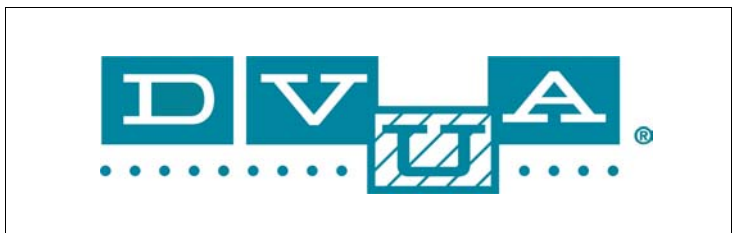


Contingent Liability Application (Bobtail & Deadhead)

COLUMBIA INSURANCE COMPANY
NATIONAL FIRE & MARINE INSURANCE COMPANY
NATIONAL INDEMNITY COMPANY
NATIONAL INDEMNITY COMPANY OF MID-AMERICA
NATIONAL INDEMNITY COMPANY OF THE SOUTH
NATIONAL LIABILITY & FIRE INSURANCE COMPANY



Policy Term From: _____ To _____

- Name (and "dba") _____
 Individual/Proprietorship Partnership Corporation Other Business Phone Number _____
- Mailing Address _____ City _____ State _____ Zip _____
- Premises Address _____ City _____ State _____ Zip _____
- Person to contact for inspection (name and phone number) _____
- Have you ever had insurance with one of the companies listed at the top of this page? Yes No
 If yes, Policy Number(s) _____ Effective Date(s) _____

DESCRIPTION OF OPERATIONS

- Describe business _____
 Years experience _____ New Venture? Yes No Seasonal? Yes No
- Is this your primary business? Yes No If no, explain _____
- Have you ever filed for Bankruptcy? Yes No If yes, when _____ Explain _____
- Gross receipts last year _____ Estimate for coming year _____ Business for sale? Yes No
- Do you operate in more than one state? Yes No If yes, list states _____
- Show largest cities entered: _____ Do you pull double trailers? Yes No Triple trailers? Yes No
- Do you operate over a regular route? Yes No If yes, show towns operated between: _____
- List all types of cargo hauled: _____
 Principal commodities outbound _____ Backhaul commodities _____
- Do you haul any hazardous or extra hazardous substances or materials as defined by EPA? Yes No
 If yes, provide complete listing identifying all material(s) and/or chemical content: _____
- What percent of time are your vehicles operating under lease or dispatch? _____
- Equipment is under permanent/long term lease to _____
- How many companies have you been leased to in the last three years? _____
- Do you lease to anyone else? Yes No If yes, percent of time _____ %, for whom and explanation _____
- Do you trip lease on back hauls to others? Yes No If yes, percent of time _____ %, for whom and explanation _____

LIABILITY COVERAGE — Complete for desired coverages by indicating limits of insurance.

LIABILITY				Medical Payments	Personal Injury Protection (where applicable)	IF PHYSICAL DAMAGE COVERAGE DESIRED, REFER TO FOLLOWING PAGE. IF IN-TOW COVERAGE DESIRED, COMPLETE TOW TRUCK SUPPLEMENT.
Combined Single Limit BI & PD	Split Limits		Property Damage			
	Bodily Injury	Each Accident				
	Each Person	Each Accident	Each Accident			

APPLICABLE PERSONAL INJURY PROTECTION, UNINSURED AND/OR UNDERINSURED MOTORISTS INSURANCE SELECTION/REJECTION PAGE IS REQUIRED TO BE COMPLETED AND SIGNED BY THE NAMED INSURED WITH THE SUBMISSION OF THIS APPLICATION.

DRIVER INFORMATION — If additional space is needed, attach separate listing.

Driver's Name	Date of Birth	Driver's Licenses				Experience	
		State	Number	Class/Type (i.e. CDL)	Years Licensed (in Class/Type)	Type of Unit (Bus, Van, Truck, Tractor, etc.)	No. of Years
1.							
2.							
3.							
4.							
5.							

DRIVER INFORMATION (Continued) — If additional space is needed, attach separate listing.								
No. Years Previous Commercial Driving Experience	Date of Hire	Accidents and Minor Moving Traffic Violations in Past 5 Years				Major Convictions (DWI/DUI, Hit & Run, Manslaughter, Reckless, Driving While Suspended/ Revoked, Speed Contest, other felony)		Employee (E) Ind. Cont. (IC) Owner/Op. (O/O) Franchisee (F)
		No. of Accidents	Date(s)	No. of Violations	Date(s)	Describe Conviction	Date(s)	
1.								
2.								
3.								
4.								
5.								

PLEASE ATTACH DETAILED EXPLANATION OF ACCIDENTS LISTED ABOVE.

20. Are drivers covered by Workers Compensation? Yes No If yes, name of carrier _____
21. Minimum years driving experience required _____ Are vehicles owner-driven only? Yes No
22. Are drivers ever allowed to take vehicles home at night? Yes No If yes, will family members drive? Yes No
23. Do you order MVR's on all drivers prior to hiring? Yes No Driver's maximum driving hours ___ daily, ___ weekly
24. Do you agree to report all newly hired operators? Yes No
25. What is the basis for driver(s) pay? Hourly Trip Mileage Other, Explain _____

SCHEDULE OF AUTOS/VEHICLES — Describe all vehicles for which application is made for insurance.

Veh. No.	Model Year	Vehicle Make & Model	Body Type (i.e. Truck, Tractor, Trailer, etc.)	Full Vehicle Identification Number	Gross Vehicle Weight (GVW)	Total # of rear axles	Principal Garaging Location (city & state)	Radius of Operation	Annual Mileage Per Vehicle	(A) Anti-Lock Brakes, (B) Air Bags
1										
2										
3										
4										
5										

26. Will lessor be added as additional insured? Yes No If yes, give name and address of lessor for each vehicle _____
27. Number of vehicles owned: Pick-Ups _____ Trucks _____ Tractors _____ Semi-Trailers _____ Trailers _____ Pup Trailers _____
28. Number of vehicles leased: Pick-Ups _____ Trucks _____ Tractors _____ Semi-Trailers _____ Trailers _____ Pup Trailers _____

PHYSICAL DAMAGE COVERAGE — Complete spaces below in detail for each respective auto/vehicle described above.

Veh. No.	Date Purchased	Cost When Purchased	Current Stated Value (excluding permanently attached equipment)	Value of Permanently Attached Special Equipment	Total Stated Amount to be Insured	Physical Damage Deductible		Cargo Limit of Insurance
						<input type="checkbox"/> Comprehensive <input type="checkbox"/> Spec. C of Loss	Collision	
1								
2								
3								
4								
5								

29. Any loss payees? Yes No If yes, give name and address of mortgagee/loss payee for each vehicle _____

LOSS EXPERIENCE — Provide prior insurance carriers information for past full three years.

Policy Term		Insurance Company Name	No. of Motor Powered Vehicles	No. of Accidents	Premium		Total Amount Claims Paid & Reserves			
From	To				Liab	Phys Dam	BI	PD	Comp/Coll	Other
/ /	/ /									
/ /	/ /									
/ /	/ /									

30. Is any applicant aware of any facts or past incidents, circumstances or situations which could give rise to a claim under the insurance coverage sought in this application? Yes No If yes, provide complete details _____
31. Have you ever been declined, cancelled or non-renewed for this kind of insurance? Yes No If yes, date and why _____

KENTUCKY NO-FAULT COVERAGE SELECTION/REJECTION FORM

(This form need only be completed when applicant wishes to elect additional Personal Injury Protection benefits or desires to reject No-Fault in its entirety.)

Coverage Desired:

- Basic Personal Injury Protection \$10,000 - No Deductible
- Optional Additional PIP Benefits - Option No. _____
(Available only for Individually Named Insureds)

Important: The following questions must be answered

Kentucky No-Fault Rejection Form KY-NF-1 (1/75) has been made available to the Insured Yes No

Insured &/or members of household has chosen to reject No-Fault Coverage and Form KY-NF-1 has been filed with the Kentucky Insurance Department Yes No

No-Fault Rejection is on file with Kentucky Insurance Department Yes No

If yes, exact status of filing and date filed: _____
(Rejection applies for a period of five years, except it may be revoked in writing.)

KENTUCKY

SELECTION/REJECTION OF UNINSURED AND/OR UNDERINSURED MOTORISTS COVERAGE

Uninsured Motorists Coverage provides for the protection of persons insured under the policy who would legally be entitled to recover damages from owners or operators of uninsured motor vehicles because of bodily injury, sickness or disease, including death, resulting therefrom, as indicated in the Statutes and/or Underinsured Motorists Coverage which provides protection for damages incurred which exceed the limit of liability coverage carried by the driver of a vehicle who injures you in an automobile accident.

Uninsured Motorists (UM) Coverage and/or Underinsured Motorists (UIM) Coverage must be offered at limits of your choice.

To be certain that this policy is issued correctly, please indicate your choice ("X" indicates your choice) of the options available, then sign and date this form as acknowledgment of your choice.

UNINSURED MOTORISTS SELECTION

- Reject Uninsured Motorists Coverage entirely;
- Elect to purchase Uninsured Motorists Coverage at limits of liability indicated below, which do not exceed your policy's Bodily Injury Liability limits:

BI Split Limits

OR

Bodily Injury Combined Single Limit

- 25/50 (min. required by law)
- \$ _____ per person
- \$ _____ per accident (optional limit)

- 60,000 (min. required by law)
- \$ _____ per accident (optional limit)

UNDERINSURED MOTORISTS SELECTION

- Reject Underinsured Motorists Coverage entirely;
- Elect to purchase Underinsured Motorists Coverage at the same limits of liability as selected for Uninsured Motorists Coverage above.

Signature

Date

Until you advise us otherwise in writing, your choice, as indicated above, will continue regardless of any addition or change in Auto coverage on your current policy or addition of any scheduled Autos and will be carried forward on all future renewal policies without additional notice.

SIGNATURE IS ALSO REQUIRED ON LAST PAGE OF APPLICATION

MUST BE SIGNED BY THE APPLICANT PERSONALLY

No coverage is bound until the Company advises the Applicant or its representative that a policy will be issued and then only as of the policy effective date and in accordance with all policy terms. The Applicant acknowledges that the **Applicant's Representative named below is acting as Applicant's agent and not on behalf of the Company. The Applicant's Representative has no authority to bind coverage, may not accept any funds for the Company, and may not modify or interpret the terms of the policy.**

The Applicant agrees that the foregoing statements and answers are true and correct. The Applicant requests the Company to rely on its statements and answers in issuing any policy or subsequent renewal. The Applicant agrees that if its statements and answers are materially false, the Company may rescind any policy or subsequent renewal it may issue.

If any jurisdiction in which the Applicant intends to operate or the FHWA requires a special endorsement to be attached to the policy which increases the Company's liability, the Applicant agrees to reimburse the Company in accordance with the terms of that endorsement.

The Applicant agrees that any inspection of autos, vehicles, equipment, premises, operations, or inspection of any other matter relating to insurance that may be provided by the Company, is made for the use and benefit of the Company only, and is not to be relied upon by the Applicant or any other party in any respect.

The Applicant understands that an inquiry may be made into the character, finances, driving records, and other personal and business background information the Company deems necessary in determining whether to bind or maintain coverage. Upon written request, additional information will be provided to the Applicant regarding any investigation.

The Applicant represents that she/he has completed all relevant sections of this Application prior to execution and that the Applicant has personally signed below (or if Applicant is a Corporation a corporate officer has signed below).

Will premium be financed? Yes No If yes, with whom? _____

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

Witness Applicant's Signature Date

TO BE COMPLETED BY APPLICANT'S REPRESENTATIVE

Is this direct business to your office? _____ If not, explain: _____

Is this new business to your office? _____ If not, how long have you had the account? _____

How long have you known applicant? _____

REQUEST TO COMPANY GENERAL AGENT:

Please quote Please bind at earliest possible date and issue policy

Please issue policy effective _____ Coverage was bound by _____
(Time and Date Bound by General Agent) (Name of Person in Company General Agency's Office Binding Coverage)

Applicant's Representative's Name and Address Phone No.



Delaware Valley Underwriting Agency, Inc.

ADDENDUM TO APPLICATION

Insured's/Applicant's Name: _____

TO BE ATTACHED TO AND MADE A PART OF ALL APPLICATIONS

It is agreed that the following FRAUD STATEMENTS are attached to the application:

APPLICABLE IN THE STATE OF PENNSYLVANIA:

WARNING: Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

APPLICABLE IN THE STATE OF NEW YORK:

WARNING: Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

APPLICABLE IN ALL OTHER STATES:

WARNING: Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act which is a crime and subjects the person to criminal and (NY: substantial) civil penalties. (Not Applicable in CO, HI, NE, OH, OK, OR, IN, DC, LA, ME and VA insurance benefits may also be denied)

I have read and accept the above (To be signed by the Insured/Applicant)

Insured/Applicant Signature

Date