



Insurance Indemnity Sections 1 through 6 must be completed for a quote indication. Sections 7 through 9 must be completed in order to bind.

1. General Information

Applicant Legal Name, Form of Business, Company Name (DBA), Tax Identification Number, Location of Business Premises, Telephone Number, Mobile Phone Number, City, State, Zip Code, County, Location Is, Mailing Address

Policy Type, Business Class, For-Hire and Private Operations

Table with 4 columns: %, Commodity, %, Commodity. Includes instruction: Please enter the percentage of loads received from a broker:

Indicate Policy Term and Payment Method: Short Term Policy, Annual Policy, Financed through outside Premium Finance Company, Continuous Until Cancelled Policy

2. Motor Carrier Filings

MCS-90 Requested, Authority Type, MC#, DOT #

3. History

Have there been any losses in the current year or the past three years? Yes No If yes, please complete below.

Table with 8 columns: Year, # Claims, \*Amount Incurred (Liability, Physical Damage, Cargo, General Liability)

Please enter the number of claims over \$100,000: Please enter the dollar amount for claims over \$100,000:

Loss runs are required for all applicants with five or more power units. Attach separate loss runs if space provided is not sufficient. \*Amount incurred should include amounts paid, reserved totals as well as any expenses.

4. Drivers

I declare the following list includes all drivers of vehicles requested to be covered under the policy including employees, leased employees, owner operators, mechanics, family members, and any other person allowed to drive an insured vehicle.

Table with 7 columns: Driver Name, Years of Experience, Convictions and MVR Record, Driver License Number, License State, Year Hired, Date of Birth

**5. Vehicles**

Description of Vehicles (trailers must be scheduled for liability coverage to apply while detached from a covered power unit)

Unit No.	Model Year	Make and Unit Type	Vehicle Identification Number (VIN)	GVW	Radius	*Stated Value	Gap Coverage (Y/N)	**Is garaging address same as physical? (Y/N)
1								
2								
3								
4								
5								

\*Only applicable if Physical Damage coverage is applied for. \*\*If a unit is not garaged at the physical address, it is necessary to list the garaging addresses in the Additional Underwriting Information section of this application.

**6. Coverage**

Coverages Desired:  Auto Liability  Auto Physical Damage  Motor Truck Cargo  Truckers General Liability

**Auto Liability Coverage Selection**

Combined Single Limit - each accident  
\$

If applying for Hired Auto coverage, please enter the annual estimated cost of hire:

If Non-Owned coverage is desired please enter the number of employees: \_\_\_\_\_

Is this a social service agency or charitable organization?  Yes  No

**Auto Physical Damage Coverage Selection**

Deductible Desired:  \$500  \$1,000  \$2,500  \$5,000  
Coverage Desired:  Collision and Specified Causes of Loss  Collision and Comprehensive (where available)

Additional Towing Limit \$ (in the event of a total loss to the described unit) \$2,500 included

Trailer Interchange Limit \$ Minus \$1,000 Deductible (UIIA container haulers)

Non-Owned Trailer Limit \$ Minus \$1,000 Deductible (coverage applies only while attached to a scheduled power unit)

**Motor Truck Cargo Coverage Selection**

Please select the desired form:  Standard  Preferred

Limit Desire Per Vehicle \$ Deductible Desired  \$500  \$1,000  \$2,500  \$5,000

Units that require specific limits other than above, please indicate below.

Unit No.	Desired Limit	Unit No.	Desired Limit
	\$		\$

**Additional Cargo Coverages or Endorsements Desired**

Refrigeration Breakdown - \$2,500 minimum deductible required  Removal of Coinsurance Clause  Removal of Commodities Theft

Earned Freight Increase to \$ (\$1,000 included)  Debris Removal Increase to \$ (\$25,000 included)

**Truckers General Liability Coverage Selection** This is for businesses solely involved in "for-hire" transportation of property

Desired Limits General Aggregate - please select one  \$1,000,000  \$2,000,000 Each Occurrence \$1,000,000 (included)

Employers Liability (Stop Gap) Coverage - Applicable only in ND, OH, WA and WY. Please select either yes or no.

Yes  No \$1,000,000 Bodily Injury by Accident - each accident \$1,000,000 Bodily Injury by Disease - each employee \$1,000,000 Bodily Injury by Disease - each policy

## 7. Additional Underwriting Information

Have any drivers been convicted of any of the following?  Yes  No

Negligent homicide, unlawful use of vehicle, speed contest or racing, reckless driving, leaving the scene of an accident or a hit and run, any felony conviction which involves a motor vehicle, speed twenty miles or more over the speed limit or driving while license is suspended or revoked in a commercial vehicle, DUI or DWI.

If yes, please provide driver name, conviction date and details:

Please complete all of the following:

- Yes  No Do you own any other businesses?
- Yes  No Have there been any changes in the ownership, management or name of the operation in the past five years?
- Yes  No Are all owned and operated power units listed on this application?
- Yes  No Do you have any mobile equipment subject to financial responsibility laws?
- Yes  No Do you act as a freight forwarder, freight broker or arrange loads for others?
- Yes  No Do you lease to others?
- Yes  No Do you haul double trailers?
- Yes  No Do you haul triple trailers?
- Yes  No Do you allow guest passengers?
- Yes  No Are any vehicles used to transport employees?
- Yes  No Do you hire owner operators on a trip lease basis?
- Yes  No Do you lend, lease or rent trucks, tractors or trailers to others without drivers?
- Yes  No Do you agree to report all drivers to your agent prior to them driving an insured unit?
- Yes  No Do you comply with all DOT regulations concerning driver employment, files and regulations?

If applying for **Non-Trucking Coverage** list name and the motor carrier number of the lessee to whom you are permanently leased.

Name of Motor Carrier:

Motor Carrier Number:

Filings Requested	Motor Carrier #	Applicant's Name and Address Exactly As It Appears On Each Permit
<input type="checkbox"/> Liability BMC 91X <input type="checkbox"/> Cargo BMC 34	MC	
<input type="checkbox"/> Liability – Form E _____ State		
<input type="checkbox"/> Oversized/Overweight		
<input type="checkbox"/> Hazardous		
<input type="checkbox"/> Cargo – Form H _____ State		
<input type="checkbox"/> SR 22- If yes explain		

Please note: The FMCSA and/or state agencies require a minimum 36 day notice of cancellation on all policies that have an MCS-90 or filings.

Certificates of Insurance	
Name	Mailing Address

Additional/Designated Insureds for Auto Liability or Truckers General Liability		
Name	Mailing Address	*Type of Additional Insured

\*Please enter each desired additional/designated insured by entering the corresponding number: **Auto Liability Additional Insureds:** 1. Designated Additional Insured, 2. Intermodal, 3. Additional Insured Waiver Rights Recovery, 4. Additional Insured Hired/Non-Owned **General Liability Additional Insureds** A. Controlling Interest, B. Designated Person or Organization, C. Managers or Lessors of Premises, D. Mortgagee, E. Owners, Lessees or Contractors, F. Co-Owner of Insured Premises, G. Vicarious Liability for Owners, Lessees or Contractors

### Please complete this section for vehicles with different ownership or different garaging addresses

Name and address of vehicle owners other than the named insured (owner types 2, 3 & 4 listed below)

Unit No.	Name of Owner	*Ownership Type	Mailing Address

\*Please enter the owner type by entering the corresponding number. 1. Owned by Named Insured, 2. Owned by Leasing Company (long term lease without a driver), 3. Owned by Owner Operator (leased with driver), 4. Owned by Employee of Named Insured (officer). Please note that coverage for owners might not be afforded if this section is not completed.

For Liability Coverage, if a unit is not garaged at the physical address of the applicant, please list the garaging addresses for each unit

Unit No.	Street Address		
City	State	Zip Code	County
Unit No.	Street Address		
City	State	Zip Code	County

<b>Please complete this section for Auto Physical Damage Loss Payees</b>			
Unit No.	Name of Loss Payee	Loss Payee Complete Address	
<b>Please List The Name and Address of Owners of Non-Owned Trailers</b>			
Name of Owner	Address of Owner		
<b>Please complete this section if Truckers General Liability coverage is desired</b>			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you haul bulk fuel? If yes, a \$1,000 deductible applies. If desired, please indicate an optional higher deductible \$	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you repair or service vehicles of others?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have dogs at premises? (see exclusion endorsement)	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you carry a firearm? (see exclusion endorsement)	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you generate income from other activities besides the operation of the trucks?	
Please list all mobile equipment owned by the applicant, if any (i.e. forklift, backhoe, mobile crane, etc.)			
<b>Please list all premises owned or rented</b>			
Street Address			
City	State	Zip Code	County

**8. MVR AND CREDIT REPORT ACKNOWLEDGEMENT**

I authorize Canal to obtain a copy of any Motor Vehicle Report for rating/underwriting the insurance for which I have applied. I also understand that a routine inquiry may be made providing information concerning my character, general reputation, personal characteristics and mode of living. Upon written request, information as to the nature and scope of the report will be provided to me.

**Disclosure:** In connection with this application for commercial automobile insurance, we may review a credit report or obtain or use a credit-based insurance score based on the information contained in that credit report. We may use a third party in connection with the development of the insurance score. Your credit report/credit-based insurance score will not be used for any purpose other than the underwriting of the commercial automobile insurance policy for which you have applied.

**Under no circumstances can the credit-based insurance score, the lack thereof, or the refusal to authorize the obtaining of a credit report or a credit-based insurance score be a factor in determining your eligibility for commercial automobile insurance, including cancellation or nonrenewal, if a policy is ultimately issued.**

I authorize Canal to obtain a credit report, including but not limited to a credit-based insurance score based on personal information provided. This authorization is valid for future reports obtained for renewal policies with Canal.

\_\_\_\_\_

Applicant's Signature \_\_\_\_\_ Date

**9. ACKNOWLEDGEMENT AND SIGNATURE**

I hereby certify that the information contained in this application is true and agree that a misrepresentation of any of the facts by me will constitute reason for the Company to void or cancel any policy issued on the basis of this application, and will hold the Company harmless for the action taken. I also agree that if a policy is issued pursuant to this application, the application and any elections or rejections, which are included with the application and signed by me, may be relied upon by the Company as accurate and shall become a part of the policy. I further understand and agree that the Company requires all units to be scheduled if I have requested an MCS-90 or filings.

I recognize that all or parts of my operations are under the Department of Transportation oversight requiring me to adhere to their rules and regulations. I acknowledge that DOT rules and regulations are understood by me, and I will adhere to the rules and regulations including, but not limited to, driver hiring, vehicle inspection, maintenance and hours of service.

**KENTUCKY FRAUD WARNING**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Signature of **APPLICANT**   X  

Type or Print Applicant Name \_\_\_\_\_

Title or Relationship to Applicant \_\_\_\_\_

Date and Time Application Completed \_\_\_\_\_

Requested Effective Date and Time \_\_\_\_\_

Signature of **AGENT** of the Applicant   X  

Agency Name \_\_\_\_\_

Address of Agency \_\_\_\_\_

Canal General Agent Use Only

Date and Time Bound: \_\_\_\_\_

**Extra Page for Additional Driver and Vehicle Information**

Drivers, continued						
I declare the following list includes all drivers of vehicles requested to be covered under the policy including employees, leased employees, owner operators, mechanics, family members, and any other person allowed to drive an insured vehicle.						
Driver Name	Years of Experience	Violations and MVR Record	Driver License Number	License State	Year Hired	Date of Birth

Drivers with Multiple Violations	
Driver Name	Conviction Date and Violation

Vehicles, continued								
Description of Vehicles (trailers must be scheduled for liability coverage to apply while detached from a covered power unit)								
Unit No.	Model Year	Make and Unit Type	Vehicle Identification Number (VIN)	GVW	Radius	*Stated Value	Gap Coverage (Y/N)	**Is Garaging address same as physical? (Y/N)
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								

\*Only applicable if Physical Damage coverage is applied for. \*\*If a unit is not garaged at the physical address, it is necessary to list the garaging addresses in the Additional Underwriting Information section of this application.

INSURANCE COMPANY  
 INDEMNITY COMPANY

**MUST be completed if Auto Liability Coverage is requested**

1. Applicant Name

2. DBA, if any

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### UNINSURED MOTORIST PROTECTION AND REPARATION BENEFITS

The laws of **Kentucky** require that all motor vehicle liability insurance policies contain uninsured motorist protection in limits of at least 25/50 for bodily injury including death unless rejected by you. Limit and premium amounts are listed below. Please initial the limit you wish to choose on the corresponding line to the left.

#### UNINSURED MOTORIST PROTECTION

\_\_\_\_ I am **rejecting all offers** of Uninsured Motorists Coverage.  
(Initial)

\_\_\_\_\_  
Signature of Applicant/Named Insured

\_\_\_\_\_  
Date

\_\_\_\_ I am **selecting** Uninsured Motorists Coverage.  
(Initial) Please make your selection of coverage below by initialing the limit you desire.

\_\_\_\_\_  
Date

Initial	Limits	Premium
_____	25/50	25
_____	60/60	58
_____	100/100	117
_____	250/250	146
_____	300/300	162
_____	350/350	181
_____	500/500	227
_____	750/750	348
_____	1000/1000	458

\_\_\_\_\_  
Applicant's Initials

The laws of **Kentucky** do not require that all motor vehicle liability insurance policies contain underinsured motorist protection. However, we are required to offer them if you request coverage. Limit and premium amounts are listed below should you choose to request this coverage.

**UNDERINSURED MOTORIST PROTECTION**

\_\_\_\_\_ I am **rejecting all offers** of Underinsured Motorists Coverage.

(Initial)

\_\_\_\_\_  
Signature of Applicant/Named Insured

\_\_\_\_\_  
Date

I am **selecting** Underinsured Motorists Coverage.

(Initial) Please make your selection of coverage below by initialing the limit you desire.

\_\_\_\_\_  
Date

Initial	Limits	Premium
_____	25/50	45
_____	60/60	48
_____	100/100	75
_____	250/250	90
_____	300/300	98
_____	350/350	110
_____	500/500	145
_____	750/750	249
_____	1000/1000	277

**PERSONAL INJURY PROTECTION**

The laws further provide that your policy contain Basic Reparation Benefits of \$10,000 and limitations on your right to sue or you may reject Basic Reparation Benefits and limitation on your right to sue by completing a separate form that your agent has. You may also choose deductibles and higher limits for this coverage by asking your agent. Limit and premium information is shown below. Please initial the limit you wish to choose on the corresponding line to the left.

Initial	Limit	Deductible	Premium
_____	10,000	None	35
_____	10,000	250	30
_____	10,000	500	25
_____	10,000	1,000	15
_____	20,000	None	110
_____	20,000	1,000	83
_____	30,000	None	160
_____	30,000	1,000	120
_____	40,000	None	200
_____	40,000	1,000	150
_____	50,000	None	250
_____	50,000	1,000	188

For limits not shown, interpolate.

\_\_\_\_\_  
Applicant's Initials

**APPLICANT'S ACKNOWLEDGMENT**

The undersigner hereby acknowledges they have read, or have had read to them and understand, the above explanations and offers of Uninsured Motorist Coverage, Underinsured Motorist Coverage and Personal Injury Protection Coverage. Selections have been made by initialing the appropriate lines above. The signature appearing below is that of the named insured or authorization has been given to the signer of this Offer of Uninsured Motorist Coverage, Underinsured Motorist Coverage and Personal Injury Protection Coverage to select or reject coverage and limits on the behalf of the named insured.

Date Application Completed	_____	Signature of Agent of Applicant	_____
Signature of Applicant	_____ <b>X</b>	Address of Agent	_____ _____