

# 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

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.  IF IN-TOW COVERAGE DESIRED, COMPLETE TOW TRUCK SUPPLEMENT.
Combined Single Limit BI & PD	Split Limits		Property Damage			
	Bodily Injury	Each Accident				
	Each Person	Each Accident	Each Accident			

**APPLICABLE PERSONAL INJURY PROTECTION, UNINSURED AND/OR UNDERINSURED MOTORISTS INSURANCE SELECTION/REJECTION PAGE IS REQUIRED TO BE COMPLETED AND SIGNED BY THE NAMED INSURED WITH THE SUBMISSION OF THIS APPLICATION.**

## 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) Ind. Cont. (IC) Owner/Op. (O/O) 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 MVR's 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 <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	To				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 \_\_\_\_\_

# MICHIGAN NO-FAULT and COLLISION COVERAGE SELECTION FORM

## **MICHIGAN PERSONAL INJURY PROTECTION**

Public Act No. 72 of 1974 provides that a reduction in Michigan Personal Injury Protection premiums may be afforded with respect to vehicles owned by an individual if there exists other insurance, such as group medical, individual medical, Medicare, which provides hospital, surgical, medical and/or loss of time benefits and the insured elects to make these benefits primary as respects himself, his spouse and other relatives residing with him.

Such an election would make the automobile policy secondary, and your automobile policy would be responsible only for those personal protection benefits not covered by your health insurer, thereby eliminating any duplication of benefits.

So that your policy may be properly rated, would you kindly "X" the appropriate statement(s) below:

- I have other insurance to cover allowable medical expenses and wish this automobile policy to become secondary to such insurance;
- I have other insurance to cover work loss and wish this automobile policy to become secondary to such insurance;
- I have no other insurance to cover either allowable medical expense or work loss and/or wish this automobile policy to be primary insurance.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Named Insureds

## **NOTICE** **LIMITED ACCIDENT DAMAGE RECOVERY INSURANCE**

**THIS "NOTICE" IS TO ADVISE YOU OF CHANGES IN THE AUTO COVERAGES AVAILABLE TO YOU. PLEASE READ IT CAREFULLY.**

Changes in the Insurance Laws may make **you** pay for damages, of up to \$500, which are caused as a result of an automobile accident in Michigan.

If **you** caused the accident which damaged another auto, and the owner cannot make a full recovery from an insurance policy, he can sue **you** in the Michigan Small Claims Court. If he wins, **you** will have to pay for those unrecovered damages, up to \$500.

We will provide you with the insurance to pay the amount awarded, at an additional premium. To make certain that **your** new policy is issued correctly, please **indicate your choice** (by marking "x") where shown and sign this statement as acknowledgement of **your** choice and understanding of this election.

("X" indicates choice)

- COVERAGE REJECTION – The undersigned has had this explained and does not want to purchase this Limited Accident Recovery Insurance. The undersigned understands that if rejected, no coverage will be afforded for any amount awarded by the Michigan Small Claims Court, as judgement for unrecovered damages from an automobile accident occurring in Michigan.
- LIMITED ACCIDENT RECOVERY INSURANCE – The undersigned has had this coverage explained and will pay the additional premium to purchase this additional coverage. The undersigned understands that the Company's maximum limit of liability for this coverage shall be \$500.

I understand that this coverage is optional and have indicated my choice above.

\_\_\_\_\_  
Date

X \_\_\_\_\_

\_\_\_\_\_  
Signature of Named Insureds

## **COLLISION COVERAGE OPTIONS**

You have an option to purchase collision coverage on a Limited, Regular or Broad Form basis.

When collision coverage is to be provided, designate your option by marking ("x") the appropriate box.

- Limited Collision
- Regular Collision
- Broad Form Collision



**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 FHWA 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.