

# Contingent Liability Application (Bobtail & Deadhead)

NATIONAL INDEMNITY COMPANY OF THE SOUTH  
NATIONAL LIABILITY & FIRE INSURANCE COMPANY

Administrative Office - Omaha, Nebraska

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 Seasonal?  Yes  No
- Is this your primary business?  Yes  No If no, explain \_\_\_\_\_
- 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 \_\_\_\_\_
- Show largest cities entered: \_\_\_\_\_ Do you pull double trailers?  Yes  No Triple trailers?  Yes  No
- Do you operate over a regular route?  Yes  No If yes, show towns operated between: \_\_\_\_\_
- List all types of cargo hauled: \_\_\_\_\_  
 Principal commodities outbound \_\_\_\_\_ Backhaul commodities \_\_\_\_\_
- 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: \_\_\_\_\_
- What percent of time are your vehicles operating under lease or dispatch? \_\_\_\_\_
- Equipment is under permanent/long term lease to \_\_\_\_\_
- How many companies have you been leased to in the last three years? \_\_\_\_\_
- Do you lease to anyone else?  Yes  No If yes, percent of time \_\_\_\_\_ %, for whom and explanation \_\_\_\_\_
- Do you trip lease on back hauls to others?  Yes  No If yes, percent of time \_\_\_\_\_ %, for whom and explanation \_\_\_\_\_

LIABILITY COVERAGE — Complete for desired coverages by indicating limits of insurance.						
Combined Single Limit BI & PD	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.
	Split Limits					
	Bodily Injury		Property Damage			
	Each Person	Each Accident	Each Accident			

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**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 (i.e. Truck, Tractor, Trailer, etc.)	Full Vehicle Identification Number	Gross Vehicle Weight (GVW)	Total # of rear axles	Principal Garaging Location (Complete Street Address, City, State & Zip)	Radius of Operation	Annual Mileage Per Vehicle	(A) Anti-Lock Brakes, (B) Air Bags
1										
2										
3										
4										
5										

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								

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 \_\_\_\_\_

**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 FHWA 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? \_\_\_\_\_

\_\_\_\_\_  
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

\_\_\_\_\_  
Applicant's Representative's Agent License ID Number

\_\_\_\_\_  
Phone No.

**COVERAGE ELECTION NOTICE**  
**Regarding Uninsured Motorists Coverage**  
**FLORIDA**

**YOU ARE ELECTING NOT TO PURCHASE CERTAIN VALUABLE COVERAGE WHICH PROTECTS YOU AND YOUR FAMILY OR YOU ARE PURCHASING UNINSURED MOTORIST LIMITS LESS THAN YOUR BODILY INJURY LIABILITY LIMITS WHEN YOU SIGN THIS FORM. PLEASE READ CAREFULLY.**

Uninsured Motorist Coverage provides for payment of certain benefits for damages caused by owners or operators of uninsured motor vehicles because of bodily injury or death resulting therefrom. Such benefits may include payments for certain medical expenses, lost wages, and pain and suffering, subject to limitations and conditions contained in the policy. For the purpose of this coverage, an uninsured motor vehicle may include a motor vehicle as to which the bodily injury limits are less than your damages.

Florida law requires that automobile liability policies include Uninsured Motorist Coverage at limits equal to the Bodily Injury Liability limits in your policy unless you select a lower limit offered by the company, or reject Uninsured Motorist entirely.

Please indicate whether you desire to entirely reject Uninsured Motorist Coverage, or whether you desire this coverage at limits lower than the Bodily Injury Liability limits of your policy:

- a. I hereby reject Uninsured Motorist Coverage
- b. I hereby select Uninsured Motorist limits of \_\_\_\_\_ which are lower than my Bodily Injury Liability limits.

**STACKING OF UNINSURED MOTORISTS LIMITS APPLIES ONLY TO CLASS I INSUREDS (THE NAMED INSURED, IF AN INDIVIDUAL, AND ANY FAMILY MEMBERS). CLASS II INSUREDS ARE NOT REQUIRED TO COMPLETE THIS SECTION.**

**ELECTION OF NON-STACKED COVERAGE**  
(Do not complete if you have rejected Uninsured Motorist)

You have the option to purchase, at a reduced rate, a non-stacked (limited) type of Uninsured Motorist Coverage. Under this form if injury occurs in a vehicle owned or leased by you or any family member who resides with you, this policy will apply only to the extent of coverage (if any) which applies to that vehicle in this policy. If an injury occurs while occupying someone else's vehicle, or you are struck as a pedestrian, you are entitled to select the highest limits of Uninsured Motorist Coverage available on any one vehicle for which you are a named insured, insured family member, or insured resident of the named insured's household. This policy will not apply if you select the coverage available under any other policy issued to you or the policy of any other family member who resides with you.

If you do not elect to purchase the non-stacked form, your policy limit(s) for each motor vehicle are added together (stacked) for all covered injuries. Thus, your policy limits would automatically change during the policy term if you increase or decrease the number of autos covered under the policy.

- I hereby elect the non-stacked form of Uninsured Motorist Coverage.

I understand and agree that selection of one of the above options applies to my liability insurance policy and future renewals or replacements of such policy which are issued at the same Bodily Injury Liability limits. If I decide to select another option at some future time, I must let the company or my agent know in writing.

Signed: \_\_\_\_\_  
(Named Insured)

Date: \_\_\_\_\_

**NO FAULT COVERAGE** - In accordance with Florida Statutes, you must carry no-fault insurance of \$10,000. If your motor vehicles are owned by an individual or husband and wife, the named insured may elect a deductible and exclude coverage for loss of gross income and loss of earning capacity ("lost wages"). These elections apply to the named insured alone, or to the named insured and all dependent resident relatives. A premium reduction will result from these elections. The named insured is hereby advised not to elect the lost wage exclusion if the named insured or dependent resident relatives are employed, since lost wages will not be payable in the event of an accident. Deductible or reduced benefits are not available to a partnership, corporation or other non-individual entity. Please choose either A or B.

- A. \$10,000 Coverage (no deductible)
  - Exclude work loss for Named Insured
  - Exclude work loss for Named Insured and Dependent Relatives
- B. \$10,000 Coverage less Deductible of \*\$\_\_\_\_\_
  - Named Insured
  - Named Insured and Dependent Relatives

\*Deductible Available (\$250) (\$500) (\$1,000)

Applicant's Signature \_\_\_\_\_

Applicant's Signature \_\_\_\_\_