- ☐ NATIONAL INDEMNITY COMPANY
- ☐ NATIONAL FIRE & MARINE INSURANCE COMPANY
- ☐ NATIONAL LIABILITY & FIRE INSURANCE COMPANY
- ☐ NATIONAL INDEMNITY COMPANY OF MID-AMERICA

SUBMIT TO: Surplex Underwriters, Inc.
P. O. Box 998
Portland,, ME 04104
Phone: 207-856-0261
(General Agent) Fax: 207-856-0260

APPLICATION FOR INSURANCE FOR NON-TRUCKING USE ONLY

(Equipment must be under permanent/long term lease to permitted carrier to be eligible)

1. Applicant's Name ______________________________
2. Applicant is: ☐ Individual ☐ Partnership ☐ Corporation
3. Name of Legal Owner of Business: ______________________________
4. (a) Business Address ______________________________
   (Number) (Street) (City) (County) (State) (Zip Code)
   (b) Is this location within the corporate city limits? ☐ Yes ☐ No
5. Garaging Address (If Different From Business Address) ______________________________
   (Number) (Street) (City) (County) (State) (Zip Code)
6. Mailing Address (If Different From Business Address) ______________________________
   (Number) (Street) (City) (County) (State) (Zip Code)
7. Person to Contact (Name and phone number) ______________________________
8. Is this a new operation? ☐ Yes ☐ No Is this operation currently for sale? ☐ Yes ☐ No
9. Maximum Radius of Operations: ______________ miles
10. Insurance is desired from: ______________________ to ______________________
11. Has your current policy been cancelled or nonrenewed? ☐ Yes ☐ No If yes, why? ______________
12. (a) Have you ever filed for reorganization or bankruptcy? ☐ Yes ☐ No If yes, show date (month and year) and explain:
    ____
    (b) Have you been released from reorganization or bankruptcy? ☐ Yes ☐ No Date released ______________
13. **Complete for desired coverages:**

LIABILITY LIMITS DESIRED									Physical Damage Deductible	
BI & PD Combined CSL	BI		PD	U.M.			Medical Payments	PIP	Specified Causes of Loss	Collision
	Per Person	Per Accident	Per Accident	CSL	Per Person	Per Accident				

14. Number of tractors with front brakes ______________
15. Number of trailers with mid mount turn signals ______________
16. (a) Is equipment owner-driven only? ☐ Yes ☐ No If no, are any drivers considered independent contractors? ☐ Yes ☐ No
    Who is responsible for driver control? ☐ Owner ☐ Operator
    (b) Are all drivers covered by Workers' Compensation Insurance? ☐ Yes ☐ No
17. What percent of time are your vehicles operating under lease or dispatch? ______________
18. Equipment is under permanent/long term lease to ______________
19. How many companies have you been leased to in the last three years? ______________
20. Do you lease to anyone else? ☐ Yes ☐ No If yes, percent of time ________ %, for whom and explanation ______________
    ____
21. Do you trip lease on back hauls to others? ☐ Yes ☐ No If yes, percent of time ________ %, for whom and explanation ______
    ____
22. **If dead head (Tractor and Empty Trailer) answer these questions:**
    Do you haul any hazardous or extra hazardous substances or materials as defined by EPA? ☐ Yes ☐ No
    If yes, what type(s) materials being hauled? (Give complete listing naming materials and/or chemical content):
    ____
    Do you pull double trailers? ☐ Yes ☐ No Triple trailers? ☐ Yes ☐ No
23. **If physical damage desired answer these questions:**
    List all kinds and types of cargo hauled: ______________________________
    Principal commodities outbound: ______________________________
    Backhaul commodities: ______________________________
    Do you operate over a regular route? ☐ Yes ☐ No If yes ______________ %
    Estimate percent of annual miles driven on interstate highways: ______________ %
    Do you use two man teams? ☐ Yes ☐ No

24. **Provide loss experience from prior insurance carriers for past full three years. List in order with most recent carrier first.**

Policy Term		Insurance Company Name	Policy #	# of Power Units	# of Accidents	Premium		Total Amount Claims Paid & Reserve			
From	To					Liab	Phys Dam	BI	PD	Coll	Other
/ /	/ /										
/ /	/ /										
/ /	/ /										
/ /	/ /										

25. Is any insured aware of any facts or past incidents, circumstances or situations which could give rise to a claim under the insurance coverage sought in this application? ☐ Yes ☐ No If yes, provide complete details ______________________________

____

DRIVER INFORMATION

26. Has applicant or any driver had his license revoked or suspended within last 3 years? ☐ Yes ☐ No If yes, explain ________

____

27. Do you or any of your employees have more than 1 commercial license? ☐ Yes ☐ No If yes, explain ________________

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28. **Drivers** (if more space needed add extra sheet)

Driver's Name	Date of Birth	Social Security #	Driver License #	State Where Licensed	# Years driving similar vehicles	Date of Hire	Full or Part Time (F or P)	Married (Y or N)	# of accidents past 3 years	# of traffic violations past 3 years

29. **VEHICLES** (Information must be provided on all vehicles owned or leased, even if you do not plan on insuring.)

Auto No.	DESCRIPTION				Estimated Annual Mileage	Anti-Lock Brakes (A), Airbags (B) or Anti-Theft Devices (C)	Size GVW, GCW of Vehicle	Radius of Operation (In Miles)	Town & State where Principally Garaged	Do You Want To Insure? (Y or N)	
	Year Model	Trade Name	Body Type, Tractor, Trailer, Semi-Trailer	Serial No. (S) Vehicle ID No. (VIN)						Liability	Physical Damage
1											
2											
3											
4											
5											

Auto No.	Owned Leased (O or L)	Date Purchased	Cost When Purchased	Purchased New or Used (N or U)	Present Stated Value	Amount of Insurance	Specified Causes of Loss Deductible	Collision Deductible	Use* Symbol	
									1	2
1										
2										
3										
4										
5										

*If tractor and equipped with front brakes, check Box 1. If trailer and equipped with side mount turn signals, check Box 2.

30. **PREMIUMS**

Auto No.	Liability	P.I.P.	Added P.I.P.	Auto. Med. Pay	Uninsured Motorists	Underinsured Motorists	U.M. P.D.	Specified Causes of Loss	Collision
1									
2									
3									
4									
5									

31. Any loss payees? ☐ Yes ☐ No If yes, give name and address of loss payees: ______________________________

____

MUST BE SIGNED BY THE APPLICANT PERSONALLY

No coverage is bound until the Company advises the Applicant or its representative that a policy will be issued and then only as of the policy effective date and in accordance with all policy terms. The Applicant acknowledges that the **Applicant's Representative named below is acting as Applicant's agent and not on behalf of the Company. The Applicant's Representative has no authority to bind coverage, may not accept any funds for the Company, and may not modify or interpret the terms of the policy.**

The Applicant agrees that the foregoing statements and answers are true and correct. The Applicant requests the Company to rely on its statements and answers in issuing any policy or subsequent renewal. The Applicant agrees that if its statements and answers are materially false, the Company may rescind any policy or subsequent renewal it may issue.

If any jurisdiction in which the Applicant intends to operate or the Interstate Commerce Commission requires a special endorsement to be attached to the policy which increases Company's liability, the Applicant agrees to reimburse the Company in accordance with the terms of that endorsement.

The Applicant agrees that any inspection of autos, vehicles, equipment, premises, operations, or inspection of any other matter relating to insurance that may be provided by the Company, is made for the use and benefit of the Company only, and is not to be relied upon by the Applicant or any other party in any respect.

The Applicant understands that an inquiry may be made into the character, finances, driving records, and other personal and business background information the Company deems necessary in determining whether to bind or maintain coverage. Upon written request, additional information will be provided to the Applicant regarding any investigation.

The Applicant represents that she/he has completed all relevant sections of this Application prior to execution and that the Applicant has personally signed below (or if Applicant is a Corporation a corporate officer has signed below).

Will premium be financed? ☐ Yes ☐ No If yes, with whom ______________________________

IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

______________________ ______________________ ____________

Witness Applicant's Signature Date

TO BE COMPLETED BY APPLICANT'S REPRESENTATIVE

Is this direct business to your office? __________ If not, explain: ______________________________

Is this new business to your office? __________ If not, how long have you had the account? ____________________

How long have you known applicant? ______________________

REQUEST TO COMPANY GENERAL AGENT:

☐ Please quote

☐ Please bind at earliest possible date and issue policy

☐ Please issue policy effective ____________________ Coverage was bound by ____________________

(Time and Date Bound by General Agent) (Name of Person in Company General Agent's Office Binding Coverage)

____

Applicant's Representative's Name and Address Phone No.