



Combined Group Insurance Services, Inc.

Non-Subscription Trucking Application



All questions on application must be completed in full to receive consideration for quotation

RETAIL AGENCY

Retail Agency Name & Address		Agent Number	Retail Agent Name	Phone Number
			Retail Agent E-mail	
CSR's Name	CSR's Phone number	CSR's Email		

WHOLESALE AGENCY (Note to wholesale agents: Retail Agency and Wholesale Agency contact information **must** be completed)

Wholesale Agency Name & Address		Agent Number	Wholesale Agent Name	Phone number
			Wholesale Agent Email	

BASIC INFORMATION (please note, if the insured has been in business for less than 3, a letter of management experience is required)

Complete Legal Name	Proposed Effective Date	Years in Business	FEIN
Mailing Address	Applicant's Website Address		
<input type="checkbox"/> Sole Proprietorship, Name of SP _____ <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> LLC <input type="checkbox"/> Other			

COMPLETE DESCRIPTION OF OPERATIONS and EMPLOYEE DUTIES

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RATING INFORMATION (included executive officer payroll shall be subject to a maximum of \$62,400 annually)

Classification	NCCI Code	Renewal Payroll	# of Empl.
Trucking	7219	\$	
Mechanics	8391	\$	
Clerical	8810	\$	
Executive Officers	8809	\$	
1099 Owner Operators	7219	\$	

EXECUTIVE OFFICERS TO BE EXCLUDED (Executive officers included unless names are provided below)

#	Name/Title	#	Name/Title
1		4	
2		5	
3		6	

LOSS INFORMATION (Attach first dollar loss runs)

Policy Year	Total Incurred	# of Claims	Type of Loss	Premium	Payroll	# of Empl.
Current Year	\$		<input type="checkbox"/> N.S. <input type="checkbox"/> W.C.	\$	\$	
	\$		<input type="checkbox"/> N.S. <input type="checkbox"/> W.C.	\$	\$	
	\$		<input type="checkbox"/> N.S. <input type="checkbox"/> W.C.	\$	\$	

Show details of each claim over \$25,000 on a separate page, along with action taken to prevent reoccurrence.

DWC5 FILING ***This section to be completed ONLY for policies with an effective date of 09/01/2012 and after

As of 09/01/12, Combined Group Insurance Services, Inc. will file your annual DWC-5 form with The Texas Department of Insurance upon binding/renewal of your policy. The information you provide on the application will be used to file the DWC5.

Please provide the NAICS code for your industry (required for DWC5 filing) _____.

This information can be obtained at www.naics.com (CTRL + Click to open in new tab)

We, the insured, will file the DWC5 form with TDI per State Filing Requirements.

<https://txcomp.tdi.state.tx.us/TXCOMPWeb/nonsubscriber/SelectDWCForm.jsp?clearBackCache=Y> (CTRL + Click to open in new tab)

**By marking the above box, the insured, has chosen to file the DWC5 with The Texas Department of Insurance and provide us, Combined Group Insurance Services, Inc., with a copy confirming the filing. If this box is not marked, Combined Group Insurance Services, Inc. will file your DWC5 with TDI per State Filing Requirements. The information you provide on this application will be used on the DWC5 form.

DRIVING EXPOSURES

1	Number of company owned vehicles?	
2	Are MVRs checked?	[] Yes [] No
	How often?	
3	What is the travel radius?	mi Average Haul? mi
4	Do your drivers unload their own trailers?	[] Yes [] No
	How many?	
5	How many of your drivers travel outside of Texas?	
6	How often are DOT logs checked?	
7	What is the average tenure of your drivers?	
8	Do you use any kind of GPS or tattlers on your trucks?	[] Yes [] No
9	What range do your employees make per mile?	
10	Please give a percentage of each type of truck in the fleet:	
	Box Truck % Container % Dump Truck % Flatbeds % Refrigerated % Tankers %	
11	How many drivers have more than 3 years experience?	
12	How many drivers are part-time?	
13	What type of communication system do you provide your drivers?	
14	If you provide cell phones or allow personal cell phone do you provide hands-free devices?	[] Yes [] No
	Do you require hands-free devices?	[] Yes [] No
	How do you verify driver has hands free devise?	
15	What is your Company policy regarding texting and driving?	
16	What penalties are in place for texting and driving?	

GENERAL EXPOSURE INFORMATION

1	Max height an employee/owner operator will work while standing on a non-fixed structure?	ft
2	Average weight and typical item a driver will lift without assistance?	lbs
3	Number of employees/owner operators who operate a forklift?	
	Are they certified?	[] Yes [] No
4	Does insured manufacture, store, sell, handle or transport any explosives, asbestos products, nuclear or hazardous materials?	[] Yes [] No
5	Do you have any employees/owner operators subject to USL&H or FELA?	[] Yes [] No
6	Does insured manufacture, store, sell, handle or transport any petro or hazardous chemical products?	[] Yes [] No
7	Do you use any owner operators?	[] Yes [] No
	How many?	
8	Do you use any temporary or leased employees?	[] Yes [] No
9	Have you ever filed for bankruptcy in the last 5 years?	[] Yes [] No
10	Are any employees/owner operators hazmat certified?	[] Yes [] No
	How many?	

ERISA INFORMATION (accurate completion is required to receive consideration for quotation)

Shortly after binding coverage, you will receive a new ERISA injury benefit plan and mandatory arbitration policy for negligence liability claims, for Combined Group Insurance Services, Inc. **You must provide Combined Group proof of rollout to all covered employees within 30 days of policy inception or Notice of Cancellation will be issued.**

1. ERISA Plan Number (3-digit, 500 series number assigned by your company to this benefit plan: consecutively number all health & welfare plans, starting with 501; if incomplete or incorrect data entered, we will use number 501) _____

2. Contact information for Employee Questions and Receipt of Legal Filings:

Name: _____ Phone #: _____

Address: _____ Fax #: _____

City: _____ State: _____ Zip: _____ Email address: _____

3. Name of current legal counsel relating to "non-subscriber" issues (if available): _____

NAMED INSUREDS, DBAs & LOCATIONS (list every location including location on pg. 1)

Acceptable to show the same named insured for multiple locations			
Insured's Name	Street, City, State Zip	FEIN #	# of Empl.

Show additional named insureds & locations on separate page and include with submission.

RESPONSIBLE REPORTING ENTITY (This section must be completed upon binding in order for you to comply with Federal regulations)

A new federal law, that took effect July 1, 2009, requires all businesses that have any type of liability insurance for work-related injuries to register with the Department of Health and Human Services. Insureds must report regularly on job-related injuries beginning January 1, 2010. There are no exceptions. As a courtesy to our insureds, we will report your claims to Medicare at no additional cost to you. If you have not already registered, please do so at www.Section111.cms.hhs.gov. Register and provide us with the following information:

RRE #	PIN	Date Registered Online
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CLAIMS ADMINISTRATION

Contact information of the employee responsible for submitting claims within your organization	Name:	Phone:
	Email:	

ACCOUNTING

Contact information of the employee responsible for remitting premium invoices within your organization.	Name:	Billing Address
	Phone:	
	Email:	

SAFETY

Contact information of the employee responsible for safety within your organization.	Name:	Phone:
	Email:	

SAFETY PROGRAM

1 Do you have a formal written safety program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2 Do you have an Alcohol/Drug testing program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3 Do you have an employee/owner operator training program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4 Do you have a prescreening program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5 Is tarping loads or re-securing tarps always done with assistant for lumpers?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6 Have you had any OSHA violations in the last 5 Years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7 How often is a safety check done of the fleet?	
8 How many at-fault accidents have you had in the past 5 years?	
9 What type of footwear is worn by the drivers?	
10 How often are inspections conducted of truck steps and rails?	
11 Is there instructions to persons entering/leaving the cab to use the "three-point contact" rule (two feet and alt least one hand)	<input type="checkbox"/> Yes <input type="checkbox"/> No
12 Do you have a driver meeting for safety?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Describe:

CURRENT COVERAGE

Carrier	CSL Limit	Per Person Limit
Legal Included <input type="checkbox"/> Yes <input type="checkbox"/> No	SIR	AD&D Limit

LIMITS

Self-Insured Retention	<input type="checkbox"/> 1,000	<input type="checkbox"/> 2,500	<input type="checkbox"/> 5,000
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This is not a workers compensation policy. You do not become a subscriber to the Workers Compensation system by purchasing this policy. You lose those benefits that would accrue under the Workers Compensation Act. By signing this application, you warrant that you will comply with the Workers Compensation Law as it pertains to non-subscribers and that the required notices will be filed and posted. By signing this application, you confirm that you have been provided with and inspected a specimen copy of the chosen policy and understand the carrier's ERISA plan and arbitration requirements. We recommend that you consult with your legal advisor to ensure that you fully understand the coverage provided. You also agree that, should coverage be issued based upon this application, this application shall become a material and integral part of the policy and the statements made herein shall be construed as your representations and warranties.

Anyone who knowingly and with intent to defraud any insurance company or other persons, files a statement containing 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.

Authorized Signature of Applicant_____
Title_____
Date