



QUESTIONNAIRE – Occupational Accident Insurance

NOTE: There are six sections to this questionnaire. All sections must be completed for questionnaire to be accepted. Questionnaire must be signed.

Submission Checklist

- Copy of current Occupational Accident Insurance Policy
- Copy of current Contingent Liability Insurance Policy
- Loss runs (3-5 years)
- Historic unit counts to match the loss run term
- Explanation of losses >\$25,000
- Owner Operator Lease Agreement
- Equipment Lease Agreement (if applicable)
- Explanation of SMS scores over threshold/copy of safety manual
- Driver census listing: Name, Address, DOB

POLICY EFFECTIVE DATE: _____ **QUOTE DUE DATE:** _____

Motor Carrier Name*: _____

Street Address: _____

City: _____ State: _____ Zip: _____

USDOT Number: _____

Contact Person: _____ Title: _____

Telephone: _____ Email Address: _____

**If this Questionnaire is being completed for more than one carrier or the above carrier has more than one terminal location, please provide names/addresses below (Attach a separate sheet, if necessary):*

Name	Address
1. _____	_____
2. _____	_____
3. _____	_____

SECTION I: Motor Carrier Information

1. How many years has the motor carrier been in business? _____
2. Total number of Independent Contractors: _____
3. How many Independent Contractors are to be covered under this program? _____
4. Does the motor carrier haul hazardous materials? Yes No
 - a. If yes, what percent of **TOTAL loads** are hazardous materials? _____ %
 - b. Provide the percent of **TOTAL loads** that are:
 Flammable _____ % Fuel _____ % Caustic _____ % Poisonous _____ % Explosive _____ %
5. What is the radius of operation? 0-50 miles _____ % 51-200 miles _____ % 201+ miles _____ %
6. What do drivers haul? _____

7. What percentage of equipment is:

Equipment	Dry Van	Flatbed	Refrigerated	Container	Dump	Tanker	Other
Owned							
Leased							

- a. If other, please describe: _____
- b. Is equipment leased from the motor carrier or third party? _____
8. Do the drivers load or unload? Yes No
 - a. If yes, what percentage of time? _____ %
9. What percentage of the Independent Contractor hauls is less than load (LTL)? _____ %
10. Are casual laborers or helpers used? Yes No
 - a. If yes, where and how? _____
 - b. Do laborers/helpers require Occupational Accident insurance? Yes No

SECTION II: Driver Information

Minimum Standards for Independent Contractors:

1. What is the minimum age? _____ What is the maximum age? _____
2. Is training provided for Independent Contractors? Yes No
 - a. If yes, please describe: _____

3. Describe any other criteria for qualifying Independent Contractors: _____

Indicate number of Independent Contractors by residence:

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 another owner.

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	FO	FD	State	OO	CD	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	_____	_____	_____	_____

Totals

Owner Operators	_____
Contract Drivers	_____
Fleet Owners	_____
Fleet Drivers	_____

SECTION III: Insurance Plan and Requested Coverage

1. What is the target rate for Occupational Accident Insurance? _____

2. Is a sponsored Occupational Accident coverage currently in force? Yes No

a. If yes, please provide:

Coverage Period	Carrier	Rate	No. of Drivers
_____ to _____			
_____ to _____			
_____ to _____			
_____ to _____			
_____ to _____			

3. Why is this account out to market? _____

A. OCCUPATIONAL ACCIDENT BENEFITS

AD&D	<input type="checkbox"/> \$150,000 <input type="checkbox"/> \$200,000 <input type="checkbox"/> \$250,000 <input type="checkbox"/> \$300,000 <input type="checkbox"/> Other \$ _____
MEDICAL	<p>Accident Medical Expense Benefit <input type="checkbox"/> \$300,000 <input type="checkbox"/> \$500,000 <input type="checkbox"/> \$1,000,000 <input type="checkbox"/> Other \$ _____</p> <p>Maximum Benefit Period <input type="checkbox"/> 52 weeks <input type="checkbox"/> 104 weeks</p> <p>Benefit Waiting Period <input type="checkbox"/> 7 Days <input type="checkbox"/> 14 Days</p>
DISABILITY	<p>Temporary Total Disability Benefit <input type="checkbox"/> \$400 <input type="checkbox"/> \$500 <input type="checkbox"/> \$600 <input type="checkbox"/> Other \$ _____</p> <p>Permanent Total Disability Benefit* <input type="checkbox"/> \$400 <input type="checkbox"/> \$500 <input type="checkbox"/> \$600 <input type="checkbox"/> Other \$ _____</p>
<p><i>* Claimant must receive Social Security Disability Award to qualify for Permanent Total Disability Benefits</i></p>	

B. NON-OCCUPATIONAL ACCIDENT BENEFITS

1. Do you wish to add Non-Occupational Accident Benefits to this policy? Yes No

a. Death and Dismemberment Benefit \$7,500 \$10,000 \$15,000 Other \$ _____

b. Accident Medical Expense Benefit \$5,000 \$10,000 Other \$ _____

C. OPTIONAL COVERAGES

1. Please indicate if you wish to add the following coverages to this policy:

- a. Hernia \$5,000 \$10,000 Other \$ _____
- b. Hemorrhoid \$5,000 \$10,000 Other \$ _____
- c. Passenger Accident \$10,000
- d. Occupational Disease/
Cumulative Trauma \$5,000 \$10,000 Other \$ _____

D. CONTINGENT LIABILITY COVERAGE

1. Do you wish to add Contingent Liability coverage to this policy? Yes No

SECTION IV: Contingent Liability Information (if applicable)

1. Is there currently a Contingent Liability policy or similar coverage in place? Yes No

a. If yes, what is the name of the Insurance Company? _____

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

a. If yes, please explain: _____

3. Have you ever experienced a loss under Workers' Compensation, Contingent Liability or similar coverage where an Owner-Operator or Contract Driver has sued for employee status? Yes No

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

4. Do the drivers sign Independent Contractor agreements? Yes No

5. Is the Independent Contractor responsible for providing the truck? Yes No

6. Can the Independent Contractor receive assignments/opportunities from a freight broker or other motor carriers? Yes No

<p>Contract Liability Coverage Limits: Part One of the policy applies to Contract Liabilities incurred as the result of the Workers' Compensation laws. Part A Limits: Statutory Limits each person each Accident Statutory Limits each person each Occurrence</p> <p>Employers Liability Insurance: Part Two of the policy limits are: Bodily Injury by Accident \$1,000,000 /Policy Limit Bodily Injury by Disease \$1,000,000 /each Accident Bodily Injury by Disease \$1,000,000 /each Person</p>

SECTION V: Loss Control information

- 1. Name of Safety Manager: _____
- 2. Number of years experience in Loss Prevention: _____
- 3. Number of years working with this motor carrier: _____
- 4. Provide a brief description of the Safety Program currently in place (i.e. electronic logbooks, EOBRs, etc.):

SECTION VI: Producer Information

- 1. Are you the incumbent broker/broker of record? Yes No
- 2. Are you licensed in the motor carrier’s state (if there are multiple terminals, this refers to the motor carrier’s address registered with the DOT)? Yes No
- 3. Is the license for: Accident & Health Property & Casualty Both

Questionnaire completed by (print name): _____

Signature: _____

Title: _____ Date: _____

On Behalf of Motor Carrier: _____

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