GENERAL LIABILITY APPLICATION

Use space on last page or attach an extra sheet if there is insufficient space for answers.

TRANSPORTATION INSURORS
A DOXA COMPANY

Coverage: ☐ Truckers GL (Class Code: 99793) ☐ Freight Forwarders & Truck Brokers (Class Code: 61224)
☐ Appliances & Accessories (Class Code: 91155)

Name of Applicant ________________________________ Effective Date: ____________

Email Address ________________________________ Phone Number ________________

Address ______________________ City ____________ State ______ Zip Code __________

1. Owner Name ________________________________ Phone Number ________________
   Address ____
   City __________________ State __________ Zip Code __________ D.O.B. ____________
   Gender? ☐ Male ☐ Female *(Gender is required for our National Driver's Association Program)*

2. Please give details of commodities hauled: ____
   ____
   ____

3. Please provide driver details:

   Name ________________________________ D.O.B. (mm/dd/yy) ____________
   DL# __________________ State _____ Total Years of Commercial Driving Experience ________
   Gender? ☐ Male ☐ Female *(Gender is required for our National Driver's Association Program)*
   Any Violations/Accidents? ☐ YES ☐ NO If 'YES', please explain: ______________________
   ____

   Name ________________________________ D.O.B. (mm/dd/yy) ____________
   DL# __________________ State _____ Total Years of Commercial Driving Experience ________
   Gender? ☐ Male ☐ Female *(Gender is required for our National Driver's Association Program)*
   Any Violations/Accidents? ☐ YES ☐ NO If 'YES', please explain: ______________________
   ____

   Name ________________________________ D.O.B. (mm/dd/yy) ____________
   DL# __________________ State _____ Total Years of Commercial Driving Experience ________
   Gender? ☐ Male ☐ Female *(Gender is required for our National Driver's Association Program)*
   Any Violations/Accidents? ☐ YES ☐ NO If 'YES', please explain: ______________________
   ____

   Name ________________________________ D.O.B. (mm/dd/yy) ____________
   DL# __________________ State _____ Total Years of Commercial Driving Experience ________
   Gender? ☐ Male ☐ Female *(Gender is required for our National Driver's Association Program)*
   Any Violations/Accidents? ☐ YES ☐ NO If 'YES', please explain: ______________________
   ____

TRUCKERS GL (Class Code 99793) / APPLIANCES & ACCESSORIES (Class Code 91155)

Classification Description: Trucking for Hire

Number of Tractors: ___________

1. Year: _______ Make: _________________ Model: _________________ VIN #: _____________________
2. Year: _______ Make: _________________ Model: _________________ VIN #: _____________________
3. Year: _______ Make: _________________ Model: _________________ VIN #: _____________________
4. Year: _______ Make: _________________ Model: _________________ VIN #: _____________________
5. Year: _______ Make: _________________ Model: _________________ VIN #: _____________________
6. Year: _______ Make: _________________ Model: _________________ VIN #: _____________________
7. Year: _______ Make: _________________ Model: _________________ VIN #: _____________________
8. Year: _______ Make: _________________ Model: _________________ VIN #: _____________________

(More than 25 vehicles will require submission to Underwriters.)

FREIGHT FORWARDERS & TRUCK BROKERS (Class Code: 61224)

Classification Description: Premises

Number of Locations: ___________

Total Square Footage of All Locations: ☐ 0 - 5,000 sq. ft. ☐ 5,001 – 10,000 sq. ft. ☐ 10,000+ sq. ft.

Location 1: __________ sq. ft. Location 4: __________ sq. ft. Location 7: __________ sq. ft.
Location 2: __________ sq. ft. Location 5: __________ sq. ft. Location 8: __________ sq. ft.
Location 3: __________ sq. ft. Location 6: __________ sq. ft. Location 9: __________ sq. ft.

4. Please provide details of any additional interests.

☐ Additional Insured ☐ Additional Insured Blanket ☐ WOS ☐ WOS Blanket
For 91155 Only: ☐ PNC ☐ 2010 Additional Insured ☐ 2037 Additional Insured ☐ WOS

Name: ____
Address: ____________________________ City: ________________ State: _____ Zip Code: ___________

☐ Additional Insured ☐ Additional Insured Blanket ☐ WOS ☐ WOS Blanket
For 91155 Only: ☐ PNC ☐ 2010 Additional Insured ☐ 2037 Additional Insured ☐ WOS

Name: ____
Address: ____________________________ City: ________________ State: _____ Zip Code: ___________

☐ Additional Insured ☐ Additional Insured Blanket ☐ WOS ☐ WOS Blanket
For 91155 Only: ☐ PNC ☐ 2010 Additional Insured ☐ 2037 Additional Insured ☐ WOS

Name: ____
Address: ____________________________ City: ________________ State: _____ Zip Code: ___________

☐ Additional Insured ☐ Additional Insured Blanket ☐ WOS ☐ WOS Blanket
For 91155 Only: ☐ PNC ☐ 2010 Additional Insured ☐ 2037 Additional Insured ☐ WOS

Name: ____
Address: ____________________________ City: ________________ State: _____ Zip Code: ___________

5. Please provide your prior carrier information.

Carrier: _____
Year: _____ Policy #: _____ Premium: $_____
Effective Date: _____ Expiration Date: _____

Carrier: _____
Year: _____ Policy #: _____ Premium: $_____
Effective Date: _____ Expiration Date: _____

Carrier: _____
Year: _____ Policy #: _____ Premium: $_____
Effective Date: _____ Expiration Date: _____

6. Please provide your loss experience, whether insured or not, for the past 3 years.

Year _____ Paid $_____ Outstanding $_____
Details _____

Year _____ Paid $_____ Outstanding $_____
Details _____

Year _____ Paid $_____ Outstanding $_____
Details _____

I/we hereby declare that the statements and particulars given in this form are true to the best of my/our knowledge and belief and that I/we have not suppressed, withheld, or modified any material facts. I/we agree that should a policy be issued, this form shall be the basis of the contract, and that any change in pattern or my/our trade or trade practices shall be advised to the Underwriters who may at their discretion, vary the terms and conditions of this contract.

Applicant's Signature: _____ Date: _____

BROKER INFORMATION

Agent Signature _____ Date _____

Agency _____ Contact _____

Email Address _____ Phone Number _____

Address _____ City _____ State _____ Zip Code _____

Continued From Questions _____

_____

_____

_____

POLICYHOLDER DISCLOSURE
NOTICE OF TERRORISM
INSURANCE COVERAGE

You are hereby notified that under the Terrorism Risk Insurance Act of 2002, as amended ("TRIA"), that you now have a right to purchase insurance coverage for losses arising out of acts of terrorism, as **defined in Section 102(1) of the Act, as amended:** The term "act of terrorism" means any act that is certified by the Secretary of the Treasury, in consultation with the Secretary of Homeland Security and the Attorney General of the United States, to be an act of terrorism; to be a violent act or an act that is dangerous to human life, property, or infrastructure; to have resulted in damage within the United States, or outside the United States in the case of an air carrier or vessel or the premises of a United States mission; and to have been committed by an individual or individuals, as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the Unites Staes Government by coercion. Any coverage you purchase for "acts of terrorism" shall expire at 12:00 midnight December 31, 2027, to the date on with the TRIA program is scheduled to terminate, or the expiry date of the policy whichever occurs first and shall not cover any losses or events which arise after the earlier of these dates.

YOU SHOULD KNOW THAT COVERAGE PROVIDED BY THIS POLICY FOR LOSSES CAUSED BY CERTIFIED ACTS OF TERRORISM IS PARTIALLY REIMBURSED BY THE UNITED STATES UNDER A FORMULA ESTABLISHED BY FEDERAL LAW. HOWEVER, YOUR POLICY MAY CONTAIN OTHER EXCLUSIONS WHICH MIGHT AFFECT YOUR COVERAGE, SUCH AS AN EXCLUSION FOR NUCLEAR EVENTS. UNDER THIS FORMULA, THE UNITED STATES PAYS 80% OF COVERED TERRORISM LOSSES EXCEEDING THE STATUTORILY ESTABLISHED DEDUCTIBLE PAID BY THE INSURER(S) PROVIDING THE COVERAGE. YOU SHOULD ALSO KNOW THAT THE TERRORISM RISK INSURANCE ACT, AS AMENDED, CONTAINS A USD100 BILLION CAP THAT LIMITS U.S. GOVERNMENT REIMBURSEMENT AS WELL AS INSURERS' LIABILITY FOR LOSSES RESULTING FROM CERTIFIED ACTS OF TERRORISM WHEN THE AMOUNT OF SUCH LOSSES IN ANY ONE CALENDAR YEAR EXCEEDS USD100 BILLION. IF THE AGGREGATE INSURED LOSSES FOR ALL INSURERS EXCEED USD100 BILLION, YOUR COVERAGE MAY BE REDUCED.

THE PREMIUM CHARGED FOR THIS COVERAGE IS PROVIDED BELOW AND DOES NOT INCLUDE ANY CHARGES FOR THE PORTION OF LOSS COVERED BY THE FEDERAL GOVERNMENT UNDER THE ACT.

☐ I hereby elect to purchase coverage for acts of terrorism for a prospective premium of USD_____

☐ I hereby elect to have coverage for acts of terrorism excluded from my policy. I understand that I will have no coverage for losses arising from acts of terrorism.

_____
Policyholder/Applicant's Signature

_____
Print Name

_____
Date

_____
_____ Syndicate on behalf of certain underwriters at Lloyd's

_____
Policy Number