



CONTRACTOR APPLICATION

Contractor Services

Phone: 800-343-6885

Fax: 800-225-9268

Direct Fax: 586-920-0980



Welcome,

I would like to take the opportunity to thank you for considering Universal Am-Can Ltd. as your choice of carrier. We look forward to having you as a representative. We pride ourselves in providing support through constant communication and relationship building.

Universal Am-Can takes pride in being the premier home for independent contractors in a business known for change. To remain competitive for you and to provide quality service to our customers, we must start with a SAFETY FIRST attitude. You will see in this package the beginning of that process. The documentation needed provides a first step to safety. Once your lease is finalized, we want you to be aware of the importance of operating a well-maintained safe piece of equipment. Attention to your Hours of Service requirements will keep you safe and maximize your effectiveness.

I pledge our support to you in service and safety.

Drive Safely,

Mark Limback
President

SIGN-ON PROCESS

Our goal in the sign-on process is to complete the requirements within the time it takes to get the drug screen result. This fast completion is only possible when complete and accurate information is received.

The following steps will ensure the contractor application is processed quickly and accurately.

1. Complete the Contractor Data Sheet. Make sure all parts of the work history are completed and all gaps in employment are accounted for. If you were unemployed, so note.
2. MVR, criminal check, and work histories will be requested once the application is received.

Any failure to report information requested or falsification of information on the data sheet is serious and will be considered in conjunction with other information in making final determination. If you have any questions, call Contractor Services at 1-800-343-6885

*******To sign on with our company you will be required to provide us with an inspection that was done in the last 30 days by a nationally recognized chain garage, dealership or approved state inspection program.**

RENTAL TRAILERS

Rental trailers are available. All trailers are newer models. For trailer specifications or other trailer questions, please contact:

Van /Flatbed – Dave ext. 2201

Rates include maintenance and insurance. Equipment abuse or neglect will be the responsibility of the lessee.

*Prices subject to change. Please verify at the time of sign-on.

DRIVER QUALIFICATION REQUIREMENTS

- Must be at least 21 years of age and have a valid class “A” CDL, from state of residence.
- Must have 1 year **verifiable** experience in the last 3 years, on the equipment they will operate and an acceptable work history for the past 10 years. All gaps in employment must be accounted for.
- No more than 2 moving violations in any type of motor vehicle in the last 3 years.
- No license suspension/disqualification for traffic convictions within the last 3 years.
- No more than 2 license suspensions for non-moving violations.
- A copy of a valid long form physical and medical card performed in the last 12 months.
- A DOT drug test with a negative result is required **before** an applicant starts driving.
- No drug or alcohol (DUI/DWI) related convictions/incidents within the last 5 years. Incidents over 5 years will be reviewed.
- No felonies in the past 5 years. Felonies over five years will be reviewed.
- No more than 2 preventable accidents in the last 3 years.
- No discharge for safety reasons from a previous employer.

INDIANA PLATE PAPERWORK REQUIREMENTS

If you would like our Indiana IRP plate, we need:

- Copy of title or application for title processed by the state
- Lease agreement or power of attorney (if the name on the title is different than the name that is going to be listed on our contract)
- Current 2290
****If the truck was just purchased, a bill of sale will be accepted in place of the 2290 up to 30 days from the purchase date

If you would like to keep your own plate, we need:

- Tractor registration
- Lease agreement or a power of attorney if the title is not in your name

If you would like our trailer plate, we need:

- Title in your name or a validated, processed application for title within the past 30 days
- Lease agreement or a power of attorney if the title is not in your name



Settlement Statements and Trip Pak Fees

Settlement statements and TripPak are a vital part of your operation. In order to better serve you, we need to gather some important information about these two items.

Settlement Statements

The fastest and most secure way for you to receive your settlement statements is via e-mail and to view online. Both methods are available to you at the time each trip is settled to you in our system.

- Please provide a valid email address in the space below so we may set you up for viewing and receiving your settlements.
- Email address _____
Please print clearly
 - Should you obtain an email address in the future or change your current e-mail address, please contact the settlements department or update your contact information on our website under the contractor tab.
- Please check here if you do not have a valid email address.

TripPak Scanning and TripPak Drop Box

1. **Truck Stop Scanning and In-Cab scanning.**

This method provides a fast and secure format to get your settlement to you in the quickest format available and is provided at a deduction amount of \$2.50 per Pro number submitted. After submission of the documents, Contractor should retain the originals.

2. **TripPak Drop Box**

This method allows for the contractor to submit the required paperwork through an expedited overnight process which takes 1-2 business days to be received in our settlement department. The deduction for this process is \$4.00 dollars per week for unlimited packages and is recommended for those who submit multiple packages during any given week.

Important information you should know before you chose your preferred method

Combining of the methods: If you have selected the scanning option as your primary method and utilize the drop box for any reason, your settlement profile will convert to the Trip Pak Drop Box method. Your account will be charged \$4.00 per week and will remain in effect until you notify the settlement department.

I select the following method of settlement submission to my company

_____ TripPak scanning or In-Cab Scanning @ \$2.50 per pro submitted

_____ TripPak Drop Box @ \$4.00 per week, unlimited weekly envelopes

Please contact your settlements department if you have any questions by calling 800-635-7548

Printed Name _____
Please print clearly full name

Signature _____ **Date** _____

UACL CONTRACTOR CONTACT INFORMATION

Name _____

Physical Address _____

City _____ State _____ Zip Code _____

Mailing Address (if different from above) _____

City _____ State _____ Zip Code _____

Telephone Number _____ - _____ - _____

Cellular Number _____ - _____ - _____

Email Address _____

Emergency Contact Name _____

Address _____

City _____ State _____ Zip Code _____

Telephone Number _____ - _____ - _____

Relationship _____

Emergency Contact Name _____

Address _____

City _____ State _____ Zip Code _____

Telephone Number _____ - _____ - _____

Relationship _____

Emergency Contact Name _____

Address _____

City _____ State _____ Zip Code _____

Telephone Number _____ - _____ - _____

Relationship _____

UNIVERSAL AM-CAN LTD.

12755 EAST NINE MILE ROAD WARREN, MI 48089

CONTRACTOR DATA SHEET

TERMINAL NUMBER _____

NAME _____ BIRTH DATE _____
LAST FIRST MIDDLE

SOCIAL SECURITY NUMBER _____ PHONE NUMBER (____) _____

CELLULAR NUMBER (____) _____ E-MAIL ADDRESS _____

ADDRESSES FOR THE LAST 10 YEARS:

PRESENT ADDRESS _____ HOW LONG? _____

PREVIOUS ADDRESS _____ HOW LONG? _____

DO YOU HAVE A TRANSPORTATION WORKER IDENTIFICATION CREDENTIAL (TWIC) CARD? YES NO

HAVE YOU EVER TAKEN A TRUCK DRIVING COURSE? YES NO DATE: _____

NAME OF COURSE (ATTACH CERTIFICATE) _____

DO YOU HAVE A FREE & SECURE TRADE (FAST) CARD FOR BORDER CROSSINGS? YES NO

HAVE YOU EVER BEEN CONVICTED OF A CRIME OR ARE PRESENTLY INVOLVED IN CRIMINAL PROCEEDINGS?

YES NO IF "YES", GIVE DATE(S) AND EXPLAIN: _____

DRUG AND ALCOHOL TESTING

DID A.D.O.T. ALCOHOL TEST, CONDUCTED WITHIN THE LAST TWO YEARS, CONFIRM A B.A.C OF 0.04 OR GREATER?
 YES NO

DID A.D.O.T. CONTROLLED SUBSTANCE TEST WITHIN THE LAST TWO YEARS RESULT IN A CONFIRMED "POSITIVE" RESULT?
 YES NO

HAVE YOU EVER REFUSED TO BE TESTED AS REQUIRED BY D.O.T. REGULATIONS?
 YES NO

IF NO TO ALL OF THE ABOVE, GO TO DRIVING HISTORY ON NEXT PAGE

IF YES ON ANY OF THE ABOVE, WHAT WAS THE DATE OF THE POSITIVE TEST OR REFUSAL _____

TYPE OF TEST: ALCOHOL CONTROLLED SUBSTANCE BOTH

DID YOU RETURN TO DUTY WITH YOUR COMPANY FOLLOWING EVALUATION BY A SUBSTANCE ABUSE PROFESSIONAL (SAP)? YES NO

SUBSTANCE ABUSE PROFESSIONAL'S NAME _____

SUBSTANCE ABUSE PROFESSIONAL'S PHONE _____

WAS FOLLOW-UP TESTING REQUIRED AND PERFORMED? YES NO

DRIVING HISTORY- LIST ANY LICENSE YOU HAVE HELD IN THE LAST 10 YEARS.

CDL LICENSE	STATE	EXPIRATION DATE	CLASS	ENDORSEMENTS
CDL LICENSE	STATE	EXPIRATION DATE	CLASS	ENDORSEMENTS

Have any of these licenses been revoked, suspended, restricted or denied? Yes No
If yes explain : _____

ACCIDENTS- LIST ANY YOU HAVE BEEN INVOLVED IN FOR THE LAST 3 YEARS.

DATE	CITY/STATE	INJURIES/DEATHS	DRIVING A TRUCK?	RESPONSIBLE?	DESCRIBE
DATE	CITY/STATE	INJURIES/DEATHS	DRIVING A TRUCK?	RESPONSIBLE?	DESCRIBE

MOVING VIOLATIONS- LIST ANY YOU HAVE HAD IN THE LAST 3 YEARS.

DATE	CITY/STATE	MOVING VIOLATION	DISPOSITION
DATE	CITY/STATE	MOVING VIOLATION	DISPOSITION
DATE	CITY/STATE	MOVING VIOLATION	DISPOSITION

EXPERIENCE:

TYPE OF EQUIPMENT (VAN, FLATBED, OTHER)	O.T.R. OR LOCAL	NUMBER OF YEARS?	TYPE OF FREIGHT HAULED
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TYPE OF EQUIPMENT (VAN, FLATBED, OTHER)	O.T.R. OR LOCAL	NUMBER OF YEARS?	TYPE OF FREIGHT HAULED

WORK HISTORY: Give a COMPLETE and consecutive history of your employment for the last 10 years, starting with the present or most recent employer. Please account for all months.

REMEMBER- AN INCOMPLETE DATA SHEET WILL PREVENT PROCESSING

MOST RECENT EMPLOYER:

Company _____ Phone (____) _____ Contact _____
City & State _____ Dates _____ To _____
Position _____ Reason for leaving _____
O.T.R. or Local? _____ Van, Flatbed or other? _____

Were you subject to FMCSRs while employed? Yes No
Was your job designated as a safety-sensitive function in any DOT-regulated mode subject to the drug and alcohol testing requirements of 49 CFR Part 40? Yes No

ACCOUNT FOR ANY PERIOD BETWEEN JOBS- Include dates (month & year) and reason _____
UACL

Company _____ Phone (____) _____ Contact _____
City & State _____ Dates _____ To _____
Position _____ Reason for leaving _____
O.T.R. or Local? _____ **Van, Flatbed or other?** _____
Were you subject to FMCSRs while employed? Yes No
Was your job designated as a safety-sensitive function in any DOT-regulated mode subject to the drug and alcohol testing requirements of 49 CFR Part 40? Yes No
ACCOUNT FOR ANY PERIOD BETWEEN JOBS- Include dates (month & year) and reason _____

Company _____ Phone (____) _____ Contact _____
City & State _____ Dates _____ To _____
Position _____ Reason for leaving _____
O.T.R. or Local? _____ **Van, Flatbed or other?** _____
Were you subject to FMCSRs while employed? Yes No
Was your job designated as a safety-sensitive function in any DOT-regulated mode subject to the drug and alcohol testing requirements of 49 CFR Part 40? Yes No
ACCOUNT FOR ANY PERIOD BETWEEN JOBS- Include dates (month & year) and reason _____

Company _____ Phone (____) _____ Contact _____
City & State _____ Dates _____ To _____
Position _____ Reason for leaving _____
O.T.R. or Local? _____ **Van, Flatbed or other?** _____
Were you subject to FMCSRs while employed? Yes No
Was your job designated as a safety-sensitive function in any DOT-regulated mode subject to the drug and alcohol testing requirements of 49 CFR Part 40? Yes No
ACCOUNT FOR ANY PERIOD BETWEEN JOBS- Include dates (month & year) and reason _____

Company _____ Phone (____) _____ Contact _____
City & State _____ Dates _____ To _____
Position _____ Reason for leaving _____
O.T.R. or Local? _____ **Van, Flatbed or other?** _____
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Company _____ Phone (____) _____ Contact _____
 City & State _____ Dates _____ To _____
 Position _____ Reason for leaving _____
O.T.R. or Local? _____ **Van, Flatbed or other?** _____
 Were you subject to FMCSRs while employed? Yes No
 Was your job designated as a safety sensitive function in any DOT-regulated mode subject to the drug and alcohol testing requirements of 49 CFR Part 40? Yes No
ACCOUNT FOR ANY PERIOD BETWEEN JOBS- Include dates (month & year) and reason _____

WAIVER: I hereby authorize this company, as required by the Federal Motor Carrier Safety Administration (FMCSA) regulations section 391.23, to investigate and compile a complete history of my former work history together with any other information concerning my ability, personal character, credit, and arrest record. I do hereby authorize any present and past employers or lessor to furnish my previous work history record with them, with any reason for my separation; and any/all information which said company may have concerning me to the company's investigating agency. I authorize release of information for purposes of investigation of drug and alcohol results as required by sections 382.405(f) and 382.413 of the FMCSA regulations. I hereby authorize any local, state, or federal law enforcement agency to furnish any and all information regarding arrests or convictions listed under my name which might be in file, to the company's investigative agency. I hereby release all present and past employers, lessors and law enforcement agencies from any and all liability for damages whatsoever which may result from furnishing any information requested concerning me to the company's investigating agency. I understand that I have the following rights concerning the investigative information that is being provided by a prior employer: (1) the right to review information provided by the previous employer, (2) the right to have errors in the information corrected by the previous employer and for the corrected information to be sent to the prospective employer and (3) the right to have a rebuttal statement attached to the alleged erroneous information if I and the previous employer cannot agree on the accuracy of the information provided. In addition, I certify that this data sheet was completed by me and that all entries on it and information in it are true and complete to the best of my knowledge. I hereby authorize this company to access the FMCSA Pre-Employment Screening Program (PSP) system to seek information regarding my commercial driving safety record and information regarding my safety inspection history. I understand that I am consenting to the release of safety performance information including crash inspection data from the previous five (5) years and inspection history from the previous three (3) years. I understand and acknowledge that this release of information may assist this company in making a determination regarding my suitability. I further understand that neither this company nor the FMCSA contractor supplying the crash and safety information has the capability to correct any safety data that appears to be incorrect. I understand I may challenge the accuracy of the data by submitting a request to <http://dataqs.fmcsa.dot.gov>. If I am challenging crash or inspection information reported by a state, FMCSA cannot change or correct this data. I understand my request will be forwarded by the DataQs system to the appropriate State for adjudication.

 SIGNATURE DATE uad

APPLICATION FOR GROUP OCCUPATIONAL ACCIDENT INSURANCE

Office Use Only				
Contractor Name	Company/Division	ID number	Contract Date	Unit Number

Last Name	First Name	Middle Name
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Street Address	City, State	Zip Code
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Home Phone Number	Social Security Number	Date of Birth
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Beneficiary Name for Accidental Death Benefit	Beneficiary's Relationship to You
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ELECTION TO PURCHASE:

This group policy provides Occupational Accident, Death and Disability Insurance. IT IS NOT STATUTORY WORKERS' COMPENSATION INSURANCE, AND IT IS NOT A SUBSTITUTE FOR STATUTORY WORKERS' COMPENSATION INSURANCE. The coverage and benefits for which I am applying to purchase under this group plan may not equal benefits called for by various state Workers' Compensation Statutes.

I understand that I am electing to purchase insurance under this group plan and I understand that this is not a Workers' Compensation Insurance Policy.

I recognize that, as an Independent Contractor, I am not eligible for, and cannot be covered by, State Workers' Compensation Statutes, and my election to be covered under this group policy is an acknowledgement that State Workers' Compensation programs do not apply to me. I also recognize that as an Independent Contractor, I am not an employee of the trucking company for which I provide services and therefore, I am not entitled to Workers' Compensation Insurance from the trucking company.

ACCEPTANCE:

I request that this coverage be issued as I am qualified and eligible Independent Contractor, actively performing services on the above contract date. I authorize the trucking company listed above to deduct the premium payable to the insurance company from my settlement account. I understand that the trucking company is neither the insurance company, nor the insurance agent, and receives no compensation for this service. I hereby appoint, authorize and grant the insurance company the right to cancel this insurance on the date my Independent Contractors' Agreement with the trucking company shown above is no longer in force.

Independent Contractor Signature

___ / ___ / ____
Date

UACL

**THIS IS NOT STATUTORY WORKERS' COMPENSATION INSURANCE
THIS IS NOT GROUP ACCIDENT AND HEALTH INSURANCE**

PRE-QUALIFICATION URINALYSIS CONSENT FORM

I understand, as a pre-qualification condition, I am required by section 382.301 of Title 49, Federal Motor Carrier Safety Regulations, to submit a controlled substance test.

I agree to provide a urine sample at a location and time designated by the company to be tested for controlled substances.

I understand if I test positive for use of controlled substances, I am not medically qualified to operate a commercial motor vehicle.

The results of the controlled substance test will be maintained by the company designated review office who will report to the company whether the test result was negative or positive. I authorize the company or medical review officer to release the test results to the examining medical physician to assist in determining if I am medically qualified to operate a commercial motor vehicle. The results will not be released to any additional party without my written authorization.

I agree to submit to the required controlled substance urinalysis.

Signature

_____-_____-_____
Social Security #

___/___/_____
Date

UNAUTHORIZED PASSENGER AGREEMENT

I have read the following Motor Carrier Policy concerning "Unauthorized Passengers". I understand that if I do violate this policy that my contract is immediately cancelled.

Policy: At no time is the contractor permitted to allow an individual to travel in his/her equipment without expressed written consent from the motor carrier.

Signature

___/___/_____
Date

UACL

**Request for Taxpayer
Identification Number and Certification**

Give form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

Name (as shown on your income tax return)	
Business name, if different from above	
Check appropriate box: <input type="checkbox"/> Individual/Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ <input type="checkbox"/> Exempt payee <input type="checkbox"/> Other (see instructions) ▶	
Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
City, state, and ZIP code	
List account number(s) here (optional)	

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number
OR
Employer identification number

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here

Signature of U.S. person ▶

Date ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

Independent Contractor Membership / Insurance Application

In making application for membership, I hereby state that I am not an employee of any common or contract carrier. By signing this application, I understand that the carrier that I am leased to, collects, and pays to the insurance agent, the first month's insurance premium, plus two months deposit for bobtail and one months deposit for the occupational accident insurance.

I desire to purchase the following insurance coverage's:

_____ _____ _____	Decline Accept _____ _____ _____	Non-Trucking Liability Insurance (\$50 per month) - \$2,000,000 policy If you decline, you must show proof of a \$2,000,000 policy prior to sign on Physical Damage (4.2% of 5,000 to 30,000 -- 3.6% of 31,000 and above) Occupational Accident Insurance (\$136 per month/driver) If you decline, you must show proof of workman's comp. prior to drivers being approved If you accept, please fill out the Application for Group Occupational Accident Insurance
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Please complete the below in full if physical damage is requested:

Year	Make	Tractor/Trailer	Serial Number	Physical Damage Amount Requested
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____

Lien holder: Describe equipment to which applicable

Serial Number: _____	Name: _____
	Address: _____
	City, State, ZIP: _____
Serial Number: _____	Name: _____
	Address: _____
	City, State, ZIP: _____

In making application for membership(s) in insurance programs(s) with the company I am leasing to and for the above insurance coverage's requested and obtained in my behalf, I hereby authorize the company to whom I am under contract to make deductions from my account of an amount equal to the cost of the insurance premiums and to remit same.

I understand that the coverage's afforded under the policy terminates when my lease agreement with the common carrier (motor carrier) terminates, or when otherwise lawfully canceled by insurance company.

Signature: _____ Date: _____
(Owner of the equipment) UACL

INVENTORY FORM

Tractor Information –

VIN _____

Make _____

Model Year _____

Color _____

Headache Rack Yes No

Trailer Information –

Do you own your own trailer or will you be renting?

Own Rent company trailer Other

If other, please specify _____

Year- _____ Make- _____

Type- _____
(van, flat, step, RGN, double drop)

Length- _____ Width- _____
Axles- _____ *Well Length- _____
*(DD only)

Please complete the following –

Number of steel tarps _____

Bulkhead? Yes No

Side Kit? Yes No

Number of pipe stakes _____

Number of coil racks _____

Number of chains _____

Number of straps _____

Number of binders _____

Number of edge protectors _____

Spread? Yes No

Number of axles _____

Length _____ Width _____ Air _____ Springs _____

Please check off all that apply to your tractor.

IDLING CONTROL STRATEGIES

Direct Fired Heater	
Auxiliary Power Unit	
Truck Stop Electrification	
Team Driver	
Engine Shut Down	

AERODYNAMIC DEVICES

Aero Profile Tractor	
Cab-Over Engine	
Integrated Cab Roof Fairing	
Cab Roof Fairing	
Cab Roof Deflector	
Cab Side Fairing	
Cab Front Air Dam Front Bumper	
Cab Aero-Dynamic Mirrors	

TIRE TECHNOLOGY

Single Wide Tires	
Automatic Tire Inflation	

ADVANCED LUBRICANTS

Low Friction Engine Lubricant	
Low Friction Drive Train Lubricant	

	Yes	No
Synthetic Engine Oil		
Synthetic Transmission Lube		
Synthetic Rear End Grease		
Is Engine Governed?		

Truck Max Speed	
Fifth Wheel Height	
Tire Size	

