



11811 North Tatum Blvd, Ste 4010, Phoenix, AZ 85028  
Toll-Free: 800-418-9763 • Fax: 602-324-2306

## 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
Alabama	_____	_____	_____	_____
Alaska	_____	_____	_____	_____
Arizona	_____	_____	_____	_____
Arkansas	_____	_____	_____	_____
California	_____	_____	_____	_____
Colorado	_____	_____	_____	_____
Connecticut	_____	_____	_____	_____
Delaware	_____	_____	_____	_____
D.C.	_____	_____	_____	_____
Florida	_____	_____	_____	_____
Georgia	_____	_____	_____	_____
Hawaii	_____	_____	_____	_____
Idaho	_____	_____	_____	_____
Illinois	_____	_____	_____	_____
Indiana	_____	_____	_____	_____
Iowa	_____	_____	_____	_____
Kansas	_____	_____	_____	_____
Kentucky	_____	_____	_____	_____
Louisiana	_____	_____	_____	_____
Maine	_____	_____	_____	_____
Maryland	_____	_____	_____	_____
Massachusetts	_____	_____	_____	_____
Michigan	_____	_____	_____	_____
Minnesota	_____	_____	_____	_____
Mississippi	_____	_____	_____	_____
Missouri	_____	_____	_____	_____

State	OO	CD	FO	FD
Montana	_____	_____	_____	_____
Nebraska	_____	_____	_____	_____
Nevada	_____	_____	_____	_____
New Hampshire	_____	_____	_____	_____
New Jersey	_____	_____	_____	_____
New Mexico	_____	_____	_____	_____
New York	_____	_____	_____	_____
North Carolina	_____	_____	_____	_____
North Dakota	_____	_____	_____	_____
Ohio	_____	_____	_____	_____
Oklahoma	_____	_____	_____	_____
Oregon	_____	_____	_____	_____
Pennsylvania	_____	_____	_____	_____
Puerto Rico	_____	_____	_____	_____
Rhode Island	_____	_____	_____	_____
South Carolina	_____	_____	_____	_____
South Dakota	_____	_____	_____	_____
Tennessee	_____	_____	_____	_____
Texas	_____	_____	_____	_____
Utah	_____	_____	_____	_____
Vermont	_____	_____	_____	_____
Virginia	_____	_____	_____	_____
Washington	_____	_____	_____	_____
West Virginia	_____	_____	_____	_____
Wisconsin	_____	_____	_____	_____
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

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

#### 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                                     | <input type="checkbox"/> \$5,000  | <input type="checkbox"/> \$10,000 | <input type="checkbox"/> Other \$ _____ |
| b. Hemorrhoid                                 | <input type="checkbox"/> \$5,000  | <input type="checkbox"/> \$10,000 | <input type="checkbox"/> Other \$ _____ |
| c. Passenger Accident                         | <input type="checkbox"/> \$10,000 |                                   |   |
| d. Occupational Disease/<br>Cumulative Trauma | <input type="checkbox"/> \$5,000  | <input type="checkbox"/> \$10,000 | <input type="checkbox"/> 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

#### 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

#### 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

## 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: \_\_\_\_\_

RT Workers' Comp operations are conducted by RT Workers' Comp Specialty, a part of the RT Specialty division of RSG Specialty, LLC (RSG Specialty) and by International Facilities Insurance Services, Inc. (IFIS). RSG Specialty is a Delaware limited liability company based in Illinois. IFIS is a California corporation based in California. RSG Specialty and IFIS are subsidiaries of Ryan Specialty Group, LLC. RT Workers' Comp works directly with brokers, agents and insurance carriers, and as such does not solicit insurance from the public. Some products may only be available in certain states, and some products may only be available from surplus lines insurers. In California: RSG Specialty Insurance Services, LLC (License #0G97516) and International Facilities Insurance Services, Inc. (License #0B23543). ©2022 Ryan Specialty Group, LLC