

Truckers Occupational Accident Insurance Questionnaire



Submission Date: _____ Quote Due Date: _____

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

RISK INFORMATION

Name _____

Street Address _____

City _____ State _____ Zip _____

Telephone Number (_____) _____ Fax Number (_____) _____

Nature of Business _____ Standard Industrial Classification (SIC): _____
If known

1. Federal Employer Identification Number (FEIN): _____

2. Describe and give percentages of specific commodities hauled. (Avoid general terms.) Please use a separate sheet, if necessary.

Commodity								Total
Percent Hauled								100%

3. What percentage of total truck loads are manually loaded or unloaded?
Manually Loaded: _____% Manually Unloaded: _____% No trucks are manually loaded or unloaded.

4. What percentage of vehicles are: Box: _____% Flatbed: _____% Tanker: _____% Dump: _____% Other: _____%
Describe types and quantity of vehicles marked as "Other": _____

5. Number of leased independent owner-operators/contract drivers: _____

6. In which states are your owner-operators and contract drivers domiciled? (Attach a separate sheet, if necessary.)

State							
Number of Drivers Domiciled							

7. What percentage of your owner-operators'/contract drivers' trips are:
1-50 Miles: _____% 51-200 Miles: _____% Over 200 Miles: _____%

8. Is there any exposure to flammables, explosives, caustics, or fumes? Yes No
If Yes, please explain and provide percentage of exposure: _____

9. Is there any exposure to radioactive materials? Yes No
If Yes, please explain and provide percentage of exposure: _____

10. Is a formal safety program in operation? Yes No
If Yes, please describe. If No, please explain: _____

11. Are pre-employment physicals required? Yes No

12. Describe your new-driver screening procedures for hiring leased owner-operators/contract drivers: _____

13. Please complete the chart below. Valuation Date: _____

Term	Earned Premium	Number of Insured Owner-Operated	Owner-Operator Monthly Premium	Incurred Losses	Number of Losses

14. Have you had Occupational Accident Insurance or Workers' Compensation coverages on your leased owner-operators/contract drivers previously? Yes No If No, please explain how on-the-job injuries were covered: _____

15. Please attach separate sheets listing prior Workers' Compensation or Occupational Accident Insurance currently valued detailed loss information for the past five years. If no prior coverage, please provide a list of any deaths, dismemberments, permanent total disabilities, or claims over \$1,000 in the past five years.

16. Is this a voluntary program? Yes No

If Yes, please explain how enrollment will be handled: _____

17. BENEFIT PLAN DESIRED

Accidental Death & Dismemberment

Accidental Death (Lump Sum): \$ _____

Survivors Benefits: \$ _____ for _____ Months

Accidental Dismemberment: \$ _____

Lump Sum or Monthly Benefit: _____ Months

Paralysis Principal Sum: \$ _____

Lump Sum or Monthly Benefit: _____ Months

Accident Medical Expense

Benefit Amount: \$ _____

Benefit Period: _____ Week(s)

Deductible Amount: \$ _____

Benefits Are (choose one): Primary or Excess

Temporary Total Disability (TTD)

Benefit Amount: \$ _____

Waiting Period: _____ Day(s)

Benefit Period: _____ Week(s)

Participation Percentage: _____ %

Continuous Total Disability (CTD)

Must be same Benefit Amount as for TTD.)

Waiting Period: _____ Day(s)

Benefit Period: _____ Week(s)

Participation Percentage: _____ %

Combined Single Limit

Aggregate Per Person: \$ _____

Aggregate Per Occurrence: \$ _____

Non-Occupational Accident Coverage

Accidental Death: \$ _____

Accidental Dismemberment: \$ _____

Accident Medical Expense

Benefit Amount: \$ _____

Benefit Period: _____ Week(s)

Deductible Amount: \$ _____

Benefits are on the same basis (primary or excess) as for occupational accident coverage.

Passenger Accident Coverage

Accidental Death: \$ _____

Accidental Dismemberment: \$ _____

Lump Sum or Monthly Benefit: _____ Months

Paralysis Principal Sum: \$ _____

Lump Sum or Monthly Benefit: _____ Months

Accident Medical Expense

Benefit Amount: \$ _____

Benefit Period: _____ Week(s)

Deductible Amount: \$ _____

Benefits are on the same basis (primary or excess) as for occupational accident coverage.

Any other benefits desired? (State benefits and limits.)

I hereby acknowledge that all answers and statements contained, including the attached data, are true and complete. 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. I also understand that these are accident insurance coverages and are not in lieu of or in fulfillment of Workers' Compensation insurance.

Broker/Agent Authorized Signature: _____ Applicant Authorized 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: _____

Underwritten by National Union Fire Insurance Company of Pittsburgh, Pa.; and American International Life Assurance Company of New York, each with its principal place of business in New York, NY; and AIG Life Insurance Company (AIG Life), with its principal place of business in Wilmington, DE (collectively referred to as the "Insurance Company"), members of American International Group, Inc. Coverage is not available in all states or outside the U.S. AIG Life does not solicit business in New York.