

Upon completion, please fax to (334) 323-0580

PALOMAR INSURANCE CORPORATION

OCCUPATIONAL ACCIDENT QUESTIONNAIRE

MOTOR CARRIER: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE NUMBER: _____ FAX NUMBER: _____

NATURE OF BUSINESS: _____ FEIN: _____

1. Terminal Locations (attach a separate sheet if necessary): _____

2. Describe/give percentages of commodities hauled. Attach separate sheet if necessary.

Commodity							
Percent Hauled							

3. What percentage of total truck loads are manually loaded or unloaded?
_____ % Manually Loaded _____ % Manually Unloaded _____ % None

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 and/or Contract Drivers: _____

6. In which states are your Owner-Operators domiciled? Attach separate sheet if necessary.

State								
# Drivers								

7. Radius of Operations:

0-50 Miles _____ % Over 200 Miles _____ %

51-200 Miles _____ %

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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. Please describe safety program (attach separate sheet if necessary): _____

11. Describe new-driver screening procedures for hiring leased Owner-Operators and/or Contract Drivers: _____

12. Have you had Occupational Accident Insurance or Workers' Compensation coverages on your leased Owner/Operators and/or Contract Drivers previously?
 Yes No

If Yes, please complete below **and** attach available loss runs and benefits.

Coverage Period	Insurance Company	Monthly O/O premium	Earned Premium	Number of Losses	Incurred Losses

13. Desired benefits & coverages:
- a. Accidental Death & Dismemberment (each): _____
- b. Accidental Medical Reimbursement: _____
- c. Temporary Total Disability: _____
- d. Continuous Total Disability: Yes No
- e. Non-Occupational Accident benefits: _____ AD&D
_____ MED
- f. Contingent Liability Coverage: Yes No
- g. Other: _____

PALOMAR INSURANCE CORPORATION

Broker Information

Agency: _____

Contact: _____ Email: _____

Address: _____

Phone Number: _____ Fax Number: _____

To be completed by Palomar Insurance Corporation

Date received

Date submitted

Sent To

Sent By