GREAT AMERICAN INSURANCE GROUP
Trucking Division

☐ Quote
☐ Issue

Effective Date _____

OCCUPATIONAL ACCIDENT QUESTIONNAIRE

MOTOR CARRIER INFORMATION

Name _____

Street Address _____

City _____ State _____ Zip _____

Telephone Number ( ) _____

1. Have you had Occupational Accident Insurance in the past? ☐ Yes ☐ No If No, please explain how on-the-job injuries were covered.

   _____

2. Have you ever had Occupational Accident Insurance canceled, refused or non-renewed? ☐ Yes ☐ No

   If yes, give Company name, date and reason _____

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

Commodity							Total
Percent Hauled							100%

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

   Manually loaded _____ % Manually unloaded _____ % ☐ No trucks are manually loaded or unloaded

5. What percentage of vehicles are: Box _____ % Flatbed _____ % Tanker _____ % Dump_____% Other _____ %

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

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 describe. If no, please explain _____

10. Are pre-employment physical required? ☐ Yes ☐ No

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

    Minimum age _____ Maximum age _____ Do you run MVRs? ☐ Yes ☐ No

12. Please complete the chart below. (Please attach actual loss runs, if available) Valuation Date _____

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

13. Please attach separate sheets listing prior Workers' Compensation or Occupational Accident insurance currently valued detail information for the past three years. If no prior coverage, please provide a list of any deaths, dismemberments, permanent total claims in the past three years.

14. Is this a voluntary program? ☐ Yes ☐ No If yes, please provide number of participating drivers _____

Explain enrollment process _____

17. **BENEFIT PLAN DESIRED**

☐ Plan A ☐ Plan B ☐ Plan C ☐ Plan D ☐ Other Plan (complete below)

Accidental Death & Dismemberment

Accidental Death (Lump Sum): $ _____

Survivors Benefits: $ _____ 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: $_____

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 for TTD.

Waiting Period: _____Day(s)

Benefit Period: _____ Week(s)

Participation Percentage: _____ %

Combined Single Limit

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 een approved by Great American Insurance Trucking Division. I also understand that these are accident insurance coverages and not in lieu of or fulfillment of Workers' Compensation Insurance.

Broker/Agent Authorized Signature: _____ Applicant Authorized Signature: _____

Date: _____ Date: _____

AGENCY INFORMATION

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

Contact Person: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Fax Number: _____

E-mail Address: _____ Web Address: _____

Requested Commission: _____

Occupational Accident Insurance **is an admitted contractual policy and is underwritten by Great American Insurance Company.**

CONTINGENT LIABILITY QUESTIONNAIRE

1. 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 _____

   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 _____

2. Have you ever had experienced a loss under Workers' Compensation, contingent liability, or similar coverage where an Independent Contractor/Owner-Operator/Contract Driver has become an employee? ☐ Yes ☐ No

Date	Description	Amount of Loss

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

3. 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 _____

4. **COVERAGE LIMITS**

Coverage A (Benefits)

☐ Statutory Workers' Compensation

☐ Other _____

_____

_____

_____

_____

_____

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)

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 _____

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.

Insurance for this program may be provided by a surplus lines insurer. Risks placed with a surplus lines insurer must be placed in accordance with state and federal law, including applicable surplus lines laws. Surplus lines insurers do not generally participate in State Guaranty Funds and thus insureds are not protected by such funds.

TO BE COMPLETED BY SURPLUS LINES AGENT/BROKER

Broker / Agency _____

Contact Person _____

Street Address _____

City _____ State _____ Zip _____

Telephone Number _____ Fax Number _____

Contingent Liability Insurance **is a non-admitted (surplus lines) contractual liability policy and is underwritten by Great American E&S Insurance Company.**