please explain the circumstances.	☐	☐
8. Do Independent Contractors utilize helpers or casual laborers? How are they insured?	☐	☐

9. Please attach driver census containing the following information: Classes of Eligible Persons (see below), DOB, and state.

Classes of Eligible Persons:

1. **Owner-Operators:** A person who has entered into a Covered Contract with the Motor Carrier for the leasing of the power unit.
2. **Co-Drivers:** A person who drives in the same unit on a full-time basis with the Primary Owner-Operator.
3. **Contract Drivers:** A person who does not own nor lease a power unit, operates a unit owned or leased by an Owner-Operator and is not an employee of the Owner-Operator or Motor Carrier.
4. **Authorized Passengers:** A person authorized by the Owner-Operator or Contract Driver who is a minimum of sixteen (16) years of age and who does not drive the power unit.
5. **Casual Laborers:** A temporary helper or laborer who is not an employee of the Motor Carrier and who does not operate the power unit.
6. **Other:** Please Describe.

	Yes	No
10. Has applicant performed the required analysis under applicable law, including but not limited to Cal. Labor Code § 2775(b)(1), to confirm the worker status of its Independent Contractors? **If no**, please explain.	☐	☐

Benefit Plan Desired

Coverage	**Class** _____		**Class** _____		**Class** _____	
	Occupational	**Non-Occupational**	**Occupational**	**Non-Occupational**	**Occupational**	**Non-Occupational**
Accidental Death & Dismemberment Benefit Amount	☐ $200,000 ☐ $250,000 ☐ $300,000 ☐ $ _____	☐ $10,000 ☐ $15,000 ☐ $ _____	☐ $200,000 ☐ $250,000 ☐ $300,000 ☐ $ _____	☐ $10,000 ☐ $15,000 ☐ $ _____	☐ $200,000 ☐ $250,000 ☐ $300,000 ☐ $ _____	☐ $10,000 ☐ $15,000 ☐ $ _____
Accident Medical Expense						
Benefit Amount	☐ $500,000 ☐ $750,000 ☐ $1,000,000 ☐ $ _____	☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $ _____	☐ $500,000 ☐ $750,000 ☐ $1,000,000 ☐ $ _____	☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $ _____	☐ $500,000 ☐ $750,000 ☐ $1,000,000 ☐ $ _____	☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $ _____
Benefit Period	☐ 52 weeks ☐ 104 weeks	☐ 52 weeks ☐ 104 weeks	☐ 52 weeks ☐ 104 weeks	☐ 52 weeks ☐ 104 weeks	☐ 52 weeks ☐ 104 weeks	☐ 52 weeks ☐ 104 weeks

Benefit Plan Desired *Continued*

	Occupational	Non-Occupational	Occupational	Non-Occupational	Occupational	Non-Occupational
Temporary Total Disability Benefit Amount Per Week						
Maximum	☐ $500 ☐ $600 ☐ $700 ☐ $_____		☐ $500 ☐ $600 ☐ $700 ☐ $_____		☐ $500 ☐ $600 ☐ $700 ☐ $_____	
Minimum	☐ $150 ☐ $200 ☐ $_____		☐ $150 ☐ $200 ☐ $_____		☐ $150 ☐ $200 ☐ $_____	
Benefit Period	☐ 52 weeks ☐ 104 weeks		☐ 52 weeks ☐ 104 weeks		☐ 52 weeks ☐ 104 weeks	
Continuous Total Disability Benefit Amount Per Week						
Maximum	☐ $500 ☐ $600 ☐ $700 ☐ $_____		☐ $500 ☐ $600 ☐ $700 ☐ $_____		☐ $500 ☐ $600 ☐ $700 ☐ $_____	
Minimum	☐ $150 ☐ $200 ☐ $_____		☐ $150 ☐ $200 ☐ $_____		☐ $150 ☐ $200 ☐ $_____	
Combined Single Limit Per Insured	☐ $500,000 ☐ $1,000,000 ☐ $_____		☐ $500,000 ☐ $1,000,000 ☐ $_____		☐ $500,000 ☐ $1,000,000 ☐ $_____	
Combined Single Limit Per Occurrence	☐ $500,000 ☐ $1,000,000 ☐ $_____		☐ $500,000 ☐ $1,000,000 ☐ $_____		☐ $500,000 ☐ $1,000,000 ☐ $_____	
Passenger Accident Coverage	**Occupational**	**Non-Occupational**	**Occupational**	**Non-Occupational**	**Occupational**	**Non-Occupational**
Accidental Death & Dismemberment Benefit Amount	☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ $_____		☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ $_____		☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ $_____	
Accident Medical Expense						
Benefit Amount	☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ $_____		☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ $_____		☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ $_____	
Benefit Period	☐ 52 weeks ☐ 104 weeks		☐ 52 weeks ☐ 104 weeks		☐ 52 weeks ☐ 104 weeks	
Other	_____		_____		_____	

Optional Riders *(Please contact underwriter for range of limits)*

** Coverages are not available in all states*

☐ Hernia	☐ Natural Disaster	☐ In-Hospital Indemnity
☐ Hemorrhoid	☐ Pre-Existing Condition	☐ Commuting
☐ Occupational Disease	☐ Seat Belt & Air Bag	☐ Home Alteration & Vehicle
☐ Occupational Cumulative Trauma	☐ Hijacking	☐ Trauma Counseling
☐ Coma	☐ Rehabilitation	☐ Severe Burn

Optional Riders *Continued*

☐ Emergency Evacuation	☐ Occupational HIV & Hepatitis	☐ Child Care Benefit
☐ Felonious Assault	☐ Repatriation of Remains	☐ Special Education
☐ Truck Payment		

Contingent Liability Questionnaire

	Yes	No
1. Has any prior Workers' Compensation, Contingent Workers' Compensation, Contingent Liability, or similar coverage been declined, canceled, or non-renewed in the past three years?	☐	☐

If yes, please explain. _____

Please provide information on your current Workers' Compensation policy, Contingent Workers' Compensation policy, Contingent Liability policy, or similar coverage. Please specify which policy.

Insurer Name _____

Policy Number _____ Term _____

State of Domicile _____ Type of Policy _____

If Workers' Compensation, please provide the Experience Modification Factor. _____

2. Have you ever experienced a loss under Workers' Compensation, Contingent Liability, or similar coverage where an Independent Contractor/Owner-Operator has claimed employee status?	☐	☐

If yes, please give details of each loss. *(Attach a separate sheet, if necessary.)*

Date	Description	Amount of Loss

3. Have you been cited for any Occupational Safety and Health Administration (OSHA) violations in the past five years?	☐	☐

If yes, please provide details. _____

4. Coverage Limits

Coverage A *(Benefits)*

☐ Statutory Workers' Compensation

☐ Other

Coverage B *(Employer's Liability)*

☐ $100,000 Bodily Injury by Accident *(Each Accident)*

☐ $500,000 Bodily Injury by Disease *(Policy Limit)*

☐ $100,000 Bodily Injury by Disease *(Each Employee)*

☐ Other _____

$ _____ Bodily Injury by Accident *(Each Accident)*

$ _____ Bodily Injury by Disease *(Policy Limit)*

$ _____ Bodily Injury by Disease *(Each Employee)*

I hereby acknowledge that all answers and statements contained, including the attached data, are true and complete. I understand that the Contingent Liability contract is registered and delivered as a surplus lines coverage under applicable state law. I also understand that no coverage will become effective until an application has been signed and approved by the Insurance Company, a Policy of Insurance is issued, and the required premium is paid.

Broker/Agent Signature _____ **Date** _____

Applicant Signature _____ **Date** _____

	Yes	No
Is Agent/Broker Surplus Lines licensed in state of policy issuance?	☐	☐
If no, please name Agent/Broker authorized to assume duties and responsibilities of Registered Surplus Lines Agent/Broker, below.		

Insurance for this program may be provided by a surplus lines insurer. Risks placed with a surplus lines insurer must be placed in accordance with state and federal law, including applicable surplus lines laws. Surplus lines insurers do not generally participate in State Guaranty Funds and thus insureds are not protected by such funds.

To Be Completed By Surplus Lines Agent/Broker

Broker/Agency _____

Contact Person _____

Street Address _____

City _____ State _____ Zip _____

Telephone Number _____ Fax Number _____

Contingent Liability Insurance is a non-admitted (surplus lines) contractual liability policy and is underwritten by Great American E&S Insurance Company.