

## MOTOR TRUCK CARGO APPLICATION

Insured Name:		Business is:	<input type="checkbox"/> Common Carrier						
Mailing Address:			<input type="checkbox"/> Contract Carrier						
City, State Zip:		Routes - What principal cities:	<input type="checkbox"/> Private Carrier (Owned goods on own vehicle)						
Terminal Location:		Operates in what States:							
City, State Zip:		Present Ins. Carrier Name:							
Phone Number:		Deductibles on Prior Policy(ies)	\$						
Fax Number:		Policy # of Prior Policy(ies):							
Inspection Contact(s):		Present Policy Conditions:	<input type="checkbox"/> Non-Renewing (Give Details) <input type="checkbox"/> Canceled (Give Details)						
How Long in Business:		<input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation							
Policy Period	From:	To:							
Name(s) & Titles of Officers, Owners or Partners:		Present Insuring Conditions:							
		Form & Deductible Requested:							
Limits Requested		Average Exposure Per Vehicle:	Maximum Exposure Per Vehicle:						
Per Vehicle	Per Disaster								
\$	\$	\$	\$						
Is Terminal Coverage Required? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, complete the details on page 2.		Is Liquor or Manufactured Tobacco transported? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, give details separately.							
Operations Radius (list # of Units in each box or %)			# of Vehicles:    Cars                      Tractors						
Vehicle Type	0-100 mi. Local	101-300 mi. Intermediate	301-500 mi Long Haul	Vehicle Type	Van	Flat-bed	Refrigerated	Tank	Bulk
Trucks				Trucks					
Tractors				Semi – Trailers					
Do you own or use equipment other than listed above? <input type="checkbox"/> No <input type="checkbox"/> Yes, Give Separate Details				Full – Trailers					
Do you lease, loan, or rent any of your equipment to others? <input type="checkbox"/> No <input type="checkbox"/> Yes, Give Separate Details.									
Gross Receipts for the Past Four Years & This Coming Year (NOTE: If Annual Trucking Revenue Exceeds \$1,000,000. Attach Financial Statement)									
Period				Cargo Rate			Revenue		
From:	To:						\$		
From:	To:						\$		
From:	To:						\$		
From:	To:						\$		
Estimated for This Coming Year/Period:							\$		

**Experience – Current & Past 2 Years: \*\* FLEETS ATTACH LOSS RUNS; IF MULTIPLE LOSSES - ITEMIZE**

Period From: To:	Premium	# of Claims	Amt. of Losses Paid and Outstanding					
			Fire	Collision	Overturn	Theft	Other (List)	Totals
	\$		\$	\$	\$	\$	\$	\$
	\$		\$	\$	\$	\$	\$	\$
	\$		\$	\$	\$	\$	\$	\$

Please Give Details of Large Losses or Other Category:

**DRIVER'S FULL NAME (AS IT APPEARS ON LICENSE) & INFORMATION**

FULL NAME	BIRTH DATE	STATE & DRIVER LIC. #	DATE EMPLOYED

**DESCRIPTION OF EQUIPMENT – ALL VEHICLES DO NOT HAVE TO CARRY THE SAME LIMIT**

Unit #	Trade Name	Yr. Built	Type	Radius	ID Number	Limit
						\$
						\$
						\$
						\$
						\$
						\$
						\$
						\$
						\$

COMMODITIES	% of Total	Avg. Value	Max Value	TERMINALS:	#1	#2
		\$	\$	Lighted		
		\$	\$	Fenced		
		\$	\$	Sprinklered		
		\$	\$	Burglary Alarm		
		\$	\$	Watchman		
		\$	\$	Construction Type		
		\$	\$	Fire Contents Rate		
		\$	\$	Limit Required		
		\$	\$	Average Values		

<b>Agency &amp; Contact:</b>		<b>Agency Address:</b>	
<b>Agency Phone #:</b>		<b>Agency Fax#:</b>	
<b>Agency Signature:</b>			<b>Date:</b>
<b>Insured's Signature:</b>			<b>Date:</b>