

LOUISIANA

Truck Application (Physical Damage Only)

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

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

Policy Term From: _____ To: _____

- Name of Applicant _____
- Address of Applicant _____
 (Number) (Street) (City) (County) (State) (Zip Code)
- Applicant is: Individual Partnership Corporation
- Applicant's business to be covered? _____ Years experience in this business? _____
- Date coverage to be effective _____
- Person to contact for inspection (name and phone number) _____
- Is this a new operation? Yes No Is your operation currently for sale? Yes No Seasonal in nature? Yes No
- Give estimate of financial worth \$ _____ Gross receipts last year? _____ Estimate for coming year? _____

DESCRIPTION AND AREA OF OPERATIONS

- Define normal areas of operations: _____
- Maximum radius operated by all trucks? 50 51-200 Over 200 Do you haul for hire? Yes No
- List kinds and types of cargo hauled: _____
- Do you haul any hazardous or extra hazardous substances or materials as defined by EPA? Yes No
 If yes, what type(s) materials is being hauled? (give complete listings, naming material(s) and/or chemical content): _____
- Do you pull double trailers? Yes No Triple trailers? Yes No
- Number of vehicles owned and/or leased: Pick-Ups _____ Trucks _____ Tractors _____ Semi-Trailers _____ Trailers _____ Dollies _____

PREVIOUS INSURANCE CARRIER AND LOSS EXPERIENCE

- Provide prior insurance carriers information for past full three years. List in order with most recent carrier first.

Policy Term		Insurance Company Name	Policy Number	Number of Motor Powered Vehicles	Number of Accidents	Premium	Total Amount Claims Paid & Reserves	
From	To					Physical Damage	Collision	Specified Causes of Loss
/ /	/ /							
/ /	/ /							
/ /	/ /							

DRIVER INFORMATION

- Does any driver listed have any convictions such as DWI/DUI of alcohol or drugs, license suspensions for moving violations, felonies, hit and run, eluding an officer, reckless/negligent operation of a vehicle, driving while under suspension or revocation or other violations not listed above?
 Yes No If yes, describe (including dates) _____
- Driver's pay scale is (check all that apply): Union Non-Union Hourly Trip Mileage
 Other, explain: _____
- Are you familiar with the U.S. Dept. Of Transportation driver regulations? Yes No Are you complying with regulations? Yes No
- SCHEDULE OF ALL DRIVERS NOW EMPLOYED (if not enough space, attach separate listing)**

Driver's Name	Date of Birth	Driver License No.	State Where Licensed	Years Experience Driving Trucks	Date of Hire	Married (Y or N)	List All Violations/ Convictions in Past 5 Years	List All Accidents in Past 3 Years

20. **SCHEDULE OF AUTOS/VEHICLES TO BE COVERED**

Auto/ Vehicle No.	Year Model	Trade Name	Body Type PP Auto, Pick-Up, Truck, Tractor, Semi-Trailer, Trailer, Cargo Van	Serial No. (S) Vehicle ID No. (VIN)	Maximum Gross Weight of Vehicle and Load (lbs.)	Estimated Annual Mileage	Anti-Lock Brakes (A), Airbags (B) or Anti-Theft Devices (C)	Use* S) Service R) Retail C) Comm B) Bus. Use PP	Size GVW, GCW of Vehicle	Maximum Radius of Operations (miles)
1										
2										
3										
4										
5										

*Vehicle Use: S) Service - Transportation of Personnel, Tools, and Equipment and usually parked at job site. C) Commercial - All other.
 R) Retail - House to house delivery. B) Private Passenger Vehicles Used in business.

21. **PHYSICAL DAMAGE COVERAGES DESIRED (complete spaces below in detail for each respective auto/vehicle described above.)**

Auto/ Vehicle No.	Town & State Where Principally Garaged	Original Cost New of Chassis, Body & Equipment	Date Purchased Mo/Yr	Purchased New (N) Used (U)	Cost When Purchased	Value of Vehicle Excluding Permanently Attached Special Equipment	Value of Permanently Attached Special Equipment	Specified Causes of Loss		Collision	
								Amount of Insurance	Deductible	Amount of Insurance	Deductible
1											
2											
3											
4											
5											

22. **Any loss payees?** Yes No If yes, indicate for which vehicle(s) and give name and address of loss payees: _____

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:	
<input type="checkbox"/> Please quote <input type="checkbox"/> Please bind at earliest possible date and issue policy	
<input type="checkbox"/> 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. _____