

COMMERCIAL TRUCK INSURANCE APPLICATION

SUBMITTED BY:

Texas Partners Insurance Group and Financial Services, L.L.C.
 Kyle E. Hern
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 Montgomery, TX 77356
 Office: 936-588-2202
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No coverage is effective until approved by the General Agent

Effective Date: _____
 Quote Needed By: _____
 Contact Person: _____
Agency: _____

Phone: _____ Fax: _____ **Agent E-mail:** Sales@texaspartnersinsurance.com

General Information

Is this new business to your agency? No Yes

Name of Risk: _____ **Operations began:** _____

Mailing address: _____

Building address: _____

E-mail address: _____ Fax No: _____

Inspection contact: _____ Phone No: _____

FEIN or Social Security # _____ **MC #** _____

Personnel:

Owner/ President: _____
 Safety Supervisor: _____
 Maintenance Manager: _____
 Accounting Manager: _____
 Claims Contact: _____
 Telephone Number: _____

Description of Operations

- Reefer Dry Van
- Flatbed LTL
- Heavy Hauler
- Farm to Market
- Other (describe)

Policy Information

Inception Date: _____ Risk is: Individual Partnership Corporation

Any policy cancellations/non-renewals in the last three years? No Yes, If yes why _____

Has the risk filed for bankruptcy in the last five years? No Yes, has it be discharged? No Yes

Current DOT safety rating: _____ Please explain "any" rating other than "Satisfactory"

IMPORTANT

COVERAGE LIMITS

Liability	_____	Medical Payments	\$
UM/UIM	_____	GL Payroll	\$
PIP	\$	GL Deductibles:	\$
Hired Auto <input type="checkbox"/> Yes	\$ _____ cost	GL payroll – all employees except the drivers	
Unhooked Trailer Coverage <input type="checkbox"/> Yes		GL available only for "Truckers" class/operations	

Physical Damage
 Deductibles: _____ Collision: _____ Spec Perils: _____
 Tractors values: _____ Trailer values: _____
 Total Values: _____ Maximum value (one tractor/trailer)

Trailer Interchange

Number of trailers used daily: _____ Limit \$ _____ Or **Maximum \$**
 Number days trailers are used weekly: _____ Deductible _____ Or **Std.**

Cargo:
 Per vehicle: \$ _____ Per Occurrence/Disaster \$ _____
 Terminal limit & location: \$ _____ Address: _____

Deductibles: Non-refrigerated operations \$

Refrigerated units \$

Minimum

Operations: This section applies for all lines of business

Nearest metropolitan city:

Authorities held: CONTRACT / COMMON

ICC docket #:

Brokerage Name: _____ Docket #: _____

Annual brokerage revenue: \$ _____ Certificates of insurance required from other carrier? No Yes

Total trip lease revenue: \$ _____ Percentage under applicant's authority: _____ 0%

Radius of Operation

Operations from Headquarters	0-50 miles	51-200 miles	201-500 miles	Unlimited
Percentage of total mileage	_____ %	_____ %	_____ %	_____ %

Principal states of operation

Major metro areas entered with %:

Major Shippers:

Commodities Hauled

Commodities	% Of Revenue	Average Value	Maximum Value
	_____ %	\$ _____	\$ _____
	_____ %	\$ _____	\$ _____

Exposure History:

Year	Revenue	Mileage	Units	Fleet Value
	\$ _____			
	\$ _____			
	\$ _____			
	\$ _____			

Estimate for coming year Revenue: \$ _____ Mileage: _____

Equipment Summary	Tractors	Trailers	Straight Trucks
Owned Units			
Owner / Operator Units			

Do your owner –operators carry non-trucking liability? No Yes, Please provide copy of your standard lease.

SCHEDULE OF EQUIPMENT (if over four units attach page with this same information)

Year	Make/Model	17 digit Identification Number	Value	GVW

▶ ▶ ▶ ▶ ▶ Remember to attach a list of drivers and include DATE OF HIRE ◀ ◀ ◀ ◀ ◀ ◀

Do you allow non-employees to travel with your drivers? No Yes

EXPERIENCE SUMMARY

Liability:

Coverage Year	Carrier	Loss Reserves	Total Incurred (include expense)	Deductible	Number of accidents	# Of Insured units	Fre-quency	Valuation date
		\$	\$	\$				
		\$	\$	\$				
		\$	\$	\$				
		\$	\$	\$				
		\$	\$	\$				

Comments – Losses over \$50,000 - Provide additional information where necessary.

Date of Loss	Amount: Paid	Reserve	Description
	\$	\$	
	\$	\$	
	\$	\$	
	\$	\$	

Physical Damage:

Coverage Year	Carrier	Loss Reserves	Total Incurred (include expense)	Deductible	Number of accidents	# Of Insured Units	Fre-quency	Valuation Date
		\$	\$	\$				
		\$	\$	\$				
		\$	\$	\$				
		\$	\$	\$				
		\$	\$	\$				
		\$	\$	\$				

Cargo:

Coverage Year	Carrier	Loss Reserves	Total Incurred (include expense)	Deductible	Number of accidents	# Of Insured Units	Fre-quency	Valuation Date
		\$	\$	\$				
		\$	\$	\$				
		\$	\$	\$				
		\$	\$	\$				

Special Exposures: Do you pull "double" or "triple" trailers? No Yes

Oversize/ Overweight? No Yes if "yes", percentage of revenue: _____ %

"Haz Mat" No Yes if "yes", percentage of revenue: _____ % with placarding _____ %

EPA # _____ Typical "Haz Mat" items are: _____

- Applicant owns or leases **vehicles not specified in this application**? No Yes
- Applicant **hires vehicles** from others? No Yes ▪ Applicant **hauls for other truckers**? No Yes
- Applicant **rents/ leases vehicles** or equipment to others **with or without drivers**? No Yes, _____ % revenue
- **Other truckers operate under the authority of the applicant**? No Yes, _____ % of revenue # units

DRIVERS: All Drivers must meet the company's guideline, which will be provided with our quote. Attach a list of drivers, which includes their date of hire (DOH) and (if available) each driver's years of experience as a class A CDL driver.

Safety:

Safety meeting held: No Yes How often? _____ *Forward mandatory DOT Driver Signature Attendance List

Bonus for safety driving: No Yes _____

Accidents reviewed for preventability: No Yes _____

Minimum driver age and experience: _____

Current number of drivers: _____ Hired last twelve months: _____ Terminated: _____

Maintenance:

Written P/M program: No Yes Send copy of Preventative Maintenance Checklist

Service/Repair done: No Yes By whom: _____

Number of mechanics: Fulltime _____ Part time _____ **Work for others performed?** No Yes

Equipment Inspections:

Pre-trip: No Yes Periodic: No Yes, every _____ Miles

Service records maintained: No Yes Where: _____ By whom: _____

COVERAGE ELECTIONS – Go to _____ for Uninsured Motorists and/or No Fault (PIP) attach ACORD election form(s)

Filings:

Address (If different than shown) _____ Zip _____

Base State: _____ **If applicable, Ohio #** _____ **Oregon #** _____

FRAUD STATEMENT NOTICE

ANY PERSON WHO KNOWINGLY AND WITH THE INTENT TO DEFRAUD ANY INSURANCE COMPANY, OR OTHER PERSON WHO FILES AN APPLICATION FOR INSURANCE, OR MAKES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING ANY INFORMATION CONCERNING ANY MATERIAL FACT, THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

THE SCHEDULE OF VEHICLES (TRACTORS, TRUCKS AND TRAILERS) IN THIS APPLICATION INCLUDES ALL VEHICLES REGISTERED IN THE NAME OF THE NAMED INSURED ON THIS APPLICATION INCLUDING ALL VEHICLES LEASED TO OR FROM THIRD PARTIES.

DO NOT SIGN THIS APPLICATION UNTIL YOU COMPLETELY READ AND FULLY UNDERSTAND IT.

X _____ X _____
Insured's Signature Date Agent's Signature Date