

Applicant Information

Business Full Name:			
Business Address:			
Mailing Address (If Different than Above):			
Garaging Address (Where Vehicles are Parked):			
Contact Name:	DOT #:	MC #:	Years In Business:
Phone #:	Cell Phone #:	Email Address:	
FEIN:	Owner's SS #:	Annual Gross Trucking Revenue: \$	

Insurance Information

Renewal Date:	Current Insurance Company(s):		
Auto Liability: <input type="checkbox"/> Yes <input type="checkbox"/> No	UM/UIM: <input type="checkbox"/> Yes <input type="checkbox"/> No	PIP/MedPay: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Physical Damage: <input type="checkbox"/> Yes <input type="checkbox"/> No	Total Equipment Values: \$	Physical Damage Deductible: \$	
Motor Truck Cargo: <input type="checkbox"/> Yes <input type="checkbox"/> No	Cargo Limit: \$	Cargo Deductible: \$	Reefer Breakdown: <input type="checkbox"/> Yes <input type="checkbox"/> No
Trailer Interchange: <input type="checkbox"/> Yes <input type="checkbox"/> No	Trailer Interchange Limit: \$	UIIA Endorsements: <input type="checkbox"/> Yes <input type="checkbox"/> No	
General Liability: <input type="checkbox"/> Yes <input type="checkbox"/> No	Other Coverages/Limits:		

Cargo Carried

Commodity (Please Specify):	% Hauled:	Max Value:	Commodity (Please Specify):	% Hauled:	Max Value:
	%	\$		%	\$
	%	\$		%	\$

Radius

% Under 75 Miles: %	% 76-150 Miles: %	% 151-300 Miles: %	% 301-500 Miles: %	% 500+ Miles: %
Total Annual Mileage:		States Most Traveled Through/To:		
Major Cities Traveled Through/To:				

Equipment (You may also attach a separate schedule)

Year:	Make:	Type:	Full VIN:	Stated Value:	Owner-Operator:
				\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
				\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
				\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
				\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
				\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
				\$	<input type="checkbox"/> Yes <input type="checkbox"/> No

Drivers (You may also attach a separate schedule)

Name:	Date of Birth:	License #:	State:	Date of Hire:	Yrs Experience:	Owner-Operator:
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No

Checklist – Please attach the following items to this application

<input type="checkbox"/> MVRs for All Drivers (Must be ordered within the past 60 days)
<input type="checkbox"/> Loss Runs for Prior 3 Years of Coverage <input type="checkbox"/> Check here if you would like us to send you Loss Run request letters
<input type="checkbox"/> IFTAs for Prior 4 Quarters <input type="checkbox"/> Check here if you do not file IFTAs
<input type="checkbox"/> Equipment Schedule (Must include Year, Make, Type, Full VIN, Stated Value, Specify Owner-Operator Units)
<input type="checkbox"/> Driver Schedule (Must include Full Name, DOB, License #, State, Date of Hire, Years of Experience, Specify Owner-Operators)