GREAT AMERICAN INSURANCE GROUP
Trucking Division

☐ Quote
☐ Issue

Effective Date ______________________

OCCUPATIONAL ACCIDENT QUESTIONNAIRE

MOTOR CARRIER INFORMATION

Name ______________________

Street Address ______________________

City ______________________ State __________ Zip ______________________

Telephone Number ( ) ______________________

1. Have you had Occupational Accident Insurance in the past? ☐ Yes ☐ No If No, please explain how on-the-job injuries were covered.

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2. Have you ever had Occupational Accident Insurance canceled, refused or non-renewed? ☐ Yes ☐ No

If yes, give Company name, date and reason ______________________

3. Describe and give percentages of specific commodities hauled. (Avoid general terms.) Please use a separate sheet, if necessary.

Commodity							Total
Percent Hauled							100%

4. What percentage of total truck loads are manually loaded or unloaded?

Manually loaded __________ % Manually unloaded __________ % ☐ No trucks are manually loaded or unloaded

5. What percentage of vehicles are: Box ________ % Flatbed ________ % Tanker ________ % Dump________ % Other ________ %

Describe types and quantity of vehicles marked as “Other” ______________________

6. In which states are your owner-operators and contract drivers domiciled? (Attach a separate sheet, if necessary.)

State							
Number of Drivers Domiciled							

7. What percentage of your owner-operators’/contract drivers’ trips are ______________________

1-50 Miles __________% 51-200 Miles __________ % Over 200 Miles __________ %

8. Is there any exposure to flammables, explosives, caustics, or fumes? ☐ Yes ☐ No

If yes, please describe. If no, please explain ______________________

10. Are pre-employment physical required? ☐ Yes ☐ No

11. Describe your driver screening procedures for hiring leased owner-operators/contract drivers ______________________

Minimum age __________ Maximum age __________ Do you run MVRs? ☐ Yes ☐ No

12. Please complete the chart below. (Please attach actual loss runs, if available) Valuation Date ______________________

Term	Earned Premium	Number of Insured Owner-Operators	Owner-Operator Monthly Premium	Incurred Losses	Number of Losses

13. Please attach separate sheets listing prior Workers’ Compensation or Occupational Accident insurance currently valued detail information for the past three years. If no prior coverage, please provide a list of any deaths, dismemberments, permanent total claims in the past three years.

14. Is this a voluntary program? ☐ Yes ☐ No If yes, please provide number of participating drivers ____________________

Explain enrollment process ____________________

17. **BENEFIT PLAN DESIRED**

☐ Plan A ☐ Plan B ☐ Plan C ☐ Plan D ☐ Other Plan (complete below)

Accidental Death & Dismemberment

Accidental Death (Lump Sum): $ ____________

Survivors Benefits: $ ________ for ________ Months

Accidental Dismemberment: $____________

☐ Lump Sum or ☐ Monthly Benefit: ________ Months

Paralysis Principal Sum: $____________

☐ Lump Sum or ☐ Monthly Benefit: ________ Months

Accident Medical Expense

Benefit Amount: $____________

Benefit Period: ________ Week(s)

Deductible Amount: $____________

Temporary Total Disability (TTD)

Benefit Amount: $____________

Waiting Period: ________Day(s)

Benefit Period: ________ Week(s)

Participation Percentage: ________ %

Continuous Total Disability (CTD)

Must be same Benefit Amount as for TTD.

Waiting Period: ________Day(s)

Benefit Period: ________ Week(s)

Participation Percentage: ________ %

Combined Single Limit

Aggregate Per Person: $____________

Aggregate Per Occurrence: $____________

Non-Occupational Accident Coverage

Accidental Death: $____________

Accidental Dismemberment: $____________

Accident Medical Expense

Benefit Amount: $____________

Benefit Period: ________ Week(s)

Deductible Amount: $____________

Benefits are on the same basis (primary or excess) as for occupational accident coverage.

Passenger Accident Coverage

Accidental Death: $____________

Accidental Dismemberment: $____________

☐ Lump Sum or ☐ Monthly Benefit: ________ Months

Paralysis Principal Sum: $____________

☐ Lump Sum or ☐ Monthly Benefit: ________ Months

Accident Medical Expense

Benefit Amount: $____________

Benefit Period: ________ Week(s)

Deductible Amount: $____________

Benefits are on the same basis (primary or excess) as for occupational accident coverage.

Any other benefits desired? (State benefits and limits.)

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I hereby acknowledge that all answers and statements contained, including the attached data are true and complete. I also understand that no coverage will become effective until an application has een approved by Great American Insurance Trucking Division. I also understand that these are accident insurance coverages and not in lieu of or fulfillment of Workers' Compensation Insurance.

Broker/Agent Authorized Signature: ____________ Applicant Authorized Signature: ____________

Date: ____________ Date: ____________

AGENCY INFORMATION

Producer Name: ____________ Agency Code (if known): ____________

Contact Person: ____________

Street Address: ____________

City: ____________ State: ________ Zip Code: ________

Telephone Number: ____________ Fax Number: ____________

E-mail Address: ____________ Web Address: ____________

Requested Commission: ____________

Occupational Accident Insurance **is an admitted contractual policy and is underwritten by Great American Insurance Company.**

CONTINGENT LIABILITY QUESTIONNAIRE

1. Has any prior Workers' Compensation, contingent Workers' Compensation, contingent liability, or similar coverage been declined, canceled, or non-renewed in the past three years? ☐ Yes ☐ No

   If yes, please explain ______________________________

   Please provide information on your current employee Workers' Compensation policy, contingent Workers' Compensation policy, contingent liability policy, or similar coverage. Please specify which policy.

   Insurer Name ______________________________

   Policy Number ______________________ Term ______________________

   State of Domicile ______________________ Type of Policy ______________________

If Workers" Compensation, please provide the Experience Modification Factor ______________________

2. Have you ever had experienced a loss under Workers' Compensation, contingent liability, or similar coverage where an Independent Contractor/Owner-Operator/Contract Driver has become an employee? ☐ Yes ☐ No

Date	Description	Amount of Loss

   If yes, please give details of each loss. (Attach a separate sheet, if necessary.)

3. Have you been cited for any Occupational Safety and Health Administration (OSHA) violations in the past five years?

   ☐ Yes ☐ No If yes, please provide details ______________________________

4. **COVERAGE LIMITS**

   Coverage A (Benefits)

   ☐ Statutory Workers' Compensation

   ☐ Other ______________________________

   ____

   ____

   ____

   ____

   ____

   Coverage B (Employer's Liability)

   ☐ $100,000 Bodily Injury by Accident (Each Accident)

   ☐ $500,000 Bodily Injury by Disease (Policy Limit)

   ☐ $100,000 Bodily Injury by Disease (Each Employee)

   ☐ Other ______________________________

   $ ____________ Bodily Injury by Accident (Each Accident)

   $ ____________ Bodily Injury by Disease (Policy Limit)

   $ ____________ Bodily Injury by Disease (Each Employee)

I hereby acknowledge that all answers and statements contained, including the attached data, are true and complete. I understand that the Contingent Liability contract, is registered and delivered as a surplus lines coverage under applicable state law, I also understand that no coverage will become effective until an application has been signed and approved by the insurance Company, a policy of Insurance is issued, and the required premium is paid.

Broker/Agent Signature ______________________________ Applicant Signature ________________________________

Date ____ Date ____

Is Agent/Broker Surplus Lines licensed in state of policy issuance? ☐ Yes ☐ No If no, please name Agent/Broker authorized to assume duties and responsibilities of Registered Surplus Lines Agent/Broker, below.

Insurance for this program may be provided by a surplus lines insurer. Risks placed with a surplus lines insurer must be placed in accordance with state and federal law, including applicable surplus lines laws. Surplus lines insurers do not generally participate in State Guaranty Funds and thus insureds are not protected by such funds.

TO BE COMPLETED BY SURPLUS LINES AGENT/BROKER

Broker / Agency ____

Contact Person ____

Street Address ____

City ____ State _____________ Zip _________________

Telephone Number ____________________________________ Fax Number ______________________________

***Contingent Liability Insurance* is a non-admitted (surplus lines) contractual liability policy and is underwritten by Great American E&S Insurance Company.**