One Premier Drive, Fenton, MO 63026 | Phone: 800-325-3619 | Fax: 800-858-5190 | www.vanliner.com

New Business Supplemental Application
Home Delivery – Last Mile Operations

For use with Contract Carriers with 5 Power Units or more.

APPLICANT INFORMATION

Effective Date: ____________________ Expiration Date: ____________________

Requested Coverage: ❒ Auto Liability ❒ Physical Damage ❒ General Liability ❒ Cargo ❒ Umbrella ❒ Workers Comp.

Business Name*: ____________________
**includes any business DBA name(s)*

Business Owner Name: ____________________

Year Established: ____________________ FEIN: ____________________

Mailing Address: ____________________

City: ____________________ State: ________ Zip: ____________

Physical Address: ____________________

City: ____________________ State: ________ Zip: ____________

❒ Check if mailing address is same as physical address.

Home Phone #: ____________________ Email: ____________________

Cell Phone #: ____________________ Company Website: ____________________

Company Type: ❒ Sole Proprietor/Individual ❒ Partnership ❒ Limited Liability Corp (LLC) ❒ Corporation

a) Partner or Officer Name: ____________________ % of Ownership: ______

b) Partner or Officer Name: ____________________ % of Ownership: ______

In what states will you deliver? ____________________

Where are the terminals located in which you will regularly report?

	City	State	Zip
Terminal 1			
Terminal 2			
Terminal 3			
Terminal 4			

	City	State	Zip
Terminal 5			
Terminal 6			
Terminal 7			
Terminal 8			

Is this company a subsidiary of another entity or does this company have any subsidiaries? ❒ Yes ❒ No

a) If yes, please identify all parent companies and/or subsidiaries: ______________________

____

Are you involved in any other operations **NOT** related to Last Mile Delivery? ❒ Yes ❒ No

a) If yes, please explain: ______________________

____

Number of years of **current CONTINUOUS** experience in Transportation and/or Last Mile Delivery operations: __________

Do you intend to maintain this insurance policy(s) and operate at least one vehicle for the next 12 months performing Last Mile Delivery operations? ❒ Yes ❒ No

a) If no, please explain: ______________________

____

What are the names of the logistics providers you provide delivery services for?

Name of Logistics Provider	% of Your Shipments	Total Yearly Revenue	Total Units	# of Years Contracted With

Is there a written vehicle maintenance program? ❒ Yes ❒ No

If yes, does it include:

a) Regular preventative maintenance? ❒ Yes ❒ No
b) Safety & pre-tip inspections? ❒ Yes ❒ No
c) Certified mechanics? ❒ Yes ❒ No

Hiring Practices:

a) Do you obtain/review Motor Vehicle Reports (MVRs) on new drivers prior to hiring? ❒ Yes ❒ No

b) Do you review MVRs on all drivers annually? ❒ Yes ❒ No

c) How are drivers compensated? ❒ Hourly ❒ Per Job ❒ % of Revenue ❒ Other: ______________

d) Do you order a background check on all employees/contractors and potential hires? ❒ Yes ❒ No

e) Do you conduct drug and alcohol testing on all drivers and laborers at the following intervals:

- Prehire? ❒ Yes ❒ No
- Random? ❒ Yes ❒ No
- Post-accident? ❒ Yes ❒ No

f) Is there a formal applicant screening process? ❒ Yes ❒ No

If yes, please describe: ______________________

g) Do you lease employees? ❒ Yes ❒ No

h) Are drivers required to have at least two years of experience driving similar equipment for hiring or contract purposes? ❒ Yes ❒ No

i) Do you utilize independent contractors? ❒ Yes ❒ No

If yes, you must provide a copy of the Independent Contract agreement you utilize.

j) Do you hire day laborers or casual labor? ❒ Yes ❒ No

If yes, how are they paid: ______________

If yes, please describe your employment process for hiring day laborers/casual labor: ______________

____

Do you lease, hire, rent or borrow any vehicles other than the specified vehicles listed on this application? .... ❒ Yes ❒ No

(HIRED AUTOS – autos you lease, hire, rent or borrow that are used in connection with your business)

a) How often do you lease, hire, rent or borrow vehicles? ____________________
b) What is the average term of the lease? __________________
c) What is your annual cost to lease, hire, rent or borrow vehicles? ___________________________

Do any employees or non-employees use their autos in your business? .... ❒ Yes ❒ No

(NON-OWNED AUTOS – autos you do not own, lease, hire or borrow that are used in connection with your business)

a) If yes, please describe under what circumstances this occurs and how often this occurs. ______________________
b) If yes, what limit of liability insurance are they required to maintain? _______________________________________
c) Do you keep evidence of their insurance on file? .... ❒ Yes ❒ No
d) How many total employees do you have? ________________

Filing Information:

To ensure proper filing, the information provided below must match your current filing exactly.

a) Name: ____
b) Address: ____
c) City: ____ State:_________ Zip: _________________
d) USDOT #: __________________________________ MC #: ____
e) If you require an Intrastate Auto or Cargo Filing, please provide the following information:

State	State ID # / PUC #	Auto	Cargo
		❒	❒
		❒	❒
		❒	❒
		❒	❒

OPERATIONS AND INSTALLATIONS INFORMATION

Do you perform any on-site assembly of products (not including appliances)? .... ❒ Yes ❒ No

a) If yes, what percent is this of your total daily deliveries? ________%
b) If yes, what type of items are assembled as a % of total installation deliveries (total must equal 100%)?

Furniture _______%
Exhibits/Displays _______%
Other (please describe) _______%
Consumer Electronics _______%
Exercise Equipment _______%

____

Do you perform any on-site installations of appliances? .... ❒ Yes ❒ No

a) If yes, what percent is this of your total daily deliveries? _______%
b) Do you perform any on-site installations involving water? .... ❒ Yes ❒ No
   i. If yes, what percent is this of your total daily deliveries? _______%
c) Do you perform any on-site installations involving gas? .... ❒ Yes ❒ No
   ii. If yes, what percent is this of your total daily deliveries? _______%
d) Do you perform any installation(s) that requires a contractor's license? .... ❒ Yes ❒ No
   iii. If yes, are you a licensed contractor? .... ❒ Yes ❒ No

e) Are you and your employees/contractors trained on procedures that meet manufacturer installation specifications? .... ❒ Yes ❒ No

Provide the following historical information for your total operations:

Estimated Annual…	Projected Year	Current Year	First Prior Year	Second Prior Year	Third Prior Year	Fourth Prior Year
% of deliveries, including assembly						
% of water installations						
% of gas installations						
Revenue						

LOSS HISTORY

Have you had commercial insurance on this operation during the previous 5 years? .... ❒ Yes ❒ No

Are you able to provide loss runs for your operations for the previous 5 years? .... ❒ Yes ❒ No

a) If yes, please provide company issued loss runs for the current year and four (4) prior years valued within the past 60 days for all lines of coverage, along with details on all claims in excess of $25,000.

b) If no, you must complete the historical loss summary chart below.

Provide the following historical information for your operation:

	Current Year	First Prior Year	Second Prior Year	Third Prior Year	Fourth Prior Year
Insurance Carrier					
Incept Date					
Expiration Date					
Total # of claims incurred (open and closed)					
Total dollars of claims incurred (open and closed)					
Total # of open claims only					
Total dollars of open claim reserves only					
Total # of full-time vans operated					
Total # of full-time box/straight trucks					
Total # of part-time vans operated and added by endorsement for less than 45 days					
Total # of part-time box/straight trucks operated and added by endorsement for less than 45 days					

VEHICLE INFORMATION

Utilize enclosed Fleet List format.

Collect driver's information through Drivers List.

WORKERS COMP.

Individuals to Be Excluded *(Only list the Partners, Officers or Others to be excluded in this section)*

All employees to be included should be listed either in the Driver section or the Other Employee section below.

Name	Title	Relationship Type	% Ownership	Exclude
				Exclude
				Exclude
				Exclude
				Exclude
				Exclude

Driver Information

The following information must be provided for all employees that may drive any vehicle for this business.

Name	Date of Birth	Height (ft/in)	Weight	Duties	Class Code	Annual Salary	Full-time or Part-time	Paid: W9 or 1099
				Driver	7219			
				Driver	7219			
				Driver	7219			
				Driver	7219			
				Driver	7219			
				Driver	7219			
				Driver	7219			
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				Driver	7219			
				Driver	7219			
				Driver	7219			
				Driver	7219			

Other Employee Information (helpers, warehouse, sales, clerical, etc.)

The following information must be provided for all other employees of this business.

Name	Date of Birth	Height (ft/in)	Weight	Duties	Class Code	Annual Salary	Full-time or Part-time	Paid: W9 or 1099

Payroll, E Mod. and Premium History:

Year	Total Payroll	Total Premium	EMod	Total # of Full-time Employees	Total # of Part-time Employees
Projected Year					
Current Year					
1st Prior Year					
2nd Prior Year					
3rd Prior Year					
4th Prior Year					

Is group medical provided? .... ❒ Yes ❒ No

If yes, what percent of employees are enrolled: __________%

Is there a formal accident reporting procedure in place? .... ❒ Yes ❒ No

When one of your employees reports an injury, do you direct your employee to see a particular doctor or clinic that you have chosen in advance? .... ❒ Yes ❒ No

Do you do this for all states and all locations? .... ❒ Yes ❒ No

If no, please explain. ____

____

Do you have a light or restricted duty "Return to Work" program? If yes, attach a copy. .... ❒ Yes ❒ No

Does you program have limitations (e.g. hours per week, drivers only, certain locations or states only)? .... ❒ Yes ❒ No

If yes, please explain. ____

____

If you do not offer a return to work program, are you willing to create one with Vanliner's assistance?.............. ❒ Yes ❒ No

Have you done any corporate restructuring in the past 5 years (merger/sale/combination/separation)? .... ❒ Yes ❒ No

If yes, please explain. ____

____

Is Workers Compensation for any state excluded from this application? .... ❒ Yes ❒ No

If yes, list states purchased separately. ____

Georgia, Virginia, Colorado, Tennessee and Pennsylvania require physician panels to direct medical care.

Which of these states do you currently have physician panels in? ____

Do you perform a pre-hire Physical Abilities Test (PAT) or Human Performance Evaluation (HPE) test on all employees? .... ❒ Yes ❒ No

Do you utilize independent contractors? .... ❒ Yes ❒ No

If yes, do your independent contractors carry their own Workers Compensation or Occupational Accident insurance? .... ❒ Yes ❒ No

If yes, do you maintain current certificates of insurance for your owner/operators as evidence of the coverage?...................... ❒ Yes ❒ No

If no, do you plan to provide coverage for your owner/operators under this Workers Compensation policy?............................ ❒ Yes ❒ No

Do you check references for all full-time and part-time employees? .... ❒ Yes ❒ No

LOSS PAYEES

Vehicle #1 Loss Payee

Vehicle Type: ____________________ Loss Payee Name: ____________________
Year: ____________________ Address: ____________________
Make: ____________________ City: ____________________
Model: ____________________ State: ____________________
VIN #: ____________________ Zip: ____________________

Loss payee also an additional insured? .... ❐ Yes ❐ No

Vehicle #2 Loss Payee

Vehicle Type: ____________________ Loss Payee Name: ____________________
Year: ____________________ Address: ____________________
Make: ____________________ City: ____________________
Model: ____________________ State: ____________________
VIN #: ____________________ Zip: ____________________

Loss payee also an additional insured? .... ❐ Yes ❐ No

Vehicle #3 Loss Payee

Vehicle Type: ____________________ Loss Payee Name: ____________________
Year: ____________________ Address: ____________________
Make: ____________________ City: ____________________
Model: ____________________ State: ____________________
VIN #: ____________________ Zip: ____________________

Loss payee also an additional insured? .... ❐ Yes ❐ No

Vehicle #4 Loss Payee

Vehicle Type: ____________________ Loss Payee Name: ____________________
Year: ____________________ Address: ____________________
Make: ____________________ City: ____________________
Model: ____________________ State: ____________________
VIN #: ____________________ Zip: ____________________

Loss payee also an additional insured? .... ❐ Yes ❐ No

POLICY LEVEL ADDITIONAL INSUREDS

Additional Insured #1

Name 1:______________________________

Name 2:______________________________

Address: ______________________________

City: ________________ State:______Zip:__________

Additional Insured #2

Name 1:______________________________

Name 2:______________________________

Address: ______________________________

City: ________________ State:______Zip:__________

Additional Insured #3

Name 1:______________________________

Name 2:______________________________

Address: ______________________________

City: ________________ State:______Zip:__________

Additional Insured #4

Name 1:______________________________

Name 2:______________________________

Address: ______________________________

City: ________________ State:______Zip:__________

Additional Insured #5

Name 1:______________________________

Name 2:______________________________

Address: ______________________________

City: ________________ State:______Zip:__________

Additional Insured #6

Name 1:______________________________

Name 2:______________________________

Address: ______________________________

City: ________________ State:______Zip:__________

Additional comments:

REQUIRED UNDERWRITING INFORMATION CHECKLIST

The information below must be submitted prior to binding coverage.

- ❒ Loss Runs for each applicable entity (company issued loss runs for the current year and four (4) prior years valued within the past 60 days for all lines, along with the circumstances of all claims in excess of $25,000)
- ❒ E-Mod worksheets for each applicable entity and state (for the current year and four (4) prior years)
- ❒ MVRs (run date within the previous 60 days; provided for all drivers).
- ❒ Applicant Statement (signed)
- ❒ UM/UIM Selection/Rejection (signed)
- ❒ Copy of any cancellation or non-renewal notice issued in the current or 4 prior years.

APPLICANT STATEMENT

Applicant and Producer: please sign and date the Applicant's Statement Below.

I hereby declare that the statements made in this application and the contents of the other documents supplied are true and correct and agree that any policy of insurance that may be issued now or in the future will be based on warranties and representations contained therein.

APPLICANT:		PRODUCER:	
Signature of Officer/Manager of Applicant	Date	Signature	Date
Print Full Name		Print Full Name	
Title		Agency	

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