

Truck Application

COLUMBIA INSURANCE COMPANY
 NATIONAL FIRE & MARINE INSURANCE COMPANY
 NATIONAL INDEMNITY COMPANY
 NATIONAL INDEMNITY COMPANY OF MID-AMERICA
 NATIONAL INDEMNITY COMPANY OF THE SOUTH
 NATIONAL LIABILITY & FIRE INSURANCE COMPANY



8400 E. Prentice Ave., Ste. 535
 Greenwood Village, CO 80111
 Phone 877.409.4855 Fax 866.610.8043

Policy Term From: _____ To _____

- Name (and "dba") _____
 Individual/Proprietorship Partnership Corporation Other Business Phone Number _____
- Mailing Address _____ City _____ State _____ Zip _____
- Premises Address _____ City _____ State _____ Zip _____
- Person to contact for inspection (name and phone number) _____
- Have you ever had insurance with one of the companies listed at the top of this page? Yes No
 If yes, Policy Number(s) _____ Effective Date(s) _____

DESCRIPTION OF OPERATIONS

- Describe business _____
 Years experience _____ New Venture? Yes No If you are a tow truck operation, do you do repossessions? Yes No
- Is this your primary business? Yes No If no, explain _____
 Seasonal? Yes No
- Have you ever filed for Bankruptcy? Yes No If yes, when _____ Explain _____
- Gross receipts last year _____ Estimate for coming year _____ Business for sale? Yes No
- Do you operate in more than one state? Yes No If yes, list states _____
- Do you haul for hire? Yes No Show largest cities entered _____
- Do you operate over a regular route? Yes No If yes, show towns operated between _____
- Are you a common carrier? Yes No Are you a contract hauler? Yes No If yes, for whom _____
- List all types of cargo hauled _____
- Do you haul any hazardous or extra hazardous substances or materials as defined by EPA? Yes No If yes, provide complete listing identifying all material(s) and/or chemical content: _____
- Do you haul your own cargo exclusively? Yes No If not, who owns it? _____
- Do you pull double trailers? Yes No Triple trailers? Yes No
- Do you rent or lease your vehicles to others? Yes No If yes, attach copy of rental or lease agreement form used.
- Do you hire any vehicles? Yes No Complete Hired and Non-Owned Supplemental Questionnaire if coverage is desired.

LIABILITY COVERAGE — Complete for desired coverages by indicating limits of insurance.

LIABILITY				Medical Payments	Personal Injury Protection (where applicable)	IF PHYSICAL DAMAGE COVERAGE DESIRED, REFER TO FOLLOWING PAGE. IF IN-TOW COVERAGE DESIRED, COMPLETE TOW TRUCK SUPPLEMENT. HIRED, NON-OWNED - M-4055.
Combined Single Limit BI & PD	Split Limits					
	Bodily Injury		Property Damage			
	Each Person	Each Accident	Each Accident			

APPLICABLE PERSONAL INJURY PROTECTION, UNINSURED AND/OR UNDERINSURED MOTORISTS INSURANCE SELECTION/REJECTION PAGE IS REQUIRED TO BE COMPLETED AND SIGNED BY THE NAMED INSURED WITH THE SUBMISSION OF THIS APPLICATION.

DRIVER INFORMATION — If additional space is needed, attach separate listing.

Driver's Name	Date of Birth	Driver's Licenses				Experience	
		State	Number	Class/Type (i.e. CDL)	Years Licensed (in Class/Type)	Type of Unit (Bus, Van, Truck, Tractor, etc.)	No. of Years
1.							
2.							
3.							
4.							
5.							

DRIVER INFORMATION (Continued) – If additional space is needed, attach separate listing.

No. Years Previous Commercial Driving Experience	Date of Hire	Accidents and Minor Moving Traffic Violations in Past 5 Years				Major Convictions (DWI/DUI, Hit & Run, Manslaughter, Reckless, Driving While Suspended/ Revoked, Speed Contest, other felony)		Employee (E) Ind. Cont. (IC) Owner/Op. (O/O) Franchisee (F)
		No. of Accidents	Date(s)	No. of Violations	Date(s)	Describe Conviction	Date(s)	
1.								
2.								
3.								
4.								
5.								

PLEASE ATTACH DETAILED EXPLANATION OF ACCIDENTS LISTED ABOVE.

20. Are drivers covered by Workers Compensation? Yes No If yes, name of carrier _____
21. Minimum years driving experience required _____ Are vehicles owner-driven only? Yes No
22. Are drivers ever allowed to take vehicles home at night? Yes No If yes, will family members drive? Yes No
23. Do you order MVR's on all drivers prior to hiring? Yes No Driver's maximum driving hours ____ daily, ____ weekly
24. Do you agree to report all newly hired operators? Yes No
25. What is the basis for driver(s) pay? Hourly Trip Mileage Other, explain _____

SCHEDULE OF AUTOS/VEHICLES – Describe all vehicles for which application is made for insurance.

Veh. No.	Model Year	Vehicle Make & Model	Body Type (Truck, Tractor, Trailer, etc.)	Full Vehicle Identification Number	Gross Vehicle Weight (GVW)	Total # of Rear Axles	Principal Garaging Location (city & state)	Radius of Operation	Annual Mileage Per Vehicle	(A) Anti-Lock Brakes, (B) Air Bags
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

26. Will lessor be added as additional insured? Yes No If yes, give name and address of lessor for each vehicle _____
27. Number of vehicles owned: Pick-Ups _____ Trucks _____ Tractors _____ Semi-Trailers _____ Trailers _____ Pup Trailers _____
28. Number of vehicles leased: Pick-Ups _____ Trucks _____ Tractors _____ Semi-Trailers _____ Trailers _____ Pup Trailers _____

PHYSICAL DAMAGE COVERAGE – Complete spaces below in detail for each respective auto/vehicle described above.

Veh. No.	Date Purchased	Cost When Purchased	Current Stated Value (excluding permanently attached equipment)	Value of Permanently Attached Special Equipment	Total Stated Amount to be Insured	Physical Damage Deductible		Cargo Limit of Insurance
						<input type="checkbox"/> Comprehensive <input type="checkbox"/> Spec. C of Loss	Collision	
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

29. Any loss payees? Yes No If yes, give name and address of mortgagee/loss payee for each vehicle _____

LOSS EXPERIENCE — Provide prior insurance carriers information for past full three years.

Policy Term		Insurance Company Name	No. of Motor Powered Vehicles	No. of Accidents	Premium		Total Amount Claims Paid & Reserves			
From	To				Liab	Phys Dam	BI	PD	Comp/Coll	Other
/ /	/ /									
/ /	/ /									
/ /	/ /									

30. Is any applicant aware of any facts or past incidents, circumstances or situations which could give rise to a claim under the insurance coverage sought in this application? Yes No If yes, provide complete details _____

31. Have you ever been declined, cancelled or non-renewed for this kind of insurance? Yes No If yes, date and why _____

CARGO INFORMATION — 100% coinsurance clause applies. Use Tow Truck Supplement for In-Tow/On Hook coverage.

PREVIOUS CARGO CARRIER AND LOSS EXPERIENCE (list for the past three years with most recent carrier first).

Policy Term		Company & Policy Number	Premium	Number of Claims	Cause of Loss	Amount Paid	Reserves
From	To						
/ /	/ /						
/ /	/ /						
/ /	/ /						

Describe Cargo Hauled	% of Hauling	Maximum Value	Average Value	Limit of Insurance	Deductible
				SEE PHYSICAL DAMAGE COVERAGE SECTION	<input type="checkbox"/> \$500
					<input type="checkbox"/> \$1,000
					<input type="checkbox"/> \$2,500
					<input type="checkbox"/> Other _____

If applicant hauls double wide mobile homes, Limit of Insurance must be equal to the value of both sides combined to satisfy co-insurance. Amount of insurance on each truck should equal maximum load carried.

32. Select type of cargo coverage desired: Named Perils or Broad Form

33. Additional Coverage Options (additional premium may apply): Additional Insured Endorsement (Lessee) Loading and Unloading Coverage Earned Freight Coverage Refrigeration Breakdown Coverage Hired Car Cargo Coverage Exclude Theft Coverage

FILING INFORMATION

34. Is an FHWA filing required? Yes No If yes, MC number _____
 Common Contract Broker Do you require FHWA cargo filing? Yes No

35. If you hold a Brokers license, identify name filed with FHWA, FHWA docket no. and receipts from brokerage operations _____

36. If you are an interstate regulated carrier, identify your registration or base state _____

37. Is an intrastate filing needed? Yes No If yes, show state and permit number _____
List states for which insured requires CARGO FILINGS (check name on permits) _____

38. Show exact name and address in which permits are issued _____

39. Is MCS 90 endorsement needed? Yes No

40. Is our policy to cover all vehicles owned, operated or under lease to applicant? Yes No If no, explain _____

41. Are oversize, overweight commodities hauled? Yes No If filing required, show states _____
Are escort vehicles towed on return trips? Yes No

42. Does your authority allow for transportation of hazardous commodities? Yes No

43. Do you allow others to haul hazardous commodities under your authority? Yes No

44. Have you ever changed your operating name? Yes No Do you operate under any other name? Yes No

45. Do you operate as a subsidiary of another company? Yes No

46. Do you own or manage any other transportation operations that are not covered? Yes No

47. Do you lease your authority? Yes No Do you appoint agents or hire independent contractors to operate on your behalf? Yes No

48. Have you purchased, sold or applied for authority over the past 3 years? Yes No

49. Have you ever lost or had authority withdrawn, or have you been/are under probation by any regulatory authority (FHWA, PUC, etc.)? Yes No

50. Is evidence/certificate(s) of coverage required? Yes No

51. Please explain any "yes" answer to questions 44 through 50 _____

52. Do you have agreements with other carriers for the interchange of equipment or transportation of loads? Yes No

If yes, attach a copy of current agreements and complete the following:

(a) With whom has such agreement(s) been made? _____

(b) Do the parties named in (a) carry automobile liability insurance? Yes No

If yes, name of insurance company and limits of liability (Bodily Injury & Property Damage) _____

(c) Under whose permit does each of the parties to the agreement(s) operate? _____

(d) Is there a hold harmless in the agreement(s)? Yes No

53. Do you barter, hire or lease any vehicles? Yes No If yes, explain _____

COLORADO COVERAGE SELECTION FORM

You should read this document carefully and contact your agent if you have any questions regarding these coverages and your options with respect to these coverages. This document generally describes these coverages, but no coverage is provided by this document. You should read your policy for complete information on the coverages you have purchased.

Bodily Injury Uninsured Motorists Coverage (UM) provides protection to an insured for damages which the insured is legally entitled to recover from the owner or operator of an uninsured motor vehicle because of bodily injury caused by an automobile accident (including injury caused by a hit-and-run vehicle). Unless rejected, your policy will include UM Coverage at limits not less than the minimum limits required by Colorado law.

Please indicate your choice for Bodily Injury Uninsured Motorists Coverage by initialing your selection:

<hr style="border: none; border-top: 1px solid black;"/> Initials	I select Bodily Injury Uninsured Motorists Coverage at limits equal to the limits of my Bodily Injury Liability Coverage (split limits) or Combined Single Limit for Liability Coverage.
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<hr style="border: none; border-top: 1px solid black;"/> Initials	<input type="checkbox"/> I select Bodily Injury Uninsured Motorists Coverage at the minimum limits required by Colorado law: <div style="display: flex; justify-content: space-around; align-items: center;">\$25,000 / \$50,000\$50,000</div> <div style="display: flex; justify-content: space-around; align-items: center;">Bodily Injury split limits (per person / per accident)Single limit</div>	<input type="checkbox"/>
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<hr style="border: none; border-top: 1px solid black;"/> Initials	<input type="checkbox"/> I select Bodily Injury Uninsured Motorists Coverage at the limits listed below, which is less than my Bodily Injury Liability Coverage limit: <div style="display: flex; justify-content: space-around; align-items: center;">/</div> <div style="display: flex; justify-content: space-around; align-items: center;">Bodily Injury split limits (per person / per accident)Single limit</div>	<input type="checkbox"/>
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<hr style="border: none; border-top: 1px solid black;"/> Initials	I <u>reject</u> Bodily Injury Uninsured Motorists Coverage.
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Property Damage Uninsured Motorists Coverage (UMPD) provides protection for persons who are legally entitled to recover damages from the owner or operator of an uninsured motor vehicle because of property damage to the motor vehicle arising out of the operation, maintenance or use of the uninsured motor vehicle. The amount of UMPD coverage available is the actual cash value of the vehicle or the cost of repair or replacement, whichever is less.

THIS COVERAGE IS AVAILABLE ONLY IF YOUR POLICY DOES NOT INCLUDE COLLISION COVERAGE.

<hr style="border: none; border-top: 1px solid black;"/> Initials	I request Property Damage Uninsured Motorists Coverage on those vehicles to which Collision coverage does not apply.
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Auto Medical Payments Coverage (Medpay) pays for medical or funeral expenses caused by an automobile accident to an insured. Unless rejected, you will receive Medpay coverage at \$5000 for each insured per accident. If you wish to reject this coverage, please initial below.

<hr style="border: none; border-top: 1px solid black;"/> Initials	I <u>reject</u> Auto Medical Payments Coverage.
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IF YOU DO NOT RETURN THIS FORM, WE WILL PROVIDE UNINSURED MOTORIST COVERAGE WITH A LIMIT EQUAL TO YOUR BODILY INJURY LIABILITY LIMIT AND AUTO MEDICAL PAYMENTS COVERAGE WITH A \$5000 LIMIT. YOU WILL NOT RECEIVE PROPERTY DAMAGE UNINSURED MOTORIST COVERAGE. THIS MAY AFFECT YOUR PREMIUM.

PLEASE SIGN AND DATE THIS FORM



Signature of Applicant / Named Insured



Date

SIGNATURE IS ALSO REQUIRED ON LAST PAGE OF APPLICATION

MUST BE SIGNED BY THE APPLICANT PERSONALLY

No coverage is bound until the Company advises the Applicant or its representative that a policy will be issued and then only as of the policy effective date and in accordance with all policy terms. The Applicant acknowledges that the **Applicant's Representative named below is acting as Applicant's agent and not on behalf of the Company. The Applicant's Representative has no authority to bind coverage, may not accept any funds for the Company, and may not modify or interpret the terms of the policy.**

The Applicant agrees that the foregoing statements and answers are true and correct. The Applicant requests the Company to rely on its statements and answers in issuing any policy or subsequent renewal. The Applicant agrees that if its statements and answers are materially false, the Company may rescind any policy or subsequent renewal it may issue.

If any jurisdiction in which the Applicant intends to operate or the Interstate Commerce Commission requires a special endorsement to be attached to the policy which increases the Company's liability, the Applicant agrees to reimburse the Company in accordance with the terms of that endorsement.

The Applicant agrees that any inspection of autos, vehicles, equipment, premises, operations, or inspection of any other matter relating to insurance that may be provided by the Company, is made for the use and benefit of the Company only, and is not to be relied upon by the Applicant or any other party in any respect.

The Applicant understands that an inquiry may be made into the character, finances, driving records, and other personal and business background information the Company deems necessary in determining whether to bind or maintain coverage. Upon written request, additional information will be provided to the Applicant regarding any investigation.

The Applicant represents that she/he has completed all relevant sections of this Application prior to execution and that the Applicant has personally signed below (or if Applicant is a Corporation, a corporate officer has signed below).

Will premium be financed? Yes No If yes, with whom _____

IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGE. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICY HOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICY HOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

Witness Applicant's Signature Date

TO BE COMPLETED BY APPLICANT'S REPRESENTATIVE

Is this direct business to your office? _____ If not, explain _____

Is this new business to your office? _____ If not, how long have you had the account? _____

How long have you known applicant? _____

REQUEST TO COMPANY GENERAL AGENT:

Please quote Please bind at earliest possible date and issue policy

Please issue policy effective _____ Coverage was bound by _____
(Time and Date Bound by General Agent) (Name of Person in Company General Agency's Office Binding Coverage)

Applicant's Representative's Name and Address Phone No.