



For all other coverage(s) desired; attach Acord applications.
Please also attach Acord's 1. Coverages/Limits section; and, 2. all Acord's state specific forms as applicable to the insured's domicile

SECTION I - ROUTING INFORMATION

Quote Only: Proposed Effective Date: _____ Need Quote by: _____
 Bind Coverage: Effective: _____ New _____ Renewal of _____ \$ _____
Quote # Policy # Premium

Agency: _____ Agent Number: _____
 Account Representative: _____ Phone #: _____ Fax #: _____

SECTION II - GENERAL INFORMATION

1 Applicant Name: _____
 2 Street Address: _____
Street City County State Zip Code
 3 Garaging Address: _____
 4 Phone #: _____ Fax #: _____ Contact: _____
 5 Legal Status: Individual Partnership Corporation Other _____
FEIN# SS#
 If Individual -- Do you have autos insured under a personal auto policy? Yes No
 6 Describe your business: _____
 7 Is this operation a new venture? Yes No *If No, how long have you been in business under the above name:* _____
 8 Have you ever operated a trucking business under any other name? Yes No *If Yes, provide DOT#* _____
Name of business and explain in Remarks Supplement
 9 Have you filed for bankruptcy under any name in the past 10 years? Yes No *If Yes, explain in Remarks Supplement*
 10 What is your (applicant's): **Net Worth** \$ _____ **Gross Income:** \$ _____
prior year estimated current year
 Financials May Be Requested
 11 Email Address _____

SECTION III - OPERATIONS

1 You are a (Check all applicable): Contract Carrier Common Carrier Exempt Carrier Freight Broker* Other
 2 List the applicable percentage of your operations next to each radius grouping:
 _____% 0 - 75 miles _____% 76 - 200 miles _____% 201 -500 miles _____% Over 500 Miles
 3. Indicate all locations where you regularly PICK-UP or DROP-OFF loads:

<input type="checkbox"/> 1 Atlanta	<input type="checkbox"/> 10 Denver	<input type="checkbox"/> 20 Memphis	<input type="checkbox"/> 29 Phoenix	<input type="checkbox"/> 41 Mountain	<input type="checkbox"/> 51 San Diego
<input type="checkbox"/> 2 Baltimore/Washington	<input type="checkbox"/> 11 Detroit	<input type="checkbox"/> 21 Miami	<input type="checkbox"/> 30 Philadelphia	<input type="checkbox"/> 42 Midwest	<input type="checkbox"/> 52 Seattle
<input type="checkbox"/> 3 Boston	<input type="checkbox"/> 12 Hartford	<input type="checkbox"/> 22 Milwaukee	<input type="checkbox"/> 31 Pittsburgh	<input type="checkbox"/> 43 Southwest	<input type="checkbox"/> 53 Sacramento
<input type="checkbox"/> 4 Buffalo	<input type="checkbox"/> 13 Houston	<input type="checkbox"/> 23 Minneap/St Paul	<input type="checkbox"/> 32 Portland	<input type="checkbox"/> 44 North Central	<input type="checkbox"/> 54 San Antonio
<input type="checkbox"/> 5 Charlotte	<input type="checkbox"/> 14 Indianapolis	<input type="checkbox"/> 24 Nashville	<input type="checkbox"/> 33 Richmond	<input type="checkbox"/> 45 Mideast	<input type="checkbox"/> Canada*
<input type="checkbox"/> 6 Chicago	<input type="checkbox"/> 15 Jacksonville	<input type="checkbox"/> 25 New Orleans	<input type="checkbox"/> 34 St Louis	<input type="checkbox"/> 46 Gulf	<input type="checkbox"/> Mexico
<input type="checkbox"/> 7 Cincinnati	<input type="checkbox"/> 16 Kansas City	<input type="checkbox"/> 26 New York City	<input type="checkbox"/> 35 Salt Lake City	<input type="checkbox"/> 47 Southeast	
<input type="checkbox"/> 8 Cleveland	<input type="checkbox"/> 17 Little Rock	<input type="checkbox"/> 27 Oklahoma City	<input type="checkbox"/> 36 San Francisco	<input type="checkbox"/> 48 Eastern	
<input type="checkbox"/> 9 Dallas/Ft Worth	<input type="checkbox"/> 18 Los Angeles	<input type="checkbox"/> 28 Omaha	<input type="checkbox"/> 37 Tulsa	<input type="checkbox"/> 49 New England	
	<input type="checkbox"/> 19 Louisville		<input type="checkbox"/> 40 Pacific Coast	<input type="checkbox"/> 50 Alaska	

4 Do you have a DOT safety Rating? Yes No *If Yes, what is it?* _____
 5. What is your MC #? _____ What is your DOT Number? _____ Is MCS-90 needed? _____

Explain all YES answers in Remarks Supplement. * Requires supplemental application.

6 Do you have any other insurance currently in force with our company?	<input type="checkbox"/> Yes <input type="checkbox"/> No	14 Will equipment be loaned/rented to others?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7 Has your insurance ever been refused, canceled or non-renewed in past 3 years? (N/A in MO)	<input type="checkbox"/> Yes <input type="checkbox"/> No	15 Do you trip lease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8 Do you haul or have the authority to haul any commodity considered hazardous by the EPA and/or the DOT?*	<input type="checkbox"/> Yes <input type="checkbox"/> No	16. Do your drivers participate in a formal safety program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		17 Are passengers permitted in vehicles?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9 Have you ever hauled to a landfill or treatment facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No	18 Do you always conduct pre-trip inspections?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Do you haul Intermodal/Containerized freight?*	<input type="checkbox"/> Yes <input type="checkbox"/> No	19 If you use dual wheel pick-ups or pick-ups, are they equipped with a 5 th wheel coupling device to pull semitrailers?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Do you pull Oversized/Overweight loads? *	<input type="checkbox"/> Yes <input type="checkbox"/> No		
12. Do you pull Double/Triple Trailers?	<input type="checkbox"/> Yes <input type="checkbox"/> No	20. Any hold harmless or waiver of subrogation agreements?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Do you use any trailers not marked with fluorescent tape?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

*** Requires supplemental application**

SECTION IV - UNIT INFORMATION

Complete Schedule of Covered Autos

SECTION V - DRIVER INFORMATION (If additional space required, attach supplement)

1 Check all practices used by your company in driver selection: MVR Check Road Test Written Application
 Physical Exam Drug Test Reference Check Employment Verification Other _____

2 Describe acceptability requirements for hiring drivers: _____

3 Use Owner/Operators? No Yes - State % of Revenues: _____ and complete owner/operator supplement

4 Use team drivers? No Yes - Number/teams: _____

5 Are Motor Vehicle Reports of employed drivers pulled and reviewed? Yes No If Yes, how often? _____ /attach copies

6 Are all drivers covered by Workers Compensation? Yes No If Yes, who is your insurer? _____
 If No explain _____

7 How many were *hired* over the last 12 months? _____ How many drivers *left* your employ over the last 12 months? _____

8 How are Drivers compensated? Hourly wage Payment Per Trip Salary Other _____

9 What are the maximum hours driven per day? _____ hours

10 What hours of the day do your drivers operate? 6 AM to 2 PM _____% 2 PM to 10 PM _____% 10 PM to 6 AM _____%

11 Where do your drivers sleep when they are on a trip? Motel In the Cab Other: _____

#	DRIVER Last name, First name, Middle Init.	Date of Birth	✓ here if O/O ¹	Social Security Number Drivers License Number	Lic. State	# Years T/T driving	Date of Hire	# Accidents # Violations in last 3 yrs ²
1								
2								
3								
4								
5								

¹O/O = Owner/Operator ²This information is not necessary if MVR is attached.

SECTION VI - INSURANCE INFORMATION (If additional space required, attach supplement.)

1. Attach currently valued loss runs for current year and three prior years.
 Explain all open BI claims and all claims \$25,000 or greater in remarks supplement.

2. Complete table below pertaining to your current Insurance:

Coverage	Name of Current Carrier	Limit	Premium	Expiration Date	Est. Renewal Prem
			\$		\$
			\$		\$
			\$		\$

SECTION VII - GENERAL INFORMATION (If additional space required, attach supplement)

1. List commodities hauled.

Commodity / Packaging	% of Revenues	Commodity / Packaging	% of Revenues

2 Do you haul your own goods exclusively? Yes No _____% Owned goods _____% Non-owned goods

3 Total Annual Mileage: Current Year _____ 1st Prior _____ 2nd Prior _____

4 Is there any Logging/Lumbering Operations? No Yes - Complete Supplement

SECTION VIII - PRIMARY AUTO LIABILITY

Primary Auto Liability – Complete Acord Coverage/Limits and State Specific Forms

1. Does your operation require filings? Yes* No Provide Docket #: **MC** _____
 * If filings are required, a **Filing Supplement** must accompany this application
- 2 Do you own any equipment not scheduled on this application? Yes No If Yes explain in Remarks
- 3 Is all equipment operating under your authority scheduled on this application? Yes No If No explain in Remarks
- 4 If you have requested Primary Liability is unhooked coverage to be provided on scheduled Trailers? Yes No
 If Yes: a Are trailers kept isolated from the public? Yes No b. Are trailers fully enclosed by a fence? Yes No

SECTION IX – ADDITIONAL REQUESTED COVERAGES

- Physical Damage** - Complete state specific Acord Coverage/Limits section form
- Hired Auto, Trailer Interchange or Non-owned Liability coverage** - Complete Additional Coverages Supplement.
- General Liability** – Complete Acord Application and LGIC Supplement
- Motor Truck Cargo** – Complete Supplement

SECTION X - NON-TRUCKING INFORMATION

- 1 Are all units leased to trucking concerns on a long term basis? Yes No
2. List all companies to whom you currently lease

Lessee Name	Lessee Address

- 3 Do you ever use the unit(s) for Personal / Family use? Yes No If Yes, percentage of usage? _____%
- 4 Do you ever haul for entities other than the Lessee? Yes No If Yes, percentage of usage? _____%

SECTION XI – SIGNATURES

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR REPRESENTATIVE THEREOF OR WHO FILES AN APPLICATION FOR INSURANCE CONTAINING ANY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACTUAL MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME

THIS FORM MUST BE SIGNED BY BOTH THE APPLICANT AND PRODUCER, AND IF APPLICABLE, WHOLESALER OR GA.

AS THIS IS THE LAST PAGE OF OUR APPLICATION FOR COMMERCIAL AUTOMOBILE AND CARGO INSURANCE, YOUR SIGNATURES BELOW ATTEST THAT THE INFORMATION PROVIDED ON THIS APPLICATION INCLUDING ALL SUPPLEMENTS, IS COMPLETE AND ACCURATE TO THE BEST OF YOUR KNOWLEDGE AND BELIEF

SIGNATURE OF FIRST NAMED INSURED

LGIC AGENCY NAME / CODE NUMBER

TITLE: (Owner Partner, President, Etc)

DATE

ADDRESS

SIGNATURE of Producer for Wholesaler or GA
Show 'N/A' if no Subproducer is involved

DATE

AGENCY SIGNATURE / DATE
If submitted by Wholesale or GA, this signature signifies receipt and submission of this application

LICENSE NUMBER



Insurance Application
Motor Truck Cargo Supplement

SECTION A - GENERAL INFORMATION

1. Applicant Name: _____ Policy Number: _____

2. Please provide commodity information in the table below (If additional space required, attach schedule.)

Commodity	Average Load Value	Maximum Load Value	%	Commodity	Average Load Value	Maximum Load Value	%

3. Do you haul under released bill of lading? Yes No *If Yes, explain in Remarks Section and attach copies.*

4. Do you back haul the property of others? Yes No *If Yes, explain in Remarks Section Include for whom and type cargos.*

5. Are vehicles left loaded overnight? Yes No *If Yes, explain in Remarks Section Include frequency*

6. How many of your units have alarm systems? _____ *If one (1) or more, explain in Remarks Section Include types.*

7. How many of your units are equipped with fire extinguishers? _____ *If any, describe types in Remarks Section.*

SECTION B - COVERAGE INFORMATION

1. Indicate Coverage desired: Broad Form Named Perils + Theft Named Perils (excluding theft)

2. Cargo Coverage Limit: \$ _____ Deductible: \$ _____ Per Item Limit: \$ _____

3. Do you want Mechanical Breakdown coverage? Yes No *If Yes, indicate desired deductible: _____*

4. Do you want cargo terminal coverage? Yes No *If Yes, complete Terminal Supplement*

5. If you desire additional coverages, describe requested coverages, applicable limits and deductibles _____

6. Does your operation require Cargo Filings? Yes No *If Yes, complete Filing Supplement.*

7. Do you want loading and unloading coverage? Yes No Describe Mechanical Equipment used in Remarks Section

8. Complete table below:

Name of Previous Carrier	Cargo Hauled	Limit	Premium	Effective Date	Expiration Date
			\$		
			\$		
			\$		

SECTION C - REMARKS SECTION

Provide additional information in the space below. If you are explaining answers to particular questions, please indicate the section and question numbers

INITIALED BY: APPLICANT: _____ DATE _____ AGENCY: _____ DATE _____



Insurance Application Filing Supplement

Applicant Name: _____ Policy Number: _____

SECTION A - GENERAL INFORMATION

Explain all **Yes** responses in Remarks Supplement.

- | | | |
|-------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|
| 1 Do you operate as a subsidiary of any other company? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2 Do you have subsidiaries operating for you? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3 Have you purchased or applied for additional authority in the past 3 years? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4 Have you sold any authority in the past 3 years? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5 Have you ever lost or had authority withdrawn? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6 Are you currently, or have you ever been under probation by any regulatory authority? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7 List all states in which your operation requires Oversized / Overweight permits? _____ | | |

Attach related questionnaire.

SECTION B - FEDERAL FILING INFORMATION

If you have, or are applying for FHWA authority and require that a filing be made on your behalf, please complete this section
Information must appear exactly as you filed it on your application for authority.

- 1 FHWA Docket #: **MC** _____ Filing type(s) needed: Liability Cargo
- 2 Name as filed: _____
- 3 Address as filed: _____

City, State Zip code
- 4 To comply with single-state registration, what state have you chosen for your **BASE STATE***: _____
 * AZ, DE, FL, MD, NJ, NV, OR, PA, VT and WY are **NOT** valid base states.

SECTION C - STATE FILINGS

Complete this section only if you have submitted a specific authority application to a state and/or province.

- 1 Check Here if name & address are the same as above. If different or if Section B does not apply, provide name/address below
- 2 Name as filed: _____
- 3 Address as filed: _____

City, State Zip code

4 Indicate all states & Canadian provinces which require a filing to be made on your behalf

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

PROVINCES: Alberta B Columbia Manitoba New Brunswick Newfoundland NW Territories
 Nova Scotia Ontario Prince Edwards Island Quebec Saskatchewan Yukon

5. List all state/province docket numbers applicable: _____

INITIALED BY: APPLICANT: _____ DATE _____ AGENCY: _____ DATE _____



Additional Coverages Hired Auto / Non-owned Auto / Trailer Interchange

Applicant Name : _____ Policy/Submission Number : _____

SECTION A - HIRED AUTO

Complete section only if you are requesting coverage

- 1 Check desired coverage(s): HIRED AUTO LIABILITY HIRED AUTO PHYSICAL DAMAGE
- 2 (a) Are Autos hired under a written lease agreement? Yes No
 (b) Do you always hire with owner/operators as drivers? Yes No
- 3 Are Drivers of hired autos scheduled on the current policy? Yes No *If No, explain how hired drivers are screened:*

When hired without driver, do you usually purchase lessor's primary liability and physical damage coverages? _____

- 4 Explain use of hired autos _____
 Is condition of vehicles confirmed in writing prior to lease? Yes No
- 5 What is the average term of the lease? _____ *If term is over 6 months, vehicles & drivers must be scheduled on policy.*
- 6 What is the estimated annual cost of hire? _____ Cost of Hire for prior years? _____
- 7 If Hired Auto Physical Damage is requested, complete table below.

Maximum Unit Value	\$
Other than Collision Deductible*	\$
<i>Check one:</i> <input type="checkbox"/> Comprehensive (where available) <input type="checkbox"/> Specified Causes of Loss	
Collision Deductible**	\$
Estimated Coverage Days	
Max. number of units hired at one time	

If Estimated Coverage Days cannot be provided:

* Use a Other than Collision deductible of \$250

** Use a Collision deductible of \$500 or \$1000

- 8 3 year loss history _____
(attach separate sheet if more space is needed)

SECTION B - NON-OWNERSHIP LIABILITY

Complete section only if you are requesting coverage

- 1 Number of Employees? _____
- 2 Percentage of employees using their own car on behalf of your business? _____ %
- 3 Explain use of vehicles by employees _____
- 4 Would you like to extend non-ownership coverage to cover the individual liability of employees while using their autos in your business? Yes No
- 5 Number of Partners? _____
- 6 3 year loss history _____
(attach separate sheet if more space is needed)

SECTION C - TRAILER INTERCHANGE

Complete section only if you are requesting coverage

- 1 Do you have a written trailer interchange agreement? Yes No
- 2 Explain use of non-owned trailers _____
- 3 Is condition of trailers confirmed in writing prior to taking possession? Yes No
 Does customer pre-load trailers? Yes No Does insured vehicle drivers always know contents of trailers? Yes No
 Does insured pick up trailers of regular customers? Yes No
- 4 Complete table below.

Maximum Trailer Value	\$
Other than Collision Deductible*	\$
<i>Check one:</i> <input type="checkbox"/> Comprehensive (where available) <input type="checkbox"/> Specified Causes of Loss	
Collision Deductible**	\$
Estimated Coverage Days ***	
Max. number of trailers hired at one time	

If Estimated Coverage Days cannot be provided:

* Use a Other than Collision deductible of \$250

** Use a Collision deductible of \$500 or \$1000

***Total number of trailers times the total number of days in possession

- 5 3 year loss history _____
(attach separate sheet if more space is needed)

SECTION D - REMARKS SECTION

Provide additional information in the space below. If you are explaining answers to particular questions, please indicate the section and question numbers.

INITIALED BY: APPLICANT: _____ DATE _____ AGENCY: _____ DATE _____