Truck Application

COLUMBIA INSURANCE COMPANY
NATIONAL FIRE & MARINE INSURANCE COMPANY
NATIONAL INDEMNITY COMPANY
NATIONAL INDEMNITY COMPANY OF MID-AMERICA
NATIONAL INDEMNITY COMPANY OF THE SOUTH
NATIONAL LIABILITY & FIRE INSURANCE COMPANY

New England Excess Exchange, Ltd.
P O Box 650 ~ Barre, VT 05641
800-548-4301 or Fax 800-347-4935
info@neee.com ~ www.neee.com

Policy Term From:_____ To _____

1. Name (and "dba") _____
   ☐ Individual/Proprietorship ☐ Partnership ☐ Corporation ☐ Other Business Phone Number _____
2. Mailing Address _____ City _____ State _____ Zip _____
3. Premises Address _____ City _____ State _____ Zip _____
4. Person to contact for inspection (name and phone number) _____
5. Have you ever had insurance with one of the companies listed at the top of this page? ☐ Yes ☐ No
   If yes, Policy Number(s) _____ Effective Date(s) _____

DESCRIPTION OF OPERATIONS

6. Describe business _____
   Years experience _____ New Venture? ☐ Yes ☐ No If you are a tow truck operation, do you do repossessions? ☐ Yes ☐ No
7. Is this your primary business? ☐ Yes ☐ No If no, explain _____
   Seasonal? ☐ Yes ☐ No
8. Have you ever filed for Bankruptcy? ☐ Yes ☐ No If yes, when _____ Explain _____
9. Gross receipts last year _____ Estimate for coming year _____ Business for sale? ☐ Yes ☐ No
10. Do you operate in more than one state? ☐ Yes ☐ No If yes, list states _____
11. Do you haul for hire? ☐ Yes ☐ No Show largest cities entered _____
12. Do you operate over a regular route? ☐ Yes ☐ No If yes, show towns operated between _____
13. Are you a common carrier? ☐ Yes ☐ No Are you a contract hauler? ☐ Yes ☐ No If yes, for whom _____
14. List all types of cargo hauled _____
15. Do you haul any hazardous or extra hazardous substances or materials as defined by EPA? ☐ Yes ☐ No If yes, provide complete listing identifying all material(s) and/or chemical content: _____
16. Do you haul your own cargo exclusively? ☐ Yes ☐ No If not, who owns it? _____
17. Do you pull double trailers? ☐ Yes ☐ No Triple trailers? ☐ Yes ☐ No
18. Do you rent or lease your vehicles to others? ☐ Yes ☐ No If yes, attach copy of rental or lease agreement form used.
19. Do you hire any vehicles? ☐ Yes ☐ No Complete Hired and Non-Owned Supplemental Questionnaire if coverage is desired.

LIABILITY COVERAGE — Complete for desired coverages by indicating limits of insurance.

LIABILITY				Medical Payments	Personal Injury Protection (where applicable)	
Combined Single Limit BI & PD	Split Limits					**IF PHYSICAL DAMAGE COVERAGE DESIRED, REFER TO FOLLOWING PAGE.**
	Bodily Injury		Property Damage			**IF IN-TOW COVERAGE DESIRED, COMPLETE TOW TRUCK SUPPLEMENT.**
	Each Person	Each Accident	Each Accident			**HIRED, NON-OWNED - M-4055.**

APPLICABLE PERSONAL INJURY PROTECTION, UNINSURED AND/OR UNDERINSURED MOTORISTS INSURANCE SELECTION/REJECTION PAGE IS REQUIRED TO BE COMPLETED AND SIGNED BY THE NAMED INSURED WITH THE SUBMISSION OF THIS APPLICATION.

DRIVER INFORMATION — If additional space is needed, attach separate listing.

Driver's Name	Date of Birth	Driver's Licenses				Experience	
		State	Number	Class/Type (i.e. CDL)	Years Licensed (in Class/Type)	Type of Unit (Bus, Van, Truck, Tractor, etc.)	No. of Years
1.							
2.							
3.							
4.							
5.							

DRIVER INFORMATION (Continued) — If additional space is needed, attach separate listing.

No. Years Previous Commercial Driving Experience	Date of Hire	Accidents and Minor Moving Traffic Violations in Past 5 Years				Major Convictions (DWI/DUI, Hit & Run, Manslaughter, Reckless, Driving While Suspended/ Revoked, Speed Contest, other felony)		Employee (E) Ind. Cont. (IC) Owner/Op. (O/O) Franchisee (F)
		No. of Accidents	Date(s)	No. of Violations	Date(s)	Describe Conviction	Date(s)	
1.								
2.								
3.								
4.								
5.								

PLEASE ATTACH DETAILED EXPLANATION OF ACCIDENTS LISTED ABOVE.

20. Are drivers covered by Workers Compensation? ☐ Yes ☐ No If yes, name of carrier _____

21. Minimum years driving experience required _____ Are vehicles owner-driven only? ☐ Yes ☐ No

22. Are drivers ever allowed to take vehicles home at night? ☐ Yes ☐ No If yes, will family members drive? ☐ Yes ☐ No

23. Do you order MVR's on all drivers prior to hiring? ☐ Yes ☐ No Driver's maximum driving hours _____ daily, _____ weekly

24. Do you agree to report all newly hired operators? ☐ Yes ☐ No

25. What is the basis for driver(s) pay? ☐ Hourly ☐ Trip ☐ Mileage ☐ Other, explain _____

SCHEDULE OF AUTOS/VEHICLES — Describe all vehicles for which application is made for insurance.

Veh. No.	Model Year	Vehicle Make & Model	Body Type (Truck, Tractor, Trailer, etc.)	Full Vehicle Identification Number	Gross Vehicle Weight (GVW)	Total # of Rear Axles	Principal Garaging Location (city & state)	Radius of Operation	Annual Mileage Per Vehicle	(A) Anti-Lock Brakes, (B) Air Bags
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

26. Will lessor be added as additional insured? ☐ Yes ☐ No If yes, give name and address of lessor for each vehicle _____

27. Number of vehicles owned: Pick-Ups _____ Trucks _____ Tractors _____ Semi-Trailers _____ Trailers _____ Pup Trailers _____

28. Number of vehicles leased: Pick-Ups _____ Trucks _____ Tractors _____ Semi-Trailers _____ Trailers _____ Pup Trailers _____

PHYSICAL DAMAGE COVERAGE — Complete spaces below in detail for each respective auto/vehicle described above.

Veh. No.	Date Purchased	Cost When Purchased	Current Stated Value (excluding permanently attached equipment)	Value of Permanently Attached Special Equipment	Total Stated Amount to be Insured	Physical Damage Deductible		Cargo Limit of Insurance
						☐ Comprehensive ☐ Spec. C of Loss	Collision	
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

29. Any loss payees? ☐ Yes ☐ No If yes, give name and address of mortgagee/loss payee for each vehicle _____

LOSS EXPERIENCE — Provide prior insurance carriers information for past full three years.

Policy Term		Insurance Company Name	No. of Motor Powered Vehicles	No. of Accidents	Premium		Total Amount Claims Paid & Reserves			
From	To				Liab	Phys Dam	BI	PD	Comp/Coll	Other
/ /	/ /									
/ /	/ /									
/ /	/ /									

30. Is any applicant aware of any facts or past incidents, circumstances or situations which could give rise to a claim under the insurance coverage sought in this application? ☐ Yes ☐ No If yes, provide complete details _____

31. Have you ever been declined, cancelled or non-renewed for this kind of insurance? ☐ Yes ☐ No If yes, date and why _____

CARGO INFORMATION — 100% coinsurance clause applies. Use Tow Truck Supplement for In-Tow/On Hook coverage.

PREVIOUS CARGO CARRIER AND LOSS EXPERIENCE (list for the past three years with most recent carrier first).

Policy Term		Company & Policy Number	Premium	Number of Claims	Cause of Loss	Amount Paid	Reserves
From	To						
/ /	/ /						
/ /	/ /						
/ /	/ /						

Describe Cargo Hauled	% of Hauling	Maximum Value	Average Value	Limit of Insurance	Deductible
				SEE PHYSICAL DAMAGE COVERAGE SECTION	☐ $500 ☐ $1,000 ☐ $2,500 ☐ Other _____

If applicant hauls double wide mobile homes, Limit of Insurance must be equal to the value of both sides combined to satisfy co-insurance.
Amount of insurance on each truck should equal maximum load carried.

32. Select type of cargo coverage desired: ☐ Named Perils or ☐ Broad Form

33. Additional Coverage Options (additional premium may apply): ☐ Additional Insured Endorsement (Lessee) ☐ Loading and Unloading Coverage ☐ Earned Freight Coverage ☐ Refrigeration Breakdown Coverage ☐ Hired Car Cargo Coverage ☐ Exclude Theft Coverage

FILING INFORMATION

34. Is an FHWA filing required? ☐ Yes ☐ No If yes, MC number _____
☐ Common ☐ Contract ☐ Broker Do you require FHWA cargo filing? ☐ Yes ☐ No

35. If you hold a Brokers license, identify name filed with FHWA, FHWA docket no. and receipts from brokerage operations _____

36. If you are an interstate regulated carrier, identify your registration or base state _____

37. Is an intrastate filing needed? ☐ Yes ☐ No If yes, show state and permit number _____
List states for which insured requires CARGO FILINGS (check name on permits) _____

38. Show exact name and address in which permits are issued _____

39 Is MCS 90 endorsement needed? ☐ Yes ☐ No

40. Is our policy to cover all vehicles owned, operated or under lease to applicant? ☐ Yes ☐ No If no, explain _____

41. Are oversize, overweight commodities hauled? ☐ Yes ☐ No If filing required, show states _____
Are escort vehicles towed on return trips? ☐ Yes ☐ No

42. Does your authority allow for transportation of hazardous commodities? ☐ Yes ☐ No

43. Do you allow others to haul hazardous commodities under your authority? ☐ Yes ☐ No

44. Have you ever changed your operating name? ☐ Yes ☐ No Do you operate under any other name? ☐ Yes ☐ No

45. Do you operate as a subsidiary of another company? ☐ Yes ☐ No

46. Do you own or manage any other transportation operations that are not covered? ☐ Yes ☐ No

47. Do you lease your authority? ☐ Yes ☐ No Do you appoint agents or hire independent contractors to operate on your behalf? ☐ Yes ☐ No

48. Have you purchased, sold or applied for authority over the past 3 years? ☐ Yes ☐ No

49. Have you ever lost or had authority withdrawn, or have you been/are under probation by any regulatory authority (FHWA, PUC, etc.)? ☐ Yes ☐ No

50. Is evidence/certificate(s) of coverage required? ☐ Yes ☐ No

51. Please explain any "yes" answer to questions 44 through 50 _____

52. Do you have agreements with other carriers for the interchange of equipment or transportation of loads? ☐ Yes ☐ No
If yes, attach a copy of current agreements and complete the following:
(a) With whom has such agreement(s) been made? _____
(b) Do the parties named in (a) carry automobile liability insurance? ☐ Yes ☐ No
If yes, name of insurance company and limits of liability (Bodily Injury & Property Damage) _____
(c) Under whose permit does each of the parties to the agreement(s) operate? _____
(d) Is there a hold harmless in the agreement(s)? ☐ Yes ☐ No

53. Do you barter, hire or lease any vehicles? ☐ Yes ☐ No If yes, explain _____

CONNECTICUT
INFORMED CONSENT FORM

NOTICE TO INSUREDS

The Automobile Insurance Reform Act, Public Law 93-297 is effective January 1, 1994. It affects your coverage in several ways. You should read this notice carefully, make your selections and return to your agent.

REPEAL OF NO FAULT

Beginning January 1, 1994, new or renewed policies are not required to include Basic Reparations Benefits (BRB). BRB provided up to $5,000 for medical expenses and lost wages caused by auto accidents.

You may have other coverage provided by your employer, or by health or disability insurance. If you don't, you should consider optional Medical Payments. Otherwise, you may bear the cost yourself.

Of course, if someone else is responsible for your losses you may seek recovery from that person.

OPTIONAL MEDICAL PAYMENTS (MED PAY) COVERAGE

You may choose to buy Medical Payments coverage to help cover your medical bills from auto accidents.

We will pay reasonable expenses incurred for necessary medical and funeral services to or for an "insured" who sustains "bodily injury" caused by "accident". We will pay only those expenses incurred, for services rendered within three years from the date of the "accident".

UNINSURED MOTORIST COVERAGE

Our law requires you to buy uninsured motorist (UM/UIM) coverage. Generally, this coverage only applies where the person who causes an accident is not an insured under your policy.

Anyone injured in an accident may seek to recover damages from the person causing the loss. These losses include your medical bills, lost wages (past and future), as well as payment for disabilities, pain and suffering and loss of enjoyment of life's activities.

Normally, these damages would be paid by the other person's insurance company. UM/UIM coverage protects you, your family and others in your car for injuries caused by someone who did not buy insurance.

You have the right to choose the amount of coverage. It can be as low as $20,000 per person and $40,000 per accident, or as high as twice your policy's bodily injury liability coverage. The amount of liability coverage you buy will govern the maximum amount of UM/UIM coverage you can buy.

This coverage also includes standard Underinsured Motorist (UIM) coverage. It protects you where injuries are caused by someone whose insurance is not enough to pay your damages and is less than your UM/UIM limits. UM coverage will pay your damages to fill in the difference between those limits. However, the protection available under standard UM coverage is usually reduced by amounts paid by worker's compensation, or by or on behalf of the person at fault.

Under our new law, you can convert standard UIM coverage to UNDERINSURED MOTORIST CONVERSION (UIMC) coverage. This coverage is not reduced by payments from any source. If your damages exceed the amount of the at fault person's insurance, or other payments, your UIMC coverage will be available for damages not paid.

Both standard (UIM) and conversion (UIMC) coverages only become available after the liability insurance of the at fault person has been fully paid.

Stacking

To make a wise decision as to the amount of UM/UIM coverage to buy, you need to understand "stacking". Stacking allows insureds to add together UM/UIM coverage under separate policies or, in multi-car policies, the insurance applicable to each car.

Unless you agreed to non-stacked coverage, all policies in effect before January 1, 1994 provide for stacking. Policies issued or renewed beginning in 1994 will no longer provide for stacking.

With stacking, if you had two insured cars and you purchased $100,000 of UM/UIM coverage you received (and you paid for) $200,000 of protection. Under the new law the purchased amount ($100,000) would not be multiplied by the number of cars insured.

Also, your UM/UIM coverage will be limited to the highest available limit under any of the policies that apply to the accident. If you are injured in a car you own you are limited to the amount of coverage for that car.

ELECTION OF COVERAGE

POLICY NUMBER _____ BODILY INJURY LIABILITY LIMIT _____

A. OPTIONAL MED PAY COVERAGE

If you do not check a box in this section and sign below your policy will be issued/renewed without Medical Payments.

MED PAY Coverage (limit) MED PAY Premium

$ _____ _____

SELECT ONE

☐ I WISH TO BUY OPTIONAL MED PAY COVERAGE AT THE PREMIUM SHOWN ABOVE.

☐ I DO NOT WISH TO BUY MED PAY COVERAGE.

B. UNINSURED MOTORIST (UM/UIM) COVERAGE

If you do not check a box below your policy will be issued/renewed with standard UIM coverage (not Conversion UIMC coverage) with limits equal to your Bodily Injury Liability (BI) coverage.

If you check more than one box your policy will be issued/renewed with the highest level of coverage selected.

SELECT ONE OPTION UNDER EITHER STANDARD UIM COVERAGE OR CONVERSION UIMC COVERAGE. DO NOT CHECK MORE THAN ONE BOX BELOW.

UM WITH STANDARD UIM COVERAGE

Total Coverage Premium

☐ Double BI Limit
$ _____ $ _____
(Indicate Double BI Limit)

☐ BI Limit
$ _____ $ _____
(Indicate equal to BI Limit)

* ☐ Statutory Minimum
$ _____ $ _____
(Indicate statutory minimum)

* ☐ Option (based upon your selection of a limit other than stated above)
$ _____ $ _____

NOTE: An asterisk (*) preceding a box indicates a reduction in coverage below your Bodily Injury Liability limit.

UM CONVERSION UIMC COVERAGE

Do not check a box below if you have checked a box for one of the standard UIM coverages above.

Total Coverage Premium

☐ Double BI Limit
$ _____ $ _____
(Indicate Double BI Limit)

☐ BI Limit
$ _____ $ _____
(Indicate equal to BI Limit)

* ☐ Statutory Minimum
$ _____ $ _____
(Indicate statutory minimum)

* ☐ Option (based upon your selection of a limit other than stated above)
$ _____ $ _____

NOTE: An asterisk (*) preceding a box indicates a reduction in coverage below your Bodily Injury Liability limit.

IF YOU HAVE CHECKED ONE OF THE BOXES PRECEDED BY AN ASTERISK (*), WHEN YOU SIGN THIS FORM, YOU ARE CHOOSING A REDUCED PREMIUM, BUT YOU ARE ALSO CHOOSING NOT TO PURCHASE CERTAIN VALUABLE COVERAGE WHICH PROTECTS YOU AND YOUR FAMILY. IF YOU ARE UNCERTAIN ABOUT HOW THIS DECISION WILL AFFECT YOU, YOU SHOULD GET ADVICE FROM YOUR INSURANCE AGENT OR ANOTHER QUALIFIED ADVISOR.

_____ _____
(Signature of Any Named Insured) (Date)

SIGNATURE IS ALSO REQUIRED ON LAST PAGE OF APPLICATION

MUST BE SIGNED BY THE APPLICANT PERSONALLY

No coverage is bound until the Company advises the Applicant or its representative that a policy will be issued and then only as of the policy effective date and in accordance with all policy terms. The Applicant acknowledges that the **Applicant's Representative named below is acting as Applicant's agent and not on behalf of the Company. The Applicant's Representative has no authority to bind coverage, may not accept any funds for the Company, and may not modify or interpret the terms of the policy.**

The Applicant agrees that the foregoing statements and answers are true and correct. The Applicant requests the Company to rely on its statements and answers in issuing any policy or subsequent renewal. The Applicant agrees that if its statements and answers are materially false, the Company may rescind any policy or subsequent renewal it may issue.

If any jurisdiction in which the Applicant intends to operate or the FHWA requires a special endorsement to be attached to the policy which increases the Company's liability, the Applicant agrees to reimburse the Company in accordance with the terms of that endorsement.

The Applicant agrees that any inspection of autos, vehicles, equipment, premises, operations, or inspection of any other matter relating to insurance that may be provided by the Company, is made for the use and benefit of the Company only, and is not to be relied upon by the Applicant or any other party in any respect.

The Applicant understands that an inquiry may be made into the character, finances, driving records, and other personal and business background information the Company deems necessary in determining whether to bind or maintain coverage. Upon written request, additional information will be provided to the Applicant regarding any investigation.

The Applicant represents that she/he has completed all relevant sections of this Application prior to execution and that the Applicant has personally signed below (or if Applicant is a Corporation, a corporate officer has signed below).

Will premium be financed? ☐ Yes ☐ No If yes, with whom _____

_____	_____	_____
Witness	Applicant's Signature	Date

TO BE COMPLETED BY APPLICANT'S REPRESENTATIVE

Is this direct business to your office? _____ If not, explain _____

Is this new business to your office? _____ If not, how long have you had the account? _____

How long have you known applicant? _____

REQUEST TO COMPANY GENERAL AGENT:

☐ Please quote ☐ Please bind at earliest possible date and issue policy

☐ Please issue policy effective _____ Coverage was bound by _____
(Time and Date Bound by General Agent) (Name of Person in Company General Agency's Office Binding Coverage)

_____
Applicant's Representative's Name and Address Phone No.