

# Contingent Liability Application (Bobtail & Deadhead)



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

P.O. Box 650 • 57 Parker Rd. • Barre, VT 05641  
 800-548-4301 • www.neee.com

Policy Term From: \_\_\_\_\_ To: \_\_\_\_\_

- Name (and "dba") \_\_\_\_\_  
 Individual/Proprietorship  Partnership  Corporation  Other Business Phone Number \_\_\_\_\_
- Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
- Premises Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
- Person to contact for inspection (name and phone number) \_\_\_\_\_
- 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

- Describe Business \_\_\_\_\_  
 Years Experience \_\_\_\_\_ New Venture?  Yes  No Seasonal?  Yes  No
- Is this your primary business?  Yes  No If no, explain \_\_\_\_\_
- Have you ever filed for bankruptcy?  Yes  No If yes, when \_\_\_\_\_ Explain \_\_\_\_\_
- Gross Receipts Last Year \_\_\_\_\_ Estimate for Coming Year \_\_\_\_\_ Business for sale?  Yes  No
- Do you operate in more than one state?  Yes  No If yes, list states \_\_\_\_\_
- Show largest cities entered \_\_\_\_\_ Do you pull double trailers?  Yes  No Triple trailers?  Yes  No
- Do you operate over a regular route?  Yes  No If yes, show towns operated between \_\_\_\_\_
- List all types of cargo hauled \_\_\_\_\_  
 Principal Commodities Outbound \_\_\_\_\_ Backhaul Commodities \_\_\_\_\_
- 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 \_\_\_\_\_
- What percent of time are your vehicles operating under lease or dispatch? \_\_\_\_\_
- Equipment is under permanent/long term lease to \_\_\_\_\_
- How many companies have you been leased to in the last three years? \_\_\_\_\_
- Do you lease to anyone else?  Yes  No If yes, percent of time \_\_\_\_\_ %, for whom and explanation \_\_\_\_\_
- Do you trip lease on back hauls to others?  Yes  No If yes, percent of time \_\_\_\_\_ %, for whom and explanation \_\_\_\_\_

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

| LIABILITY                     |               |              |                 | Medical Payments | Personal Injury Protection (where applicable) | IF PHYSICAL DAMAGE COVERAGE DESIRED, REFER TO FOLLOWING PAGE.<br><br>IF IN-TOW COVERAGE DESIRED, COMPLETE TOW TRUCK SUPPLEMENT. |
|-------------------------------|---------------|--------------|-----------------|------------------|---|---|
| Combined Single Limit BI & PD | Split Limits  |              |                 |                  |   |   |
|                               | Bodily Injury |              | Property Damage |                  |   |   |
|                               | Per Person    | Per Accident | Per Accident    |                  |   |   |
|                               |               |              |                 |                  |   |   |

| UNINSURED MOTORIST COVERAGE |               |              |
|-----------------------------|---------------|--------------|
| Single Limit                | Split Limits  |              |
|                             | Bodily Injury |              |
|                             | Per Person    | Per Accident |
|                             |               |              |

| UNDERINSURED MOTORIST COVERAGE |               |              |   |
|--------------------------------|---------------|--------------|---|
| Single Limit                   | Split Limits  |              | Underinsured Motorist Conversion Coverage<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
|                                | Bodily Injury |              |   |
|                                | Per Person    | Per Accident |   |
|                                |               |              |   |

## 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)<br>Ind. Cont. (IC)<br>Owner/Op. (O/O)<br>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 MVRs 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 (i.e. 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        |            |                      |  |                                    |                            |                       |  |                     |                            |                                    |

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 |
|----------|----------------|---------------------|---|---|-----------------------------------|--|-----------|--------------------------|
|          |                |                     |   |   |                                   | <input type="checkbox"/> Comprehensive<br><input type="checkbox"/> Spec. C of Loss | Collision |                          |
| 1        |                |                     |   |   |                                   |  |           |                          |
| 2        |                |                     |   |   |                                   |  |           |                          |
| 3        |                |                     |   |   |                                   |  |           |                          |
| 4        |                |                     |   |   |                                   |  |           |                          |
| 5        |                |                     |   |   |                                   |  |           |                          |

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 M/D/Y  | To M/D/Y |                        |                               |                  | 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 \_\_\_\_\_

**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 Federal Highway Administration 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.