



CANAL Canal Truck Insurance Application

ARKANSAS

Insurance Indemnity

Sections 1 through 6 must be completed for a quote indication. Sections 7 through 9 must be completed in order to bind.

1. General Information

Applicant Legal Name		Form of Business <input type="checkbox"/> Individual <input type="checkbox"/> LLC <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Joint Venture <input type="checkbox"/> Trust			
Company Name (DBA) (if any)		Principal or Majority Owner (please include all principals)			
Tax Identification Number or Social Security Number (If provided, certificates of insurance may be accessed from www.canal-ins.com 24 hours a day)					
Location of Business Premises or Physical Address				Telephone Number	Mobile Phone Number
City	State	Zip Code	County		
Location Is: <input type="checkbox"/> Inside City Limits <input type="checkbox"/> Outside City Limits					
Mailing Address (if different than above)					
City	State	Zip Code	County		

Please enter the month and year the current operations began: Month: _____ Year: _____

Policy Type Scheduled Vehicle Gross Receipts Gross Mileage

Business Class For Hire Trucking Private Carrier Non Trucking

For-Hire and Private Operations
 Auto or Boat Container Drive-Away Dry Bulk or Farm Products Dry Van / Box Dry Van- Doubles Dump
 Dump-Coal Flatbed Livestock Log or Pulp Mobile Home Refrigerated Special Type Operations
 Tanker-Fuel Tanker- Liquids or Compressed Gasses Towing and Recovery Waste / Garbage

Commodities Transported (Please be specific - general freight and miscellaneous is not acceptable)

%	Commodity	%	Commodity

Please enter the percentage of loads received from a broker: _____

Indicate Policy Term and Payment Method

Short Term Policy: Desired Expiration Date _____ (no payment plan available for short term policies)

Annual Policy: Full Payment to Company Company Payment Plan

Financed through outside Premium Finance Company with full payment to Canal (no double financing permitted – attach contract)

Continuous Until Cancelled Policy (2 month escrow deposit and monthly billing)

2. Motor Carrier Filings

MCS-90 Requested: Yes No **Authority Type:** Common Contract Brokerage

MC# _____ **DOT #** _____

3. History

Have there been any losses in the current year or the past three years? Yes No If yes, please complete below.
 Please complete for all lines of business for the current year, as well as for the three years prior, or submit loss runs.

Year	Liability		Physical Damage		Cargo		General Liability	
	# Claims	*Amount Incurred	# Claims	*Amount Incurred	# Claims	*Amount Incurred	# Claims	*Amount Incurred

Please enter the number of claims over \$100,000: _____ Please enter the dollar amount for claims over \$100,000: _____

Loss runs are required for all applicants with five or more power units. Attach separate loss runs if space provided is not sufficient. *Amount incurred should include amounts paid, reserved totals as well as any expenses.

4. Drivers

I declare the following list includes all drivers of vehicles requested to be covered under the policy including employees, leased employees, owner operators, mechanics, family members, and any other person allowed to drive an insured vehicle.

Driver Name	Years of Experience	Convictions and MVR Record	Driver License Number	License State	Year Hired	Date of Birth



5. Vehicles

Description of Vehicles (trailers must be scheduled for liability coverage to apply while detached from a covered power unit)

Unit No.	Model Year	Make and Unit Type	Vehicle Identification Number (VIN)	GVW	Radius	*Stated Value	Gap Coverage (Y/N)	**Is garaging address same as physical? (Y/N)
1								
2								
3								
4								
5								

*Only applicable if Physical Damage coverage is applied for. **If a unit is not garaged at the physical address, it is necessary to list the garaging addresses in the Additional Underwriting Information section of this application.

6. Coverage

Coverages Desired: Auto Liability Auto Physical Damage Motor Truck Cargo Truckers General Liability

Auto Liability Coverage Selection

Combined Single Limit - each accident
\$ _____

If applying for Hired Auto coverage, please enter the annual estimated cost of hire: _____

If Non-Owned coverage is desired please enter the number of employees: _____

Is this a social service agency or charitable organization? Yes No

Auto Physical Damage Coverage Selection

Deductible Desired		Coverage Desired	
<input type="checkbox"/> \$500	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000	<input type="checkbox"/> Collision and Specified Causes of Loss	<input type="checkbox"/> Collision and Comprehensive (where available)

Additional Auto Physical Damage Coverages Desired

Additional Towing Limit \$ _____ (in the event of a total loss to the described unit) \$2,500 included

Trailer Interchange Limit \$ _____ Minus \$1,000 Deductible (UIIA container haulers)

Non-Owned Trailer Limit \$ _____ Minus \$1,000 Deductible (coverage applies only while attached to a scheduled power unit)

Motor Truck Cargo Coverage Selection

Please select the desired form: Standard Preferred

Limit Desire Per Vehicle \$ _____ Deductible Desired \$500 \$1,000 \$2,500 \$5,000

Units that require specific limits other than above, please indicate below.

Unit No.	Desired Limit	Unit No.	Desired Limit
	\$ _____		\$ _____

Additional Cargo Coverages or Endorsements Desired

Refrigeration Breakdown - \$2,500 minimum deductible required Removal of Coinsurance Clause Removal of Commodities Theft

Earned Freight Increase to \$ _____ (\$1,000 included) Debris Removal Increase to \$ _____ (\$25,000 included)

Truckers General Liability Coverage Selection This is for businesses solely involved in "for-hire" transportation of property

Desired Limits General Aggregate - please select one \$1,000,000 \$2,000,000 Each Occurrence \$1,000,000 (included)

Employers Liability (Stop Gap) Coverage - Applicable only in ND, OH, WA and WY. Please select either yes or no.

Yes No \$1,000,000 Bodily Injury by Accident - each accident \$1,000,000 Bodily Injury by Disease - each employee \$1,000,000 Bodily Injury by Disease - each policy



7. Additional Underwriting Information

Have any drivers been convicted of any of the following? Yes No

Negligent homicide, unlawful use of vehicle, speed contest or racing, reckless driving, leaving the scene of an accident or a hit and run, any felony conviction which involves a motor vehicle, speed twenty miles or more over the speed limit or driving while license is suspended or revoked in a commercial vehicle, DUI or DWI.

If yes, please provide driver name, conviction date and details:

Please complete all of the following:

- Yes No Do you own any other businesses?
- Yes No Have there been any changes in the ownership, management or name of the operation in the past five years?
- Yes No Are all owned and operated power units listed on this application?
- Yes No Do you have any mobile equipment subject to financial responsibility laws?
- Yes No Do you act as a freight forwarder, freight broker or arrange loads for others?
- Yes No Do you lease to others?
- Yes No Do you haul double trailers?
- Yes No Do you haul triple trailers?
- Yes No Do you allow guest passengers?
- Yes No Are any vehicles used to transport employees?
- Yes No Do you hire owner operators on a trip lease basis?
- Yes No Do you lend, lease or rent trucks, tractors or trailers to others without drivers?
- Yes No Do you agree to report all drivers to your agent prior to them driving an insured unit?
- Yes No Do you comply with all DOT regulations concerning driver employment, files and regulations?

If applying for **Non-Trucking Coverage** list name and the motor carrier number of the lessee to whom you are permanently leased.

Name of Motor Carrier:

Motor Carrier Number:

Filings Requested	Motor Carrier #	Applicant's Name and Address Exactly As It Appears On Each Permit
<input type="checkbox"/> Liability BMC 91X <input type="checkbox"/> Cargo BMC 34	MC	
<input type="checkbox"/> Liability – Form E _____ State		
<input type="checkbox"/> Oversized/Overweight		
<input type="checkbox"/> Hazardous		
<input type="checkbox"/> Cargo – Form H _____ State		
<input type="checkbox"/> SR 22- If yes explain		

Please note: The FMCSA and/or state agencies require a minimum 36 day notice of cancellation on all policies that have an MCS-90 or filings.

Certificates of Insurance

Name	Mailing Address

Additional/Designated Insureds for Auto Liability or Truckers General Liability

Name	Mailing Address	*Type of Additional Insured

*Please enter each desired additional/designated insured by entering the corresponding number: **Auto Liability Additional Insureds:** 1. Designated Additional Insured, 2. Intermodal, 3. Additional Insured Waiver Rights Recovery, 4. Additional Insured Hired/Non-Owned **General Liability Additional Insureds** A. Controlling Interest, B. Designated Person or Organization, C. Managers or Lessors of Premises, D. Mortgagee, E. Owners, Lessees or Contractors, F. Co-Owner of Insured Premises, G. Vicarious Liability for Owners, Lessees or Contractors

Please complete this section for vehicles with different ownership or different garaging addresses

Name and address of vehicle owners other than the named insured (owner types 2, 3 & 4 listed below)

Unit No.	Name of Owner	*Ownership Type	Mailing Address

*Please enter the owner type by entering the corresponding number. 1. Owned by Named Insured, 2. Owned by Leasing Company (long term lease without a driver), 3. Owned by Owner Operator (leased with driver), 4. Owned by Employee of Named Insured (officer). Please note that coverage for owners might not be afforded if this section is not completed.

For Liability Coverage, if a unit is not garaged at the physical address of the applicant, please list the garaging addresses for each unit

Unit No.	Street Address		
City	State	Zip Code	County
Unit No.	Street Address		
City	State	Zip Code	County

INSURANCE COMPANY
 INDEMNITY COMPANY

MUST be completed if Auto Liability Coverage is requested

1. Applicant Name _____

2. DBA, if any _____

ARKANSAS FRAUD WARNING

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

AUTHORIZATION FOR MOTOR VEHICLE REPORTS

I hereby authorize Canal Insurance Company and/or the Producing Agent to obtain from the **Arkansas Office of Driver Services** a copy of my Motor Vehicle Report for the use in rating and/or underwriting the insurance for which I do hereby apply and any renewal thereof. I understand that in obtaining a Motor Vehicle Report a consumer reporting agency may be used by the insurer and I do hereby authorize such use. I hereby certify that the named drivers under this policy (names specified on application and/or drivers hired during the term of this insurance) have or will have authorized me to consent on their behalf for the insurer to obtain Motor Vehicle Reports for rating and/or underwriting; and I hereby certify that the information above is true and agree that a misrepresentation of any of the facts by me will constitute 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 restrictive and/or Exclusion Endorsement Text, which is included on the application and signed by me, shall become a part of the policy.

Date Application Completed _____

Signature of Agent of Applicant _____

Signature of Applicant _____ **X**

Address of Agent _____

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UNINSURED MOTORIST SELECTION / REJECTION

In accordance with **Arkansas** statutes, your policy will contain Uninsured Motorist Bodily Injury (UMBI) coverage of 25/50 unless you reject it. You may also choose limits up to your bodily injury liability limits. You may also request Uninsured Motorist Property Damage (UMPD) coverage up to your property damage liability limits or reject it. UMPD cannot be purchased alone. If UMBI is rejected, UMPD must be rejected also.

You have the option of choosing UMBI Only, UMBI/PD \$25,000, UMBI/PD \$50,000 **or** UMBI/PD \$100,000. Please indicate your selections below by initialing next to your choice in the appropriate table below or on the following pages. **These elections require payment of additional premium.**

Uninsured Motorist – Bodily Injury Only

Initial	Limit – BI Only per person/per accident (000)	Premium (\$)
_____	25/50	25
_____	50/50	30
_____	25/100	66
_____	50/100	75
_____	100/100	85
_____	100/300	100
_____	300/300	155
_____	350/350	175
_____	400/400	190
_____	500/500	230
_____	600/600	315
_____	750/750	395
_____	1,000/1,000	440

Uninsured Motorist – Bodily Injury and \$25,000 Property Damage Limit

*UMPD has a \$200 deductible

Initial	Limit – BI per person/per accident/ PD per accident (000)	Premium (\$)
_____	25/50/25	55
_____	50/50/25	60
_____	25/100/25	96
_____	50/100/25	105
_____	100/100/25	115
_____	100/300/25	130
_____	300/300/25	185
_____	350/350/25	205
_____	400/400/25	220
_____	500/500/25	260
_____	600/600/25	345
_____	750/750/25	425
_____	1,000/1,000/25	470

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(Applicant's Initials)

Uninsured Motorist – Bodily Injury and \$50,000 Property Damage Limit

*UMPD has a \$200 deductible

Initial	Limit – BI per person/per accident/ PD per accident (000)	Premium (\$)
_____	25/50/50	64
_____	50/50/50	69
_____	25/100/50	105
_____	50/100/50	114
_____	100/100/50	124
_____	100/300/50	139
_____	300/300/50	194
_____	350/350/50	214
_____	400/400/50	229
_____	500/500/50	269
_____	600/600/50	354
_____	750/750/50	434
_____	1,000/1,000/50	479

Uninsured Motorist – Bodily Injury and \$100,000 Property Damage

*UMPD has a \$200 deductible

Initial	Limit – BI per person/per accident/ PD per accident (000)	Premium (\$)
_____	25/50/100	72
_____	50/50/100	77
_____	25/100/100	113
_____	50/100/100	122
_____	100/100/100	132
_____	100/300/100	147
_____	300/300/100	202
_____	350/350/100	220
_____	400/400/100	237
_____	500/500/100	277
_____	600/600/100	362
_____	750/750/100	442
_____	1,000/1,000/100	487

Please initial your choice below that corresponds with your choice made in one of the above tables.

_____ I am rejecting all offers of Uninsured Motorist Coverage; or

_____ I am selecting Uninsured Motorist Bodily Injury Coverage only; or

_____ I am selecting Uninsured Motorist Bodily Injury Coverage with \$25,000 Property Damage; or

_____ I am selecting Uninsured Motorist Bodily Injury Coverage with \$50,000 Property Damage; or

_____ I am selecting Uninsured Motorist Bodily Injury Coverage with \$100,000 Property Damage.

Applicant Signature

Date

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Applicant's Acknowledgement

The undersigner hereby acknowledges they have read, or have had read to them and understand, the above explanations and offers of Uninsured Bodily Injury Coverage and Uninsured Motorist Property Damage Coverage. Selections have been made by initialing the appropriate lines above. The signature appearing below is that of the named insured or authorization has been given to the signer of this Offer of Uninsured Bodily Injury Coverage and Uninsured Motorist Property Damage Coverage to select or reject coverage and limits on the behalf of the named insured.

YOUR SELECTION OR REJECTION OF COVERAGE IS BINDING ON ALL PERSONS INSURED UNDER THIS POLICY.

Applicant /Named Insured: _____ Date: _____
By: _____
Title: _____

Signature of Agent of Insured: _____ Date: _____
Address: _____
