



For all other coverages(s) desired; attach Acord applications.

Please also attach Acord's 1. Coverages/Limits section; and, 2. all Acord's state specific forms as applicable to the insured's domicile.

SECTION I - ROUTING INFORMATION

Quote Only: Proposed Effective Date: _____ Need Quote by: _____

Bind Coverage: Effective: _____ New _____ Renewal of _____ \$ _____

at 12:01 A.M. Quote # Policy # Premium

Agency: _____ Agent Number: _____

Account Representative: _____ Phone #: _____ Fax #: _____

SECTION II - GENERAL INFORMATION

1. Applicant Name: _____

2. Street Address: _____
Street City County State Zip Code

3. Garaging Address: _____

4. Phone #: _____ Fax #: _____ Contact: _____

5. Legal Status: Individual Partnership Corporation Other _____
FEIN# _____ SS# _____

6. Describe your business: _____

7. Is this operation a new venture? Yes No *If No, how long have you been in business under the above name:* _____

8. Have you ever operated a trucking business under any other name? Yes No *If Yes, provide DOT# _____ and explain in Remarks Supplement.*
Name of business _____

9. Have you filed for bankruptcy under any name in the past 10 years? Yes No *If Yes, explain in Remarks Supplement*

10. What is your (applicant's): Net Worth \$ _____ Gross Income: \$ _____ \$ _____
prior year estimated current year

SECTION III - OPERATIONS

1. You are a (Check all applicable): Contract Carrier Common Carrier Exempt Carrier Freight Broker Other

2. List the applicable percentage of your operations next to each radius grouping: _____% 0 - 50 miles _____% 51 - 75 miles
_____% 76 - 200 miles _____% 201 - 300 miles _____% 301 - 500 miles _____% Over 500 Miles

3. Indicate all locations where you regularly PICK-UP or DROP-OFF loads:

<input type="checkbox"/> 1. Atlanta	<input type="checkbox"/> 10. Denver	<input type="checkbox"/> 20. Memphis	<input type="checkbox"/> 29. Phoenix	<input type="checkbox"/> 41. Mountain	<input type="checkbox"/> 51. San Diego
<input type="checkbox"/> 2. Baltimore/Washington	<input type="checkbox"/> 11. Detroit	<input type="checkbox"/> 21. Miami	<input type="checkbox"/> 30. Philadelphia	<input type="checkbox"/> 42. Midwest	<input type="checkbox"/> 52. Seattle
<input type="checkbox"/> 3. Boston	<input type="checkbox"/> 12. Hartford	<input type="checkbox"/> 22. Milwaukee	<input type="checkbox"/> 31. Pittsburgh	<input type="checkbox"/> 43. Southwest	<input type="checkbox"/> 53. Sacramento
<input type="checkbox"/> 4. Buffalo	<input type="checkbox"/> 13. Houston	<input type="checkbox"/> 23. Minneap/St. Paul	<input type="checkbox"/> 32. Portland	<input type="checkbox"/> 44. North Central	<input type="checkbox"/> 54. San Antonio
<input type="checkbox"/> 5. Charlotte	<input type="checkbox"/> 14. Indianapolis	<input type="checkbox"/> 24. Nashville	<input type="checkbox"/> 33. Richmond	<input type="checkbox"/> 45. Mideast	<input type="checkbox"/> Canada
<input type="checkbox"/> 6. Chicago	<input type="checkbox"/> 15. Jacksonville	<input type="checkbox"/> 25. New Orleans	<input type="checkbox"/> 34. St. Louis	<input type="checkbox"/> 46. Gulf	<input type="checkbox"/> Other
<input type="checkbox"/> 7. Cincinnati	<input type="checkbox"/> 16. Kansas City	<input type="checkbox"/> 26. New York City	<input type="checkbox"/> 35. Salt Lake City	<input type="checkbox"/> 47. Southeast	
<input type="checkbox"/> 8. Cleveland	<input type="checkbox"/> 17. Little Rock	<input type="checkbox"/> 27. Oklahoma City	<input type="checkbox"/> 36. San Francisco	<input type="checkbox"/> 48. Eastern	
<input type="checkbox"/> 9. Dallas/Ft worth	<input type="checkbox"/> 18. Los Angeles	<input type="checkbox"/> 28. Omaha	<input type="checkbox"/> 37. Tulsa	<input type="checkbox"/> 49. New England	
	<input type="checkbox"/> 19. Louisville		<input type="checkbox"/> 40. Pacific Coast	<input type="checkbox"/> 50. Alaska	

4. Do you have a DOT safety Rating? Yes No *If Yes, what is it?* _____

5. What is your MC #? _____ What is your DOT Number? _____ Is MCS-90 needed? _____

Explain all YES answers in Remarks Supplement and attach related supplemental application.*

6. Do you have any other insurance currently in force with our company? <input type="checkbox"/> Yes <input type="checkbox"/> No	12. Do you pull Double/Triple Trailers? <input type="checkbox"/> Yes <input type="checkbox"/> No
7. Has your insurance ever been refused, canceled, or non-renewed in past 3 years? (N/A in MO) <input type="checkbox"/> Yes <input type="checkbox"/> No	13. Do you use any trailers <u>not</u> marked with fluorescent tape? <input type="checkbox"/> Yes <input type="checkbox"/> No
8. Do you haul or have the authority to haul any commodity considered hazardous by the EPA and/or the DOT? <input type="checkbox"/> Yes <input type="checkbox"/> No	14. Will equipment be loaned/rented to others? <input type="checkbox"/> Yes <input type="checkbox"/> No
9. Have you ever hauled to a landfill or treatment facility? <input type="checkbox"/> Yes <input type="checkbox"/> No	15. Do you trip lease? <input type="checkbox"/> Yes <input type="checkbox"/> No
10. Do you haul Intermodal/Containerized freight? * <input type="checkbox"/> Yes <input type="checkbox"/> No	16. Do your drivers participate in a formal safety program? <input type="checkbox"/> Yes <input type="checkbox"/> No
11. Do you pull Oversized/Overweight loads? * <input type="checkbox"/> Yes <input type="checkbox"/> No	17. Are passengers permitted in vehicles? <input type="checkbox"/> Yes <input type="checkbox"/> No
	18. Do you always conduct pre-trip inspections? <input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION IV - UNIT INFORMATION

(If additional space required, attach supplement.)

1. Complete schedule below.

#	Auto Year	Make	Unit Type	Complete Serial #	Hired or Owned	GVW/ GCW	Principal Garaging (city, state)	Radius	Original Cost new	Current value
1										
2										
3										
4										
5										
6										
7										
8										

2. Indicate Loss Payees (LP) and/or Additional Insureds (AI) by unit. If additional space is necessary, attach schedule.

Unit Number(s)	Check All Applicable:	Name and Address of Loss Payee and/or Additional Insured Lessor
	<input type="checkbox"/> LP <input type="checkbox"/> AI	
	<input type="checkbox"/> LP <input type="checkbox"/> AI	

SECTION V - DRIVER INFORMATION

(If additional space required, attach supplement.)

- Check all practices used by your company in driver selection:
 MVR Check Road Test Written Application
 Physical Exam Drug Test Reference Check Employment Verification Other _____
- Describe acceptability requirements for hiring drivers: _____
- Use Owner/Operators? % of Revenues: _____ Yes No
- Use team drivers? Number/teams: _____ Yes No
- Are Motor Vehicle Reports of employed drivers pulled and reviewed? Yes No If Yes, how often? _____ /attach copies.
- Are all drivers covered by Workers Compensation? Yes No If Yes, who is your insurer? _____
 If No, explain _____
- How many were *hired* over the last 12 months? _____ How many drivers *left* your employ over the last 12 months? _____
- How are Drivers compensated? Hourly wage Payment Per Trip Salary Other _____
- What are the maximum hours driven per day? _____ hours
- What hours of the day do your drivers operate? 6 AM to 2 PM _____% 2 PM to 10 PM _____% 10 PM to 6 AM _____%
- Where do your drivers sleep when they are on a trip? At Home Motel In the Cab Other: _____

#	DRIVER Last name, First name, Middle Init.	Date of Birth	Sex (M/F)	Social Security Number Drivers License Number	Lic. State	# Years T/T driving	Date of Hire	# Accidents # Violations in last 3 yrs
1								
2								
3								
4								
5								

SECTION VI - INSURANCE INFORMATION

(If additional space required, attach supplement.)

1. Complete information for all losses which have occurred in the last three (3) years. Attach currently valued loss runs.

Date of Loss	Type of Loss (BI, PD, UM, UIM, PHD, MTC)	Driver	Amount Paid	Amount Reserved	Status of Claim
			\$	\$	<input type="checkbox"/> Open <input type="checkbox"/> Closed
			\$	\$	<input type="checkbox"/> Open <input type="checkbox"/> Closed
			\$	\$	<input type="checkbox"/> Open <input type="checkbox"/> Closed

Loss Details:

SECTION VI - INSURANCE INFORMATION CONTINUED

2. Complete table below pertaining to your current Insurance:

Coverage	Name of Current Carrier	Limit	Premium	Expiration Date	Est. Renewal Prem.
			\$		\$
			\$		\$
			\$		\$

SECTION VII - GENERAL INFORMATION (If additional space required, attach supplement.)

1. List commodities hauled.

Commodity / Packaging	% of Revenues	Commodity / Packaging	% of Revenues

2. Do you haul your own goods exclusively? Yes No ___% Owned goods ___% Non-owned goods

3. Total Annual Mileage: Current Year _____ 1st Prior _____ 2nd Prior _____

SECTION VIII - REQUESTED COVERAGE Lincoln General writes Primary Liability only in conjunction with Physical Damage Coverage.

Physical Damage

Complete state specific Acord Coverage/Limits section form.

To request Hired Auto, Trailer Interchange or Non-owned Liability coverage, complete **Additional Coverages Supplement**.

SECTION IX - PRIMARY LIABILITY

1. Does your operation require filings? Yes* No Provide Docket #: MC _____

* If coverage is bound, and filings are required, a **Filing Supplement** must accompany this application.

2. Do you own any equipment not scheduled on this application? Yes No If Yes, explain in Remarks.

3. Is all equipment operating under your authority scheduled on this application? Yes No If No, explain in Remarks.

4. If you have requested Primary Liability, is unhooked coverage to be provided on scheduled Trailers? Yes No
 If Yes: a. Are trailers kept isolated from the public? Yes No b. Are trailers fully enclosed by a fence? Yes No

SECTION X - NON-TRUCKING INFORMATION

1. Are all units leased to trucking concerns on a long term basis? Yes No

2. List all companies to whom you currently lease.

Lessee Name	Lessee Address

3. Do you ever use the unit(s) for Personal use? Yes No If Yes, percentage of usage? _____%

4. Do you ever haul for entities other than the Lessee? Yes No If Yes, percentage of usage? _____%

SECTION XI - MOTOR TRUCK CARGO

If coverage is desired, attach supplement.

SECTION XII - SIGNATURES If no liability coverage is requested, this section may be completed in lieu of State Selector Form.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR REPRESENTATIVE THEREOF OR WHO FILES AN APPLICATION FOR INSURANCE CONTAINING ANY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACTUAL MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

THIS FORM MUST BE SIGNED BY BOTH THE APPLICANT AND PRODUCER.

AS THIS OPTION SELECTOR IS THE LAST PAGE OF OUR APPLICATION FOR COMMERCIAL AUTOMOBILE AND CARGO INSURANCE, YOUR SIGNATURES BELOW ATTEST THAT THE INFORMATION PROVIDED IS COMPLETE AND ACCURATE TO THE BEST OF YOUR KNOWLEDGE AND BELIEF.

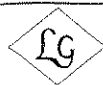
SIGNATURE OF FIRST NAMED INSURED _____

DATE _____

AGENCY NAME _____

TITLE: (Owner, Partner, President, Etc.) _____

ADDRESS _____



**Insurance Application
Primary Liability Trucking Supplement**

Do not complete this section if you are applying for Non-trucking Liability

SECTION A - GENERAL INFORMATION

1. Do you Trip Lease? Yes No *If Yes, explain operation in Remarks Supplement.*
 2. Is unhooked coverage to be provided on scheduled trailers? Yes No *If Yes, answer question a & b, below.*
 a. Are trailers kept isolated from the public? Yes No b. Are trailers fully enclosed by a fence? Yes No

SECTION B - COVERAGE INFORMATION

1. PRIMARY LIMITS*: Liability _____ Uninsured /Underinsured Motorist _____ / _____
 First Party Benefits _____
** If coverage is bound, a State Option Selector Form must accompany this application.*

2. For Hired Auto, Non-owned and Trailer Interchange coverages, complete **Additional Coverages Supplement**

Note: Lincoln General writes Primary Liability in conjunction with PHYSICAL DAMAGE COVERAGE.
 Please Complete the **Schedule of Covered Autos Supplement**.

SECTION C - INSURANCE INFORMATION

1. Has your insurance ever been canceled, non-renewed or refused in the past three (3) years? (Not applicable in MO)
 Yes No *If Yes, Explain.* _____

2. Prior Carrier Information:

LIABILITY	Name of carrier	Limit	Premium	Expiration Date	Est. Renewal Premium
Current Year			\$		\$
1st Prior Year			\$		\$
2nd Prior Year			\$		\$
PHYSICAL DAMAGE	Name of carrier	Total Value	Premium	Expiration Date	Est. Renewal Premium
Current Year			\$		\$
1st Prior Year			\$		\$
2nd Prior Year			\$		\$

SECTION D - REMARKS SECTION

Provide additional information in the space below. If you are explaining answers to particular questions, please indicate the section and question numbers.

Applicant Name _____ Policy/Submission Number _____



Insurance Application Motor Truck Cargo Supplement

SECTION A - GENERAL INFORMATION

1. Applicant Name : _____
2. Please provide commodity information in the table below. (If additional space required, attach schedule.)

Commodity	Average Load Value	Maximum Load Value	%	Commodity	Average Load Value	Maximum Load Value	%

3. Do you haul under released bill of lading? Yes No *If Yes, explain in Remarks Section and attach copies.*
4. Do you back haul the property of others? Yes No *If Yes, explain in Remarks Section. Include for whom and type cargos.*
5. Are vehicles left loaded overnight? Yes No *If Yes, explain in Remarks Section. Include frequency.*
6. How many of your units have alarm systems? _____ *If one (1) or more, explain in Remarks Section. Include types.*
7. How many of your units are equipped with fire extinguishers? _____ *If any, describe types in Remarks Section.*

SECTION B - COVERAGE INFORMATION

1. Indicate Coverage desired: Broad Form Named Perils + Theft Named Perils (excluding theft)
2. Cargo Coverage Limit: \$ _____ Deductible: \$ _____ Per Item Limit: \$ _____
3. Do you want Mechanical Breakdown coverage? Yes No *If Yes, indicate desired deductible: _____*
4. Do you want cargo terminal coverage? Yes No *If Yes, complete Terminal Supplement.*
5. If you desire additional coverages, describe requested coverages, applicable limits and deductibles. _____
6. Does your operation require Cargo Filings? Yes No *If Yes, complete Filing Supplement.*
7. Complete table below:

CARGO COVERAGE	Name of carrier	Limit	Premium	Expiration Date	Est. Renewal Premium
			\$		\$
			\$		\$

SECTION C - REMARKS SECTION

Provide additional information in the space below. If you are explaining answers to particular questions, please indicate the section and question numbers.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR REPRESENTATIVE THEREOF OR WHO FILES AN APPLICATION FOR INSURANCE CONTAINING ANY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACTUAL MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

This form must be signed by both the applicant and producer.

Named Insured or authorized representative Date

Producer (not broker) Date

Title (owner, partner, officer, etc.)

Agency Name

Name of Submission: _____
Proposed Effective Date: _____
Quote Needed By Date: _____

Submission Analysis

1) Complete Description of the Operation

2) Specific cities AND areas of travel

3) Do all drivers meet Lincoln guidelines? _____

List any drivers requiring probation or non-driving status:

4) Do all vehicles meet Lincoln's age guidelines? _____

List any vehicles that don't meet our age guidelines:

5) SAFER – Provide the following if vehicle and driver percentages are above the National Average or if risk is five or more power units.

a) Specific Maintenance program including pre/post trip inspections:

b) Safety program

6) Financials – (required for 10 or more power units). Do they show loss or profit?

7) Loss History Analysis

Three year combined loss ratio _____

Frequency _____

Name of person completing this form: _____

Date: _____