PAN-AMERICAN LIFE INSURANCE COMPANY

New Orleans, Louisiana

Truckers Blanket Occupational Accident Submission

ACCOUNT IDENTIFICATION

Legal Name: ____
Individual Corporation Limited Corp Partnership Other
Physical Address: _______________________________________
City:__________________________ State: ______ Zip:_________
Contact Person: ____
Telephone:___________________________ FAX: ____________
Email Address: ____

AGENT IDENTIFICATION

Agency Name:____
Address:____
City:______________________________ State:________ Zip:____________
Telephone:__________________________ FAX:__________________________
Contact Person:___________________ E-mail: ________________________
Requested Effective Date: ____
Date Quote Needed: ____

DRIVER INFORMATION & COMMODITIES HAULED

Number of Owner Operators:_______________ Number of Contract Drivers: ___________________ Number of Team Drivers:____________________

List all commodities hauled by percent of total for the year:

__________________ _____% ____________________ ____%
__________________ _____% ____________________ ____%

Does the Account haul: Hazardous/Waste Material Logging Explosives Flammables Refuse Radioactive Cargo

ACCOUNT INFORMATION: **#**Years in Business:_______

Type of Carrier: Common Contract Private Other: ___________________ LTL % _____ Truckload % _____ Driver Load/Unload % _________
Method of Driver Compensation: Mileage Revenue Hourly Trip Other (details) ____
Radius of round-trip by percent: more than 500 miles _____% 499 to 200 miles _____% 199 to 50 miles _____% less than 50 miles ______%
Driver's average length of haul: ____________ miles Driver's average duration of haul: _____________ days
Type of equipment by percent of total: VAN ________% REFRIGERATED _______% FLATBED _______% TANKER _______% DUMP ________%
DOUBLE TRAILERS ____% OVERSIZE/OVERWEIGHT _______% OTHER ___% (Details ____)
Does Account allow passengers: YES NO (If YES, give details) ____
Backhaul policy is under the control of ACCOUNT or at the discretion of the DRIVER --- Check one and give details: ____________________________
____
Are Drivers required to report daily: YES NO List Account Terminal Locations:____]

DRIVER DISTRIBUTION Give total number of Owner/Operators, Contract Drivers, Team Drivers to be insured by state of residence for the current policy year

Alabama _________	Idaho _______	Michigan _________	New York ___________	Tennessee ____________
Arizona _________	Illinois ______	Minnesota ________	North Carolina _______	Texas ________________
Arkansas _________	Indiana _____	Mississippi ________	North Dakota ________	Utah _________________
California _________	Iowa _______	Missouri __________	Ohio ___________	Vermont ______________
Colorado ________	Kansas _____	Montana __________	Oklahoma _________	Virginia ______________
Connecticut ______	Kentucky ______	Nebraska__________	Oregon ____________	Washington ____________
Delaware ________	Louisiana______	Nevada ___________	Pennsylvania _______	West Virginia ___________
Dist of Col _______	Maine _________	New Hampshire _______	Rhode Island ________	Wisconsin _____________
Florida _________	Maryland _______	New Jersey __________	South Carolina ______	Wyoming _____________
Georgia ________	Massachusetts ______	New Mexico __________	South Dakota _______	TOTAL_________________]

SAFETY INFORMATION

Motor Carrier's ID#:______________________ Motor Carrier's DOT #: ______________________ Motor Carrier's EIN#: ________________________]

Does the Account have a specified individual who's full-time duty is that of a Safety Director? YES NO (name:__________________________)
Does the Account have a current written safety/loss control program: YES NO - If Yes, please provide the following information:
Who Developed the program? Name: ____
Years of Experience: _______ When was the program initiated: _________________ When was it last updated: _________________________

Does the safety/loss program address the following items:
Inspections of operations, conditions and vehicles to identify hazards? YES NO
Frequency of Training of owner operators in safe work practices? YES NO
Specific owner operator rules? YES NO
How often are safety meetings conducted: _____________________ Are Owner/Operators required to attend YES NO

How often are Owner/Operator's MVRs reviewed: ________________ What is minimum age: ________ yrs What is maximum age: __________ yrs.

What MVR violation would cause Owner/Operator's Lease Agreement to be "inactive" ____________________

OCCUPATIONAL ACCIDENT COVERAGE REQUESTED

Accidental Death and Dismemberment Benefit:

Principal Sum:	$100,000____	$150,000 ____	$250,000 _____	Other ____
Lump Sum or Survivors Benefit (Please circle one)				
Accident Medical Benefit:				
Maximum Benefit:	$300,000 ____	$500,000 ____	$1,000,000 ____	Other ____
Deductible:	$0 _____	$100 _____	$500 _____	Other ____
Incurral Period:	26 weeks ____	52 weeks ____	104 weeks ____	Other ____
Temporary Total Disability Benefit:				
Percentage of Average Weekly Earnings:	66 2/3% ____	70% _____	Other _____	
Maximum Weekly Benefit:	$350 _____	$400 _____	$500 _____	Other _____
Waiting Period:	7 days _____	14 days _____	Other _____	
Benefit Period:	26 weeks ____	52 weeks _____	104 weeks _____	Other _____
Permanent Total Disability:				
Percentage of Average Weekly Earnings:	66 2/3% _____	70% _____	Other _____	
Maximum Weekly Benefit:	$350 _____	$400 _____	$500 _____	Other _____
Waiting Period:	26 weeks _____	52 weeks _____	104 weeks _____	Other _____
Benefit Period:	To age 65 _____	To age 70 _____		
Combined Single Limit:	$300,000 _____	$500,000 _____	$1,000,000 _____	Other _____

NON-OCCUPATIONAL ACCIDENT COVERAGE REQUESTED

Accidental Death and Dismemberment:

Principal Sum:	$5,000 _____	$10,000 _____	Other _____
Accident Medical Benefit:			
Maximum Benefit:	$2,500 _____	$5,000 _____	Other _____
Deductible:	$0 _____	$100 _____	Other _____
Incurral Period:	26 weeks _____	52 weeks _____	Other _____

Please provide a rate indication for Contingent Liability coverage?: YES NO

PRIOR CARRIER AND LOSS INFORMATION

Who is the current carrier: ____________________ What is the Anniversary Date: ____________________

Please provide 5 years of currently valued loss information in the grid provided below.

Policy Term	Carrier	Type of Coverage	Rate	Losses	Premium	# of Drivers

Has the account ever had an Occupational Disease, Cumulative Trauma or Contingent Type claim? YES NO

If Yes, please explain: ____________________

____

Has the Account been informed, and acknowledges:

1. **Occupational Accident coverage is not Workers' Compensation Insurance YES NO**
2. **Occupational Accident coverage does not eliminate the Applicant's responsibility to provide Workers' Compensation if required by applicable state law. YES NO**
3. **It is the Accounts responsibility for collecting premiums from the Independent Contractors and submitting them to this insurer or its duly authorized agent. YES NO**
4. **The Account and the Agent understands this form is submitted for underwriting consideration and does not bind any Agent, Carrier, or Administrator to coverage. YES NO**
5. **Coverage can be approved and made effective only in writing from the Administrator. YES NO**

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 may be guilty of a crime and subject to fines and confinement in prison.]

Signature of Applicant/Account:____________________ Date:____________________

Signature of Producer: Date:

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ADDITIONAL DRIVER INFORMATION:

Number of Team Drivers: ____________

Owner Operators driving equipment leased from company: ______________

Independent Contractor who is driving company equipment that is not leased by him/her: ____________

Owner Operators with their own equipment: ____________

Contract Drivers who are driving for an Owner Operator: _____________