NATIONAL INDEPENDENT BUSINESS ALLIANCE

Truckers' Occupational Accident Application

ACCOUNT INFORMATION:

Legal Name: _____ Physical Address: _____

City: _____ State: _____ Zip: _____ Telephone: _____ FAX:_____

Contact Person: _____ Email Address: _____

BUSINESS INFORMATION: DOT#: _____ MC#: _____ EIN#: _____

Round Trip Radius: more than 500 miles _____% 499 to 200 miles _____% 199 to 50 miles _____% less than 50 miles _____%

Type of Equipment: VAN _____% REFRIGERATED _____% FLATBED _____% TANKER _____% DUMP _____%
DOUBLE TRAILERS _____% OVERSIZE/OVERWEIGHT _____% OTHER _____%

Cargo Hauled: List commodities hauled by percentage of total: _____ _____% _____ ____%
_____ _____% _____ ____%

DRIVER INFORMATION:

 # Driver Classifications:
Owner Operators: _____ Paid by 1099
Contract Drivers: _____ (Drivers for an Owner Operator) Paid by 1099
Company Drivers _____ (Drives for MC in the Motor Carrier's Equipment) Paid by 1099 only
Team Drivers: _____
Are Casual Laborers or Helpers used? _____ Yes _____ No. If yes, provide details.

Additional Information:
Are Drivers required to report daily: _____YES _____ NO
Driver's average length of haul: _____ miles
Driver's average duration of haul: _____ days
Driver Load/Unload % _____ %
What is minimum age: _____ years. What is maximum age: _____ years.
Minimum CDL driving experience _____

Driver Locations by Home State: Give total number of Owner/Operators, Contract Drivers, Team Drivers to be insured by state of residence:

Alabama _____	Illinois _____	Michigan _____	Pennsylvania _____	Other States _____
Arizona _____	Indiana _____	Mississippi _____	South Carolina _____	_____
Arkansas _____	Iowa _____	Missouri _____	Tennessee _____	_____
Colorado _____	Kansas _____	North Carolina _____	Texas _____	
Florida _____	Kentucky _____	Ohio _____	Virginia _____	
Georgia _____	Louisiana_____	Oklahoma _____	Wisconsin _____	**Total:** _____

PRIOR INSURANCE PROGRAM AND LOSS INFORMATION:

1. Do you have a current Occupational Accident Program for your Independent Contractors? _____ Yes _____ No
2. Current carrier: _____ Anniversary Date: _____ Is the Program mandatory? ____ Yes ____ No
3. Have you ever had an Occupational Disease, Cumulative Trauma or Contingent Liability type claim? _____ Yes _____ No

AGENT IDENTIFICATION AND SIGNATURE:

Agency Name: _____ **City:** _____ **State:** _____ **Zip:**_____

Signature of Applicant/Account: _____ **Date:** _____

Signature of Producer: _____ **Date:** _____

ADDITIONAL REQUIRED INFORMATION:

1. Please provide 5 years of currently valued loss information.
2. Copy of the Lease Agreement & Lease Purchase Agreement (if applicable).
3. Initial Driver Census - include Name, DOB and State of Residence.

Truckers' Occupational Accident Application - Driver Census

DRIVER CENSUS		
NAME	DATE OF BIRTH	STATE OF RESIDENCE

Please Contact

301 Louisiana Ave., 2nd Floor
Bogalusa, LA 70427
1-844-252-1344
occacc@nibausa.com

www.nibausa.com
rseal@nibausa.com