

LOUISIANA

Contingent Liability Application (Bobtail & Deadhead)

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

Horner Insurance Services, Inc.
 5101 Wheelis Drive
 Suite 214
 Memphis, TN 38117
 (901) 684-4570 FAX: (901) 684-4565

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 _____
- 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			
	Per Person	Per Accident	Per Accident			

UNINSURED MOTORIST COVERAGE

Single Limit	Split Limits		Uninsured Motorist Economic Loss Only	Uninsured Motorist Property Damage
	Bodily Injury			
	Per Person	Per Accident		
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

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.

19. Are drivers covered by workers compensation? Yes No If yes, name of carrier _____
20. Minimum years driving experience required _____ Are vehicles owner-driven only? Yes No
21. Are drivers ever allowed to take vehicles home at night? Yes No If yes, will family members drive? Yes No
22. Do you order MVRs on all drivers prior to hiring? Yes No Driver's maximum driving hours ____ daily ____ weekly
23. Do you agree to report all newly hired operators? Yes No
24. 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 (city & state)	Radius of Operation	Annual Mileage Per Vehicle	(A) Anti-Lock Brakes, (B) Air Bags
1										
2										
3										
4										
5										

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

28. 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/Coli	Other
/ /	/ /									
/ /	/ /									
/ /	/ /									

29. 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 _____

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 Federal Highway Administration 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 _____

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.

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.

STATE OF LOUISIANA

This form may not be altered or modified.

UNINSURED/UNDERINSURED MOTORIST BODILY INJURY COVERAGE FORM

Uninsured/Underinsured Motorists Bodily Injury Coverage, referred to as "UMBI" in this form, is insurance that pays persons insured by your policy who are injured in an accident caused by an owner or operator of an uninsured or underinsured motor vehicle. Depending on the coverage purchased, UMBI Coverage can provide compensation for both economic and non-economic losses.

Economic losses are those that can be measured in specific monetary terms including but not limited to medical costs, funeral expenses, lost wages, and out of pocket expenses.

Non-economic losses are losses other than economic losses and include but are not limited to pain, suffering, inconvenience, mental anguish and other non-economic damages otherwise recoverable under the laws of this state.

By law, your policy will include UMBI Coverage at the same limits as your Bodily Injury Liability Coverage unless you request otherwise. If you wish to reject UMBI Coverage, select lower limits of UMBI Coverage, or select Economic-Only UMBI Coverage, you must complete this form and return it to your insurance agent or insurance company. (Economic-Only UMBI Coverage may not be available from your insurance company. In this case, your company will have marked options 2 and 3 below as "Not Available" or "NA".)

UNINSURED/UNDERINSURED MOTORIST BODILY INJURY COVERAGE

You may select one of the following UMBI Coverage options (initial only one option):

1. I select **UMBI Coverage** which provides compensation for economic and non-economic losses **with limits lower** than the Bodily Injury Liability Coverage limits indicated on the policy:

\$ _____ each person

\$ _____ each accident/occurrence

| OR

\$ _____ each accident/occurrence

2. I select **Economic-Only UMBI Coverage**, which provides compensation for economic losses **with the same limits** as the Bodily Injury Liability Coverage indicated on the policy.

3. I select **Economic-Only UMBI Coverage**, which provides compensation for economic losses **with limits lower** than the Bodily Injury Liability Coverage limits indicated on the policy:

\$ _____ each person

\$ _____ each accident/occurrence

| OR


\$ _____ each accident/occurrence

4. I do not want **UMBI Coverage**. I understand that I will not be compensated through UMBI coverage for losses arising from an accident caused by an uninsured/underinsured motorist.

SIGNATURE

The choice indicated and initialed on this form will apply to all persons and/or entities insured under this policy. This choice shall apply to the motor vehicles described in this policy and to any replacement vehicles, to all renewals of this policy, and to all reinstatement, substitute or amended policies until a written request is made for a change to the Bodily Injury Liability Limits, the UMBI limits or UMBI Coverage.

 _____
Signature of Named Insured or Legal Representative

 _____
Print Name

 _____
Date

**THE NATIONAL INDEMNITY GROUP OF
INSURANCE COMPANIES**