

**COMMERCIAL AUTO NON-FLEET
 INSURANCE APPLICATION**

GENERAL INFORMATION

Date Coverage Desired: From: _____ To: _____

Name: _____
 Individual Partnership Corporation LLC Other: _____

Mailing Address: _____

Phone # (including area code): _____

Website: _____ E-Mail Address: _____

Garage Location(s): _____
 (if different) Street Address State Zip Phone

If New Venture, Owner/Principal _____

Previous Employer(s): _____

Name	Address, City, State	Dates	Veh Type	Loaded Wgt	Radius

Years In Trucking Industry: _____ Business Start Date: _____

Federal ID # or S.S.# : _____ US DOT Number: _____

Have you filed for Bankruptcy or Chapter 11 in the past five years? Yes No Are you presently in bankruptcy? Yes No

DESCRIPTION OF OPERATIONS

For Hire Private Non-Trucking Other (explain): _____

Range of Transport Interstate Intrastate Local 0-100 _____ % Int.101-300 _____ % LH _____ %

Operations: Identify Metropolitan Areas Traveled Through or Into

- | | | | | | |
|--|--|--------------------------------------|--|---------------------------------------|--|
| <input type="checkbox"/> Atlanta | <input type="checkbox"/> Dallas/Ft Worth | <input type="checkbox"/> Kansas City | <input type="checkbox"/> Mpls./St Paul | <input type="checkbox"/> Philadelphia | <input type="checkbox"/> San Diego |
| <input type="checkbox"/> Balt-Washington | <input type="checkbox"/> Detroit | <input type="checkbox"/> Los Angeles | <input type="checkbox"/> New Orleans | <input type="checkbox"/> Phoenix | <input type="checkbox"/> San Francisco |
| <input type="checkbox"/> Boston | <input type="checkbox"/> Houston | <input type="checkbox"/> Miami | <input type="checkbox"/> New York City | <input type="checkbox"/> Portland | <input type="checkbox"/> Seattle |
| <input type="checkbox"/> Chicago | | | | | |

Cities other than above or regular routes: _____

COMMODITIES TRANSPORTED

Commodity	Percent of Loads	Maximum Value	Commodity	Percent of Loads	Maximum Value
		\$			\$
		\$			\$
		\$			\$
		\$			\$

GENERAL QUESTIONS

1. Are **filings** required? Yes No If yes, list Base State, FHWA and All state and permit numbers where filings are required: _____

Docket #: _____

Any Special Filings such as Oversize, Overweight, City Permits? Yes No

Give Details: _____

2. Do you haul hazardous materials? Yes No
 What Limits of Liability are required? \$ _____
3. Do you act as a freight-broker or freight-forwarder or arrange loads for others? Yes No
 Docket #: _____
 If yes, provide Brokerage Name: _____
 Annual Brokerage Revenue: \$ _____
4. Are all owned trailers equipped with reflective tape? Yes No If no, attach a list of those trailers which are not.
 (Check if listing attached.)
5. Is all equipment operated under the applicant's authority scheduled on the application? Yes No
 If no, attach explanation. (Check if explanation attached.)
6. Is all owned equipment scheduled on this application? Yes No If no, attach explanation.
 (Check if explanation attached.)
7. Is all the scheduled equipment owned by you? Yes No If no, attach explanation.
 (Check if explanation attached.)
8. Do you sub-haul, lease or hire equipment from others? Yes No
 If yes, is it: Permanently Leased Trip Leased
- a. If permanently leased, is it scheduled on this application? Yes No
 b. If permanently leased, are autos hired with drivers? Yes No
 c. If trip leased, provide the annual estimated cost of hire:
 Current Year: \$ _____ Prior Year: \$ _____
 d. What is your percentage of sub-hauling? % _____
9. Do you lease to others? Yes No If yes, who must provide primary insurance? You Other
 If you provide insurance, is coverage desired for: Named Lessee(s)
 If Named Lessee(s), attach a list of Name and Addresses for each lessee. (Check if listing attached.)
10. Do you pull doubles? Yes No
11. Do you pull triples? Yes No
12. Do you haul containers or containerized freight? Yes No
13. Do you allow passengers other than company employees? Yes No If yes, attach a copy of passenger program
 or explain program (frequency, requirements), etc. (Check if explanation attached.)
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14. Do you use any team, hot seat, slip seating or relay driver operations? Yes No
15. Do you sign contracts with shippers that give the shipper the right to determine cargo salvage values or declare
 cargos a total loss regardless of actual damage in the event of a loss? Yes No
 If yes, which shippers? _____
 What are commodities for each shipper? _____
 What is maximum load value? \$ _____
 What is percentage of loads for signed contracts limiting salvage? % _____
16. Do you operate mobile equipment subject to compulsory or financial responsibility laws or other motor vehicle
 insurance law in the state where it is licensed or principally garaged? Yes No
17. Have you ever had Truck Insurance under another name? Yes No If yes, list name and DOT #
 Name _____ DOT # _____

LEASED OR HIRED

1. Does Applicant/Insured do trip leasing to the extent that is comprises more than 5% of their gross receipts?
 Yes No If yes, explain operation in detail: (Check if explanation attached.)

2. Is equipment leased or hired? Yes No If yes, attach explanation and examples of agreements.
 (Check if explanation attached.)

	With Driver	Without Driver	Average Duration of a Trip Lease	Average # of Trip Leases Per Year	Estimated Trip Lease Payments Per Year	Insurance Provided by		With Hold Harmless Naming other Party As Additional Insured?
						Lessor	Lessee	
A. From Others						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. To Others						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No

3. Under whose Bill of Lading is shipment moved when leased to others?

From Others? _____

4. What % of Deadheading? % _____

5. Do you backhaul? Yes No If yes, what do you backhaul?

SCHEDULE OF EQUIPMENT OPERATED

Provide schedule of equipment to include: Make, Model, Year, Type, Complete VIN Number, GVW, Garaging Location, Stated Amount and Radius of Operation.

Type	Owned	Leased w/o Drivers	Owner Operators	Local (0-100)	Inter. (101-300)	Long Haul (Over 301)	TOTAL UNITS
Light Trucks							
Medium Trucks							
Heavy Trucks							
Extra Heavy Truck / Tractors							
Semi-Trailers							
Dump Trucks							
Dump Trailers							
Other							

DESCRIPTION OF VEHICLES (Semi-trailers must be scheduled for coverage to apply while detached from power unit.)

Unit No.	Model Year	Manufacturer	Vehicle Type (truck, tractor, semi-trailer, mobile equipment, etc.)	Serial Number (17 digit)	Radius	Truck GVW Tractor GCW	Owner Type *
1							
2							
3							
4							
5							

* N=Owned by Named Insured; L=Owned by Leasing Co. (long term lease without driver); O=Owned by Owner Operator; E=Owned by Employee of Named Insured (Officer).

Unit No.	Phy. Dam. Limit*	SCL Comp / Coll Deductible	Name of Loss Payee	Full Address of Loss Payee
1				
2				
3				
4				
5				

* Fill in the limit next to each vehicle if coverage is desired.

EXPOSURE HISTORY

Year	From	To	# of Units	Gross Receipts	Mileage
Current Year				\$	
1 st Prior				\$	
2 nd Prior				\$	
3 rd Prior				\$	
Projected for next 12 months:				\$	

Attach Pro-rata (Schedule B) Mileage Sheets for past three (3) years.

INSURANCE HISTORY & LOSS EXPERIENCE

HAS ANY INSURANCE COMPANY CANCELED OR NON-RENEWED YOUR POLICY IN THE LAST FOUR YEARS?

Yes No If yes, explain: _____

Is your current coverage presently under Cancellation? Yes No

If yes, explain: _____

Furnish currently valued (value dated within the last 3 months) Insurance Company produced detailed loss / experience for auto liability, physical damage and cargo. Losses runs must be for current year plus 2 (two) prior policy years.

Policy Term		Insurance Company	# of Claims	/	Total Incurred
From	To				
					\$
					\$
					\$
					\$
					\$

Describe any claim with payment or reserves over \$25,000. (Separate Sheet Attached - If necessary.)

Date of Loss	Amount of Loss / Reserve	Driver Involved in Loss	Description of Loss
	\$		
	\$		
	\$		
	\$		
	\$		

DRIVER, SAFETY AND MAINTENANCE

1. Do you have a Formal Safety Program? Yes No

2. Name, title, phone number of person responsible for safety (specify other duties): _____

3. Is this a seasonal operation? Yes No If yes, describe: _____

4. Are all drivers your employees? Yes No

5. Do you maintain employment application and personnel files for each driver? Yes No

6. Are all drivers covered by Workers Compensation Insurance? Yes No

7. Do you order MVRs on new drivers before hiring? Yes No

8. Do you verify previous employment? Yes No

9. How many drivers did you employ in the last year? _____

Cargo

- Limit \$ _____ Radius: 0 - 300 301 - 500
 Deductible \$ _____ 501 - over
- Carriers Cargo Broad Form
 Owners Cargo Broad Form
 Both Carriers and Owners Broad Forms

Optional Cargo Coverages

- Temperature Control Equipment Breakdown - minimum \$2,500 deductible applies to this option.
 Water Damage / Tarpaulin Endorsement – minimum \$2,500 deductible.
 Poultry Cages (Non-owned) Endorsement Other _____
 Special Limits Endorsement Limit \$ _____ Shipper _____ Commodity _____
 % of Loads @ higher limit _____
 Terminal Coverage Limit \$ _____ Deductible \$ _____
 Other _____
- Physical Address _____
 Describe Facility _____
 Describe Security Features _____

Combined Deductible (Physical Damage / Cargo)

- A combined deductible will apply unless declined. (if approved in state)
 Combined Deductible applies to Tractor / Trailer only.
 Combined Deductible applies to Tractor / Trailer and Cargo (if written).

CAROLINA CASUALTY INSURANCE CO LOSS PREVENTION SERVICES FOR 10+ VEHICLES

CCIC's Loss Control staff can tailor loss control **consultative services** to meet your specific needs.
 Our Loss Control staff is available to our insured's to provide a **D.O.T. audit compliance review** so that insured will be prepared for a D.O.T. compliance audit before it happens.
 CCIC insureds can take advantage of our **Safe Driver Awards Program**.
 Our Loss Control staff will help our insureds conduct **effective safety meetings**.
 Seminars are available to CCIC insureds to help with **continuing education** of your drivers and other staff members.

ADDITIONAL INSURED

Name	Mailing Address	Coverages (1)	Relationship to Insured (2)

CERTIFICATE HOLDERS

Name	Mailing Address	Coverages (1)	Relationship to Insured (2)

(1) A=Auto Liability P=Physical Damage C=Cargo (certificate holders only) Attach separate list if space above is not adequate.
 (2) Indicate lessor, lessee, shipper, broker, interchange facility owner, etc., and show vehicle number if applicable.

Please complete and attach state () specific Truck Application Supplemental page CTP5037**
and all applicable UM/UIM select/reject form(s). If needed also complete CTP 5725.**

I hereby certify that the information contained in this application is true and agree that a misrepresentation of any of the facts by me will constitute a reason for the company to void or cancel any policy issued on the basis of this application and will hold the company harmless for the action taken. I also agree that if a policy is issued pursuant to this application, the application and any elections or rejections, which are included with the application and signed by me, may be relied upon by the company as accurate and shall become part of the policy.

I recognize that all or parts of my operations are under the Department of Transportation oversight requiring me to adhere to their rules and regulations, acknowledge that DOT's rules and regulations are understood by me and I will adhere to the rules and regulations including, but not limited to, driver hiring, vehicle inspection and maintenance, and hours of service.

I authorize Carolina Casualty Insurance Co to obtain a copy of any Motor Vehicle Report for rating/underwriting the insurance for which I have applied. I also understand that a routine inquiry may be made providing information concerning my character, general reputation, personal characteristics and mode of living. Upon written request, information as to the nature and scope of the report will be provided to me.

Signature of APPLICANT _____ X _____ Type or print Applicant Name: _____ Title or relationship to Applicant: _____ Licensed Agent of the Company: _____ Licensed Agent ID#: _____	Signature of AGENT of Applicant _____ X _____ Agency Name: Address of Agency: _____ _____ Agent License or Registration #: Agent Phone Number: _____ _____ Date Application Completed: _____
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A CREDIT REPORT OR OTHER INVESTIGATIVE REPORT ABOUT YOU MAY BE REQUESTED IN CONNECTION WITH THIS APPLICATION FOR INSURANCE AND SUBSEQUENT RENEWALS. ANY INFORMATION WHICH WE HAVE OR MAY OBTAIN ABOUT YOU OR OTHER INDIVIDUALS LISTED AS POLICYHOLDERS ON YOUR POLICY WILL BE TREATED CONFIDENTIALLY. HOWEVER, THIS INFORMATION, AS WELL AS OTHER PERSONAL OR PRIVILEGED INFORMATION SUBSEQUENTLY COLLECTED, MAY, UNDER CERTAIN CIRCUMSTANCES, BE DISCLOSED WITHOUT PRIOR AUTHORIZATION TO NON-AFFILIATED THIRD PARTIES. WE MAY ALSO SHARE SUCH INFORMATION WITH AFFILIATED COMPANIES FOR SUCH PURPOSES AS CLAIMS HANDLING, SERVICING, UNDERWRITING AND INSURANCE MARKETING. CREDIT SCORING INFORMATION MAY BE USED TO DETERMINE EITHER YOUR ELIGIBILITY FOR INSURANCE, OR THE PREMIUM YOU WILL BE CHARGED. YOU HAVE THE RIGHT TO SEE PERSONAL INFORMATION COLLECTED ABOUT YOU, AND YOU HAVE THE RIGHT TO CORRECT ANY INFORMATION WHICH MAY BE WRONG. IF YOU ARE INTERESTED IN OBTAINING A DESCRIPTION OF OUR INFORMATION PRACTICES, AND YOUR RIGHTS REGARDING INFORMATION WE COLLECT, ASK YOUR AGENT, OR, IF YOU HAVE BEEN ISSUED A POLICY, PLEASE WRITE US AT THE ADDRESS PROVIDED WITH YOUR POLICY.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS THE PERSON TO CRIMINAL AND CIVIL PENALTIES.

COVERAGE HAS NOT COMMENCED. You, or your agent, may commence coverage only by requesting a licensed general agent of Carolina Casualty Insurance Company to bind coverage. A binder of insurance will be issued by our licensed general agent specifying the date and time coverage will become effective, but in no event shall coverage become effective prior to the date and time you, or your agent, contact a licensed general agent of Carolina Casualty Insurance Company and coverage is bound by him or her.