



PASSENGER ACCIDENT INSURANCE QUESTIONNAIRE

Please complete this questionnaire and submit it along with the Transportation Insurance Program (Occupational Accident and Contingent Liability) questionnaire.

SECTION I: POLICYHOLDER INFORMATION

Motor Carrier Name*: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Contact Person: _____ Title: _____

Telephone Number: _____ Fax Number: _____

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: _____

• Is there Passenger Accident coverage in force now? Yes* No

If yes, who is the carrier? _____

Please provide a copy of the policy.

What is the in force rate? \$ _____

If no, how has this exposure been handled? _____

• Is this coverage intended for Passengers of:

Owner-Operators Employees Co-Owners Leased Drivers Team Drivers

• Number of units/drivers to be covered: Units _____ Driver _____

Please provide a copy of the most current units list.

Please provide a copy of the most current drivers list.

• Do all Passengers have to be authorized by the motor carrier? Yes No

• Does the Motor Carrier require that the unit and/or driver submit a Passenger Authorization form or enrollment form to it? Yes No

• Does the Motor Carrier allow helpers/guest Passengers to load/unload? Yes No

- Average annual miles per unit/driver: _____
- What do units and/or drivers haul? _____
- Will Passenger Accident coverage be voluntary or compulsory? Voluntary Compulsory
- Will premium be paid by Motor Carrier or driver? Motor Carrier Driver
- If Motor Carrier pays premium, will premium be based upon the number of units or the number of drivers?
 - Units Drivers
- If driver pays premium, is it paid through settlement deduction? Yes No
 - If yes, please provide a copy of the settlement statement.**
 - If no, describe payment method: _____

• Situs state of Policy: _____

* **Experience:** Please provide the last three (3) years of Passenger Accident coverage loss runs. The losses should present detailed medical and indemnity claims both reserved and paid.

SECTION II: SIGNATURE

Questionnaire completed by: _____

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

On Behalf of Motor Carrier: _____ Date: _____

Signature: _____