Employer's Comp Associates, Inc.

The Road to a Better Alternative

ECA Truckers Trust Program
Insurance Questionnaire

RISK INFORMATION

Name: ______________________________ Requested Effective Date: ____________

Street Address: ______________________________ CITY ____________ ST ____ ZIP ________

Telephone Number: ____________ Fax Number: ____________ Nature of Business: ____________

1. Federal Employer Identification Number (FEIN): ______________________________
2. Describe and give percentages of specific commodities hauled. (Avoid General Terms.) Use separate sheet if necessary.

Commodity						Total
Percent Hauled						100%

3. What percentage of loads are manually loaded or unloaded *(use 0% if no manual (un)loading)*? _____% Loaded _____% Unloaded
4. What percentage of vehicles are: Box:_____% Flatbed:_____% Tanker:_____% Dump:_____% Other:_____%

Describe types 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 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 Describe your new-driver screening procedures for hiring leased owner-operators/contract drivers: ______________________________

Please complete the chart below: Valuation Date: ____________

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

12. Have you had Occupational Accident Insurance or Worker's Compensation coverage's on your leased owner-operators/contract drivers previously? ❒ Yes ❒ No If No, please explain how on-the-job injuries were covered: ______________________________
13. 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.
14. Is this a voluntary program? ❒ Yes ❒ No If yes, please explain how enrollment will be handled: ______________________________

I hereby acknowledge that all answers and statements contained, including the attached data, are true and complete. I 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 coverage's and are not in lieu of or in fulfillment of Worker's Compensation insurance.

Broker/Agent Signature: ______________________________ **Date:** ____________

Agency Address: ______________________________

Telephone Number: ______________________________ **Email Address:** ____________

Applicant Signature: ______________________________ **Date:** ____________