

Contingent Liability Questionnaire

(Addendum to Truckers Occupational Accident Insurance Questionnaire)



from the Domestic Accident & Health Division of the AIG Companies®

1. Motor Carrier Name: _____

2. Has any prior Workers' Compensation, contingent Workers' Compensation, contingent liability, or similar coverage been declined, canceled, or non-renewed in the past three years? Yes No

If Yes, please explain: _____

3. Please provide information on your current employee Workers' Compensation policy, contingent Workers' Compensation policy, contingent liability policy, or similar coverage. Please specify which policy.

Insurer Name: _____

Policy Number: _____ Term: _____

State of Domicile: _____ Type of Policy: _____

If Workers' Compensation, please provide the Experience Modification Factor: _____

4. Have you ever experienced a loss under Workers' Compensation, contingent liability, or similar coverage where an owner-operator or contract driver has become an employee? Yes No

If Yes, please give details of each loss. (Attach a separate sheet, if necessary.)

Date	Description	Amount of Loss

5. Have you been cited for any Occupational Safety and Health Administration (OSHA) violations in the past five years?

Yes No If Yes, please provide details: _____

6. COVERAGE LIMITS

Coverage A (Benefits)

Statutory Workers' Compensation

Other: _____

Coverage B (Employer's Liability)

\$100,000 Bodily Injury by Accident (Each Accident)

\$500,000 Bodily Injury by Disease (Policy Limit)

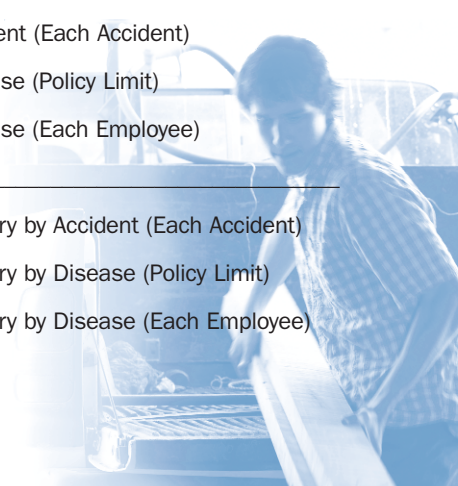
\$100,000 Bodily Injury by Disease (Each Employee)

Other: _____

\$ _____ Bodily Injury by Accident (Each Accident)

\$ _____ Bodily Injury by Disease (Policy Limit)

\$ _____ Bodily Injury by Disease (Each Employee)



7. Please complete the following chart. (Attach a separate sheet, if necessary.)

Owner-Operator Name	State of Domicile	Workers' Compensation Manual Rate for State of Domicile

I hereby acknowledge that all answers and statements contained, including the attached data, are true and complete. I understand that the Contingent Liability contract is registered and delivered as a surplus lines coverage under applicable state law. I also understand that no coverage will become effective until an application has been signed and approved by the Insurance Company, a policy of Insurance is issued, and the required premium is paid.

Broker/Agent Signature _____ Applicant Signature _____

Date: _____ Date: _____

PLEASE TELL US ABOUT YOUR ORGANIZATION.

Producer Name: _____ Producer Code: _____
(if known)

Contact Person: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Fax Number: _____

E-mail Address: _____ Web Address: _____

Requested Commission: _____

Is Agent/Broker Surplus Lines Licensed in state of policy issuance? Yes No If No, please name Agent/Broker authorized to assume duties and responsibilities of Registered Surplus Lines Agent/Broker, below.

TO BE COMPLETED BY SURPLUS LINES AGENT/BROKER

Broker/Agency: _____

Contact Person: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____

Fax Number: _____