AIG

American International Companies®

Truckers Occupational Accident Insurance Questionnaire

Submission Date: _____

Quote Due Date: _____

RISK INFORMATION

Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: (____) _____ Fax Number: (____) _____

Nature of Business: _____

1. Federal Employer Identification Number (FEIN): _____

2. Describe and give percentages of specific commodities hauled. (Avoid general terms.) Please use a separate sheet, if necessary.

Commodity							**Total**
Percent Hauled							100%

3. What percentage of total truck loads are manually loaded or unloaded?

   Manually Loaded: _____% Manually Unloaded: _____% No trucks are manually loaded or unloaded. ☐

4. What percentage of vehicles are: Box: ____% Flatbed: ____% Tanker: ____% Dump: ____% Other: ____%

   Describe types and quantity of vehicles marked as "Other": _____

5. Number of leased independent owner-operators/contract drivers: _____

6. In which states are your owner-operators and contract drivers domiciled? (Attach a separate sheet, if necessary.)

State							
Number of Drivers Domiciled							

7. What percentage of your owner-operators'/contract drivers' trips are: 1–50 Miles: ____% 51–200 Miles: ____%
   Over 200 Miles: ____%

8. Is there any exposure to flammables, explosives, caustics, or fumes? ☐ Yes ☐ No If Yes, please explain and provide percentage of exposure: _____

9. Is there any exposure to radioactive materials? ☐ Yes ☐ No If Yes, please explain and provide percentage of exposure: _____

10. Is a formal safety program in operation? ☐ Yes ☐ No If Yes, please describe. If No, please explain: _____

11. Are pre-employment physicals required? ☐ Yes ☐ No

12. Describe your new-driver screening procedures for hiring leased owner-operators/contract drivers:_____

13. Please complete the chart below. Valuation Date: _____

Term	Earned Premium	Number of Insured Owner-Operators	Owner-Operator Monthly Premium	Incurred Losses	Number of Losses

14. Have you had Occupational Accident Insurance or Workers' Compensation coverages on your leased owner-operators/contract drivers previously? ☐ Yes ☐ No If No, please explain how on-the-job injuries were covered: _____

15. Please attach separate sheets listing prior Workers' Compensation or Occupational Accident Insurance currently valued detailed loss information for the past five years. If no prior coverage, please provide a list of any deaths, dismemberments, permanent total disabilities, or claims over $1,000 in the past five years.

16. Is this a voluntary program? ☐ Yes ☐ No If Yes, please explain how enrollment will be handled: _____

_____

17. BENEFIT PLAN DESIRED

Accidental Death & Dismemberment

Accidental Death (Lump Sum): $ _____

Survivors Benefit: $ _____ for _____ Months

Accidental Dismemberment: $ _____

☐ Lump Sum *or*
☐ Monthly Benefit: ___ Months

Paralysis

Principal Sum: $ _____

☐ Lump Sum *or*
☐ Monthly Benefit: ___ Months

Accident Medical Expense

Benefit Amount: $ _____

Benefit Period: _____ Week(s)

Deductible Amount: $ _____

Benefits Are *(choose one)*: ☐ Primary *or* ☐ Excess

Temporary Total Disability (TTD)

Benefit Amount: $ _____

Waiting Period: _____ Day(s)

Benefit Period: _____ Week(s)

Participation Percentage: _____ %

Continuous Total Disability (CTD)
(Must be same Benefit Amount as TTD.)

Benefit Period: _____

Combined Single Limit Option

☐ Yes ☐ No Amount: $ _____

Aggregate Per Person: $ _____

Aggregate Per Occurrence: $ _____

Non-Occupational Accident Coverage

Accidental Death: $ _____

Accidental Dismemberment: $ _____

Accident Medical Expense

Benefit Amount: $ _____

Benefit Period: _____ Week(s)

Deductible Amount: $ _____

Benefits are on the same basis (primary or excess) as for occupational accident coverage.

Passenger Accident Coverage

Accidental Death: $ _____

Accidental Dismemberment: $ _____

☐ Lump Sum *or* ☐ Monthly Benefit: ____ Months

Paralysis Principal Sum: $ _____

☐ Lump Sum *or* ☐ Monthly Benefit: ____ Months

Accident Medical Expense

Benefit Amount: $ _____

Benefit Period: _____ Week(s)

Deductible Amount: $ _____

Benefits are on the same basis (primary or excess) as for occupational accident coverage.

Any other benefits desired? (State benefits and limits.)

_____

_____

_____

_____

_____

I hereby acknowledge that all answers and statements contained, including the attached data, are true and complete. I also understand that no coverage will become effective until an application has been signed and approved by the Insurance Company, a policy of Insurance is issued, and the required premium is paid. I also understand that these are accident insurance coverages and are not in lieu of or in fulfillment of Workers' Compensation insurance.

_____ _____

Broker/Agent Signature **Applicant Signature**

Date: _____ **Date:** _____

Please tell us about your organization.

Producer Name: _____ Producer Code: _____ *(if known)*

Contact Person: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: ( ) _____ Fax Number: ( ) _____

E-Mail Address: _____ Web Address: _____

Requested Commission: _____

AIG

The AIG Life Companies (U.S.)

Contingent Liability/Motor Carrier Protection Program Questionnaire

(Addendum to Truckers Occupational Accident Insurance Questionnaire)

Choose Appropriate Box: ☐ Contingent Liability Program
☐ Motor Carrier Protection Program (MCPP)
☐ Both

1. Motor Carrier Name: _____

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 If Yes, please explain: _____

   _____

3. Please provide information on your current employee Workers' Compensation policy, contingent Workers' Compensation policy, contingent liability policy, or similar coverage. Please specify which policy.

   Insurer Name: _____

   Policy Number: _____ Term: _____

   State of Domicile: _____ Type of Policy: _____

   If Workers' Compensation, please provide the Experience Modification Factor: _____

4. Have you ever experienced a loss under Workers' Compensation, contingent liability, or similar coverage where an owner-operator or contract driver has become an employee? ☐ Yes ☐ No If Yes, please give details of each loss. (Attach a separate sheet, if necessary.)

Date	Description	Amount of Loss
1)		
2)		
3)		
4)		
5)		

5. Have you been cited for any Occupational Safety and Health Administration (OSHA) violations in the past five years?

   ☐ Yes ☐ No If Yes, please provide details: _____

6. **COVERAGE LIMITS**

Coverage A (Benefits)

☐ Statutory Workers' Compensation

☐ Other (not available with MCPP):_____

_____

_____

_____

_____

_____

_____

Coverage B (Employer's Liability)

☐ $100,000 Bodily Injury by Accident (Each Accident)
$500,000 Bodily Injury by Disease (Policy Limit)
$100,000 Bodily Injury by Disease (Each Employee)

☐ Other

$_____ Bodily Injury by Accident (Each Accident)

$_____ Bodily Injury by Disease (Policy Limit)

$_____ Bodily Injury by Disease (Each Employee)

7. Please complete the following chart. (Attach a separate sheet, if necessary.)

Owner-Operator Name	State of Domicile	Workers' Compensation Manual Rate for State of Domicile
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		
9)		
10)		

I hereby acknowledge that all answers and statements contained, including the attached data, are true and complete. I understand that the Contingent Liability contract is registered and delivered as a surplus lines coverage under applicable state law. I also understand that no coverage will become effective until an application has been signed and approved by the Insurance Company, a policy of Insurance is issued, and the required premium is paid.

Broker/Agent Signature _____ **Applicant Signature** _____

Date: _____ **Date:** _____

Please tell us about your organization.

Producer Name: _____ Producer Code: _____ *(if known)*

Contact Person: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: (____) _____ Fax Number: (____) _____

E-Mail Address: _____ Web Address: _____

Requested Commission: _____

Is Agent/Broker Surplus Lines Licensed in state of policy issuance? ☐ Yes ☐ No If No, please name Agent/Broker authorized to assume duties and responsibilities of Registered Surplus Lines Agent/Broker, below.

TO BE COMPLETED BY SURPLUS LINES AGENT/BROKER

Broker/Agency: _____

Contact Person: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: (____) _____

Fax Number: (____) _____