Please include the items listed below with your request for a quote.

Pan-American Checklist for Trucking

1. **Completed and signed Truckers Occupational Accident Submission**
2. **Copy of current Lease Agreement**
3. **3 to 5 years of experience**
4. **List of Drivers**
5. **Minimum number of Owner Operators is 5**

PAN-AMERICAN LIFE INSURANCE COMPANY

New Orleans, Louisiana

Truckers Blanket Occupational Accident Submission

ACCOUNT IDENTIFICATION

Legal Name: _____

☐ Individual ☐ Corporation ☐ Limited Corp ☐ Partnership ☐ Other

Physical Address: _____

City: _____ State: _____ Zip: _____

Contact Person: _____

Telephone: _____ FAX: _____

Email Address: _____

AGENT IDENTIFICATION

Agency Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ FAX: _____

Contact Person: _____ E-mail: _____

Requested Effective Date: _____

Date Quoted Needed: _____

DRIVER INFORMATION & COMMODITIES HAULED

Number of Owner Operators: _____ Number of Contract Drivers: _____ Number of Team Drivers: _____

List all commodities hauled by percent of total for the year:

_____% _____%

_____% _____%

Please provide a copy of the Driver Lease Agreement: ☐ Included ☐ Not Included

Does the Account haul: ☐ Hazardous/Waste Material ☐ Logging ☐ Explosives ☐ Flammables ☐ Refuse ☐ Radioactive Cargo

ACCOUNT INFORMATION: #Years in Business: _____

Type of Carrier: ☐ Common ☐ Contract ☐ Private ☐ Other:_____ LTL % ____ Truckload % _____ Driver Load/Unload % _____

Method of Driver Compensation ☐ Mileage ☐ Revenue ☐ Hourly ☐ Trip ☐ Other (details) _____

Radius of round-trip by percent: more than 500 miles ___% 499 to 200 miles ___% 199 to 50 miles ___% less than 50 miles ___%

Driver's average length of haul: _____ miles Driver's average duration of haul: _____days

Type of equipment by percent of total: VAN ___% REFRIGERATED ___% FLATBED ___% TANKER ___% DUMP ___%

DOUBLE TRAILERS ___% OVERSIZE/OVERWEIGHT ___% OTHER ___% (Details) _____

Does Account allow passengers: YES ☐ NO ☐ (If YES, give details) _____

Backhaul policy is under the control of ACCOUNT ☐ or at the discretion of the DRIVER ☐ --- Check one and give details: _____

_____

Are Drivers required to report daily: YES ☐ NO ☐ List Account Terminal Locations: _____

DRIVER DISTRIBUTION Give total number of Owner/Operators, Contract Drivers, Team Drivers to be insured by state of residence for the current policy year

Alabama	_____	Idaho	_____	Michigan	_____	New York	_____	Tennessee	_____
Arizona	_____	Illinois	_____	Minnesota	_____	North Carolina	_____	Texas	_____
Arkansas	_____	Indiana	_____	Mississippi	_____	North Dakota	_____	Utah	_____
California	_____	Iowa	_____	Missouri	_____	Ohio	_____	Vermont	_____
Colorado	_____	Kansas	_____	Montana	_____	Oklahoma	_____	Virginia	_____
Connecticut	_____	Kentucky	_____	Nebraska	_____	Oregon	_____	Washington	_____
Delaware	_____	Louisiana	_____	Nevada	_____	Pennsylvania	_____	West Virginia	_____
Dist of Col	_____	Maine	_____	New Hampshire	_____	Rhode Island	_____	Wisconsin	_____
Florida	_____	Maryland	_____	New Jersey	_____	South Carolina	_____	Wyoming	_____
Georgia	_____	Massachusetts	_____	New Mexico	_____	South Dakota	_____	TOTAL	**0**_____

SAFETY INFORMATION

Motor Carrier's ID#:_____ Motor Carrier's DOT #:_____Motor Carrier's EIN#:_____

Does the Account have a specified individual who's full-time duty is that of a Safety Director? YES ☐ NO ☐ (name: _____)

Does the Account have a current written safety/loss control program: YES ☐ NO ☐ - If Yes, please provide the following information:

Who Developed the program? Name: _____

Years of Experience: _____ When was the program initiated: _____ When was it last updated: _____

Does the safety/loss program address the following items:

Inspections of operations, conditions and vehicles to identify hazards?	YES ☐	NO ☐
Frequency of Training of owner operators in safe work practices?	YES ☐	NO ☐
Specific owner operator rules?	YES ☐	NO ☐
How often are safety meetings conducted: _____ Are Owner/Operators required to attend	YES ☐	NO ☐

How often are Owner/Operator's MVRs reviewed: _____ What is minimum age: _____ yrs What is maximum age: _____ yrs.
What MVR violation would cause Owner/Operator's Lease Agreement to be "inactive" _____

OCCUPATIONAL ACCIDENT COVERAGE REQUESTED

Accidental Death and Dismemberment Benefit:							
Principal Sum:	$100,000	☐	$150,000	☐	$250,000	☐	Other ☐
Lump Sum or Survivors Benefit (Please circle one)							
Accident Medical Benefit:	$300,000	☐	$500,000	☐	$1,000,000	☐	Other ☐
Maximum Benefit:	$0	☐	$100	☐	$500	☐	Other ☐
Incurral Period:	26 weeks	☐	52 weeks	☐	104 weeks	☐	Other ☐
Temporary Total Disability Benefit:							
Percentage of Average Weekly Earnings:	66 2/3%	☐	70%	☐	Other	☐	
Maximum Weekly Benefit:	$350	☐	$400	☐	$500	☐	Other ☐
Waiting Period:	7 days	☐	14 days	☐	Other	☐	
Benefit Period:	26 weeks	☐	52 weeks	☐	104 weeks	☐	Other ☐
Permanent Total Disability:							
Percentage of Average Weekly Earnings:	66 2/3%	☐	70%	☐	Other	☐	
Maximum Weekly Benefit:	$350	☐	$400	☐	$500	☐	Other ☐
Waiting Period:	26 weeks	☐	52 weeks	☐	104 weeks	☐	Other ☐
Benefit Period:	To Age 65	☐	To Age 70	☐			
Combined Single Limit:	$300,000	☐	$500,000	☐	$1,000,000	☐	Other ☐

NON-OCCUPATIONAL ACCIDENT COVERAGE REQUESTED

Accident Death and Dismemberment:						
Principal Sum:	$5,000	☐	$10,000	☐	Other	☐
Accident Medical Benefit:						
Maximum Benefit:	$2,500	☐	$5,000	☐	Other	☐
Deductible:	$0	☐	$100	☐		
Incurral Period:	26 weeks	☐	52 weeks	☐	Other	☐

Please provide a rate indication for "If Any" Workers' Compensation coverage: YES ☐ NO ☐

PRIOR CARRIER AND LOSS INFORMATION

Who is the current carrier: _____ What is the Anniversary Date: _____
Please provide 5 years of currently valued loss information in the grid provided below.

Policy Term	Carrier	Type of Coverage	Rate	Losses	Premium	# of Drivers

Has the account ever had an Occupational Disease, Cumulative Trauma or Contingent Type claim? YES ☐ NO ☐

If Yes, please explain: _____

Has the Account been informed, and acknowledges:

1. **Occupational Accident coverage is not Workers' Compensation Insurance YES ☐ NO ☐**
2. **Occupational Accident coverage does not eliminate the Applicant's responsibility to provide Workers' Compensation if required by applicable state law. YES ☐ NO ☐**
3. **It is the Accounts responsibility for collecting premiums from the Independent Contractors and submitting them to this insurer or its duly authorized agent. YES ☐ NO ☐**
4. **The Account and the Agent understands this form is submitted for underwriting consideration and does not bind any Agent, Carrier, or Administrator to coverage. YES ☐ NO ☐**
5. **Coverage can be approved and made effective only in writing from the Administrator. YES ☐ NO ☐**

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines and confinement in prison.

Signature of Applicant/Account: _____ Date: _____

Signature of Producer:_____ Date_____

Click here to submit form and add attachments