TRUCKING SUPPLEMENTARY
WORKERS COMPENSATION APPLICATION

LEMIC Insurance Company
c/o CCMSI
Post Office Box 6967
Metairie, La 70009
Phone (866) 314-9970 Fax: (866) 883-8413

NAME OF APPLICANT: ____

MAILING ADDRESS: ____

CITY / STATE / ZIP: ____

GENERAL EXPOSURE INFORMATION

Description of Operations:
____

Number of years in business under the above name / operations:
____

Prior Workers Compensation Coverage:
_______ Yes _______ No

Name of Current Carrier
____

a. If none, provide the owner(s) experience in managing or operation this type of business:
____

Does the applicant own any business other than this submission:
_______ Yes (if yes, explain) _______ No

____

List all types of commodities that are carried on a normal basis:
____

Does the applicant transport toxic chemicals, hazardous materials, gases, gasoline or flammables, explosives or explosive materials?
_______ Yes (if yes, explain) _______ No

What is the radius of operations? (include state(s) other than home base traveled to)
____

List total number of vehicles owned by Company. ____

Are trucks equipped with sleeping accommodations? _______ Yes _______ No
What is the total number of employees listed under direct payroll? (W2 filed)? ______________________

Full time employees ____________________ Part time employees _______________________

Does the insured utilize contracted / subcontracting staffing for any services?
(include owner operator exposure)

_______ Yes _______ No (if yes, answer sections below)

a. Percentage of annual exposure (based on cost of labor / material) ________________________

b. Type of work contracted on normal basis? ____

c. Are Certificates of Insurance maintained for the Workers Comp coverage?
_______ Yes _______ No
(if no, exposure not indicated will be picked up at audit by Carrier)

Does applicant have a formal safety program incorporated in operations?
_______ Yes _______ No

a. Does program include the incorporation of the following?

Periodical Safety Meeting(s), documented?	YES	NO
Written Safety Inspection Program?	YES	NO
Formal Lift Protection Plan?	YES	NO
Formal Fall Protection Plan?	YES	NO
Pre Hire Drug Testing?	YES	NO
Post Accident Drug Testing?	YES	NO
Second Injury Questionnaire Completed?	YES	NO

b. If No to above, is applicant willing to implement safeguards into program?
_______ Yes _______ No

Are MVRs and driver physicals reviewed on an annual basis?
_______ Yes _______ No

Do drivers loading and/or unloading commodities haul?
_______ Yes _______ No

Are pre-trip inspection logs required to be submitted by drivers?
_______ Yes _______ No

Are vehicle maintenance schedules performed by company personnel?
_______ Yes _______ No

Who is responsible for routine maintenance of equipment? ______________________________________

Do Drivers provide repair request forms to notify of equipment deficiencies?
_______ Yes _______ No

Does company allow usage of retread tires?
_______ Yes _______ No

Do they change their own tires? _______ Yes _______ No If yes are cages used?

Describe any driver safety or incentive programs.
____

The purpose of Truckers Supplemental Application is to assist in the underwriting process. Information contained herein is specifically relied upon in the determination of insurability. The undersigned therefore warrants that the information contained herein is true and accurate to the best of his knowledge, information and belief. The supplemental application and the application to which it is appended, shall be the basis of any insurance policy that may be issued and will become part of such policy. A signature is required on completed form at the time of binding and will be subject to verification as determined by Loss Control Survey required by Carrier. Any information not provided and / or proved to vary form the above will be subject to review for possible cancellation.

Signature of Applicant*

____

*must be completed by an owner, officer or authorized representative

Name & Title of Above
____Date____