QUESTIONNAIRE – Transportation Insurance Program

NOTE: There are 4 sections to this questionnaire. All sections must be completed for questionnaire to be accepted.

SECTION I: Policyholder Information

Motor Carrier Name*: ____________________

Street Address: ____________________

City: ____________________ State: ________ Zip: ____________________

Contact Person: ____________________ Title: ____________________

Telephone: ____________________ Fax No: ____________________

Email address: ____________________ USDOT Number: ____________________

* If this Questionnaire is being completed for more than one insured or the above insured has more than one location, please provide:

____

Please complete the following:

- Number of years in business:
- Number of Independent Contract Drivers to be covered:
  Please provide a copy of the most current drivers list.
- Average annual miles per driver:
- Radius of operation: 0-50 miles ____% 50-200 miles ____% 200+miles ____%
- Max length of haul: ___________ miles
- What do drivers haul? ____________________
- Percentage of equipment: Box _____% Flatbeds _____% Tankers _____% Refrigerated _____%
  Container _____% Dump _____%,
  Other (describe) ____________________ _____%
- Do the drivers load or unload? ☐ Yes ☐ No If yes, what percentage of time? ______%
- Is the driver responsible for maintenance of the truck? ☐ Yes ☐ No
- How are the drivers compensated?** ____________________
- Do you have employee drivers? ☐ Yes ☐ No If yes, how many? ________________
- Do drivers sign Owner-Operator Lease Agreements? ☐ Yes ☐ No
  If yes, provide a copy of the Lease Agreement.
- Do you lease Contract Drivers from fleet operations? ☐ Yes ☐ No
  If yes, how many? ________________
- Do you require that the Contract Drivers submit an application or enrollment form to you? ☐ Yes ☐ No
- Do you lease out drivers to other motor carriers? ☐ Yes ☐ No
  If yes, to whom and how many? ____________________
- Are Casual Laborers or Helpers used? ☐ Yes ☐ No
  If yes, where and how? ____________________

- Do you provide light or restricted duty for drivers? ☐ Yes ☐ No
  If yes, describe: ____________________
- Terminal locations (attach list if needed): ____________________
- Indicate number of Owner-Operators by state of residence:

_____Alabama	_____Louisiana	_____Oklahoma
_____Alaska	_____Maine	_____Oregon
_____Arizona	_____Maryland	_____Pennsylvania
_____Arkansas	_____Massachusetts	_____Puerto Rico
_____California	_____Michigan	_____Rhode Island
_____Colorado	_____Minnesota	_____South Carolina
_____Connecticut	_____Mississippi	_____South Dakota
_____Delaware	_____Missouri	_____Tennessee
_____District of Columbia	_____Montana	_____Texas
_____Florida	_____Nebraska	_____Utah
_____Georgia	_____Nevada	_____Vermont
_____Hawaii	_____New Hampshire	_____Virginia
_____Idaho	_____New Jersey	_____Washington
_____Illinois	_____New Mexico	_____West Virginia
_____Indiana	_____New York	_____Wisconsin
_____Iowa	_____North Carolina	_____Wyoming
_____Kansas	_____North Dakota	
_____Kentucky	_____Ohio	_____ **TOTAL**

- Provide details of minimum standards for Owner-Operators:
  Minimum age: ________ Maximum age: ________
  Minimum prior experience as an Owner-Operator: ________
  Minimum prior experience driving similar equipment: ________
  Maximum number of accidents permitted: #________ in past ________ years
  Maximum number of violations permitted: #________ in past ________ years
  Do you provide training for the Owner-Operator? ☐ Yes ☐ No
  Describe any other criteria for qualifying Owner-Operators: ____________________
- Has an Owner-Operator or Contract Driver filed a Workers' Compensation claim in the past three (3) years? ☐ Yes ☐ No
  If yes, what was the disposition of such claim(s): ____________________
- Provide information about Safety and Loss Control
  Name of safety manager: ____________________
  Number of years experience in loss prevention: ________ Number of years working with motor carrier: ________
  Provide details of in force safety program: ____________________
- Please indicate the situs state where the **Policyholder's** contract is to be issued: ____________________

****Please provide a copy of the standard settlement statement provided to the drivers.**

SECTION II: Insurance Plan Design

A. OCCUPATIONAL ACCIDENT BENEFITS: request specific benefits and coverages per Accident to be quoted

1. **Death and Dismemberment Benefit:** ☐ $150,000 ☐ $200,000 ☐ $250,000 ☐ $300,000 ☐ other $ ___________

2. **Accident Medical Expense Benefit:** ☐ $300,000 ☐ $500,000 ☐ $1,000,000 ☐ other $ ___________

Maximum Benefit Period: ☐ 52 weeks ☐ 104 weeks ☐ Hernia ☐ Hemorrhoid ☐ other ______________________

3. **Temporary Total Disability Benefit:** ☐ $400 ☐ $500 ☐ $600 ☐ other __________
   Benefit Waiting Period: ☐ 7 days ☐ 14 days
   Maximum Benefit Period: ☐ 52 weeks ☐ 104 weeks

4. **Continuous Total Disability Benefit**: ☐ $200,000 ☐ $300,000 ☐ other __________
   (Claimant must receive Social Security Disability Award to qualify for Continuous Total Disability Benefits)

- Will Occupational Accident coverage be: ☐ voluntary ☐ compulsory
- Is there sponsored Occupational Accident coverage in force now? ☐ Yes ☐ No
  If yes, provide copy of the policy and fill out chart below.

  If yes, who is the carrier? ________________________________ What is the in-force rate? $ _________

Coverage period	Coverage type/ Insurance type	Premium	Losses incurred (include reserves)	Number of drivers	Monthly premium per driver

If no, how is coverage being addressed?: ____

Experience: Please provide: (1) the last three (3) years of Occupational Accident coverage loss runs. The losses should present detailed medical and indemnity claims both reserved and paid; and (2) a complete description of injury and circumstances of any loss to an Owner-Operator involving death, dismemberment, or TTD/CTD losses in excess of $25,000.

B. NON-OCCUPATIONAL ACCIDENT BENEFITS: ☐ Yes ☐ No **request specific benefits and coverages to be quoted**

1. **Death and Dismemberment Benefit:** $7,500 $10,000 $15,000 other $_________

2. **Accident Medical Expense Benefit:** $5,000 $10,000 other $_________

C. CONTINGENT LIABILITY: ☐ Yes ☐ No

- Is the Broker licensed in the situs state for Surplus lines? ☐ Yes ☐ No
  If yes, please provide license number:
- Is there a current Contingent Liability policy in force? ☐ Yes ☐ No
  If yes, complete the chart on next page.

Insured name	Policy number	Term	Expiring rate	State of domicile

- Has any prior workers' compensation, contingent workers' compensation, contingent liability or similar coverage been declined, cancelled, or non-renewed in the past three years? ☐ Yes ☐ No

  If yes, please explain ______________________________

- Has there ever been a loss under workers' compensation, contingent liability, or similar coverage where an owner-operator or contract driver has been deemed an employee?: ☐ Yes ☐ No

If yes, please provide the details of each loss:

Date	Description	Amount of loss

- Have there been any citations for any Occupational Safety and Health Administration (OSHA) violations in the last five years? ☐ Yes ☐ No

  If yes, please provide the details: ______________________________

Experience: Please provide the last three (3) years of Contingent Liability coverage loss runs.

D. OTHER COVERAGES:

Passenger Accident: ☐ Yes ☐ No If yes, a separate Passenger Accident Questionnaire must be completed.

SECTION III: Producer Information ***

Agent/Broker: ______________________ Name of Firm: ______________________

Street Address: ______________________

City: ______________________ State: ____________ Zip: ____________

Telephone Number: ______________________ Fax Number: ______________________

Producer Number: ______________________ Commission: ______________________

Email: ______________________

- Broker of Record for this risk? ☐ Yes ☐ No
- Is Broker licensed in contract situs state? ☐ Yes ☐ No
- Is the license a: ☐ resident license ☐ non-resident license
- Is the license for: ☐ Accident & Health ☐ Property & Casualty ☐ Both

NOTE: THIS QUESTION MUST BE ANSWERED FOR QUESTIONNAIRE TO BE CONSIDERED:

Is the Broker licensed in the situs state for Surplus lines? ☐ Yes ☐ No

If yes, please provide license number: ______________________

*****If you are a new agent for OneBeacon, you will need to complete a new agent appointment profile.**

SECTION IV: Signature

Questionnaire completed by: ______________________________________ (print name)

Title: ____
(Risk manager or the person responsible for insurance procurement)

Signature: ____

On Behalf of Motor Carrier: _______________________________________ Date: ______________________