PENNSYLVANIA

Canal Commercial Combination Insurance Application

Entire Application Must Be Completed and Signed

☐ **CANAL INSURANCE COMPANY**

☐ **CANAL INDEMNITY COMPANY**

Canal General Agent Use Only
Date and Time Coverage is Bound by Canal

Requested Effective Date _____

1. *GENERAL INFORMATION*

Applicant Legal Name		Form of Business ☐Individual ☐LLC ☐Partnership ☐Corporation ☐Joint Venture ☐Other	
Company Name (DBA) (if any)		Principal or Majority Owner (please include all principals)	
DOT Number	Telephone Number	Mobile Phone Number	
*Tax Identification Number or Social Security Number	E-Mail Address	Fax Number	
Location of Business Premises or Physical Address			
City	State	Zip Code	County
Location Is ☐ Inside City Limits ☐ Outside City Limits			
Mailing Address (if different than above)			
City	State	Zip Code	County

*If provided, certificates of insurance can be accessed from www.canal-ins.com 24 hours a day.

2. *GENERAL QUESTIONS*

Policy Type

☐ Scheduled Vehicle ☐ Gross Receipts (only available for 25 or more power units) ☐ Gross Mileage (only available for 25 or more power units)

How long has this operation been in business?

☐ Less than one year ☐ One to two years ☐ Two or more years

Have you ever had insurance with Canal?

☐ Yes ☐ No

If yes, please provide policy number or year(s) and name on policy.

Business Class

☐ For Hire Trucking (hauls goods for others) ☐ Private Carrier (hauls owned goods) ☐ Public Auto/Taxi ☐ Non Trucking ☐ Small Commercial

If applying for **Non-Trucking Coverage** list name and the motor carrier number of the lessee to whom you are permanently leased.

Name of Motor Carrier	Motor Carrier Number

If applying for **Small Commercial**, describe type of business and use of vehicle(s).

Type of Business	Use of Vehicle(s)

Do you own any other businesses?

☐ Yes ☐ No

If yes, please provide the name, address and details.

Have there been any changes in the ownership, management or name of the operation in the past five years?

☐ Yes ☐ No

If yes, please provide details.

Indicate Policy Term and Payment Method

☐ Short Term Policy***** Desired Expiration Date: _____ *****(No company payment plan available for short term policies.)

☐ Continuous Until Cancelled Policy (2 month escrow deposit and monthly billing)

☐ Annual Policy: ☐ Full Payment to Company ☐ Company Payment Plan ☐ Financed through outside Premium Finance Company with full payment to Canal (no double financing permitted – attach contract)

3. *MOTOR CARRIER FILINGS*

Do you need an MCS-90? ☐Yes ☐No

Authority Type

☐ **Common** ☐ **Contract** ☐ **Brokerage**

If brokerage, please provide the percentage of total revenue generated by brokerage operations and MC number

_____
Applicant's Initials

MOTOR CARRIER FILINGS continued

Filings Required	Motor Carrier #	Applicant's Name and Address Exactly As It Appears On Each Permit
☐ Liability BMC 91X ☐ Cargo BMC 34	MC	
☐ Liability – Form E _____ State		
☐ Oversized/Overweight		
☐ Hazardous		
☐ Cargo – Form H _____ State		
☐ SR 22- If yes explain		

If an MCS-90 is issued, Canal will issue with the required limits as posted on the FMCSA website. Please note: 36 days notice of cancellation is mandatory on all policies that have an MCS-90 or filings. Canal requires all units to be scheduled when an MCS-90 or filings are issued.

4. *OPERATIONS*

Please Identify Metropolitan Areas Traveled Through or Into

☐ Atlanta	☐ Cleveland	☐ Jacksonville	☐ Milwaukee	☐ Philadelphia	☐ San Diego
☐ Baltimore/DC	☐ Dallas/Ft. Worth	☐ Kansas City	☐ Mpls/ St. Paul	☐ Phoenix	☐ San Francisco
☐ Boston	☐ Denver	☐ Little Rock	☐ Nashville	☐ Pittsburgh	☐ Seattle
☐ Buffalo	☐ Detroit	☐ Los Angeles	☐ New Orleans	☐ Portland	☐ Tulsa
☐ Charlotte	☐ Hartford	☐ Louisville	☐ New York City	☐ Richmond	☐ _____
☐ Chicago	☐ Houston	☐ Memphis	☐ Oklahoma City	☐ St. Louis	☐ _____
☐ Cincinnati	☐ Indianapolis	☐ Miami	☐ Omaha	☐ Salt Lake City	☐ _____

☐ Yes ☐ No **Do you act as a freight forwarder, freight broker or arrange loads for others?**
☐ Yes ☐ No **Do you lease to others?**
☐ Yes ☐ No **Do you allow guest passengers?**
☐ Yes ☐ No **Do you haul double trailers?**
☐ Yes ☐ No **Do you haul triple trailers?**
☐ Yes ☐ No **Are any vehicles used to transport employees?**
☐ Yes ☐ No **Do you hire owner operators on a trip lease basis?**
☐ Yes ☐ No **Do you lend, lease or rent trucks, tractors or trailers to others without drivers?**

Please explain all "Yes" answers

5. *HISTORY*

Have there been any losses in the current year or the past three years? ☐Yes ☐No If yes, please complete below.
Please complete for all lines of business for the current year, as well as for the three years prior, or submit loss runs.

Policy Term From Month	From Year	To Month	To Year	Company Name	Liability # Claims	Liability *Amount Incurred	Physical Damage # Claims	Physical Damage *Amount Incurred

Attach separate loss runs if space provided is not sufficient. *Amount incurred should include paid as well as reserved total.

Policy Term From Month	From Year	To Month	To Year	Company Name	Cargo # Claims	Cargo *Amount Incurred	General Liability # Claims	General Liability *Amount Incurred

Attach separate loss runs if space provided is not sufficient. *Amount incurred should include paid as well as reserved total.

Please describe all claims over $10,000

_____
Applicant's Initials

6. *DRIVERS*

I declare the following list includes all drivers of vehicles requested to be covered under the policy including employees, leased employees, owner operators, mechanics, family members, and any other person allowed to drive an insured vehicle.

Driver Name	Date of Birth	Driver License State	Driver License Number	No. of Moving Violations in Past 3 Years	No. of Accidents in Past 3 Years	Year Hired	Years of Experience

Have any drivers been convicted of any of the following? ☐ Yes ☐ No

Negligent homicide, unlawful use of vehicle, speed contest or racing, reckless driving, leaving the scene of an accident or a hit and run, any felony conviction which involves a motor vehicle, speed twenty miles or more over the speed limit or driving while license is suspended or revoked in a commercial vehicle, DUI or DWI.

If yes, please provide driver name and details.

☐ Yes ☐ No **Do you agree to report all drivers to your agent prior to them driving an insured unit?**

☐ Yes ☐ No **Do you comply with all DOT regulations concerning driver employment, files and regulations?**

7. *VEHICLES*

Description of Vehicles (trailers must be scheduled for liability coverage to apply while detached from a power unit)

Unit No.	Model Year	Make and Unit Type	Serial Number	Number of Axles	GVW	*Owner Type	**Is Garaging address same as physical?
1							☐ Yes ☐ No
2							☐ Yes ☐ No
3							☐ Yes ☐ No
4							☐ Yes ☐ No
5							☐ Yes ☐ No

*Please enter the owner type by entering the corresponding number. 1. Owned by Named Insured, 2. Owned by Leasing Company (long term lease without a driver), 3. Owned by Owner Operator (leased with driver), 4. Owned by Employee of Named Insured (officer)

**If a unit is not garaged at the physical address, it is necessary to complete the sections below for additional garaging addresses.

Name and address of vehicle owners other than the named insured (owner types 2, 3 & 4 listed above)

Unit No.	Name of Owner	Mailing Address

Please note that coverage for owners might not be afforded if this section is not completed.

****If a unit is not garaged at the physical address of the applicant, please complete the garaging addresses for each unit**

Unit No.	Street Address			
City		State	Zip Code	County
Unit No.	Street Address			
City		State	Zip Code	County

Applicant's Initials

VEHICLES (continued)

Are all owned and operated power units listed on this application?

☐ Yes ☐ No

If no, please provide details.

Do you have any mobile equipment subject to financial responsibility laws?

☐ Yes ☐ No

If yes, please provide details of equipment.

8. *PRIMARY OPERATION*

Please indicate the percentage of operations for each of the following:

_____ Dump _____ Flatbed _____ Log Hauling _____ Refrigeration _____ Tank _____ Dry Van

_____ Auto Hauler _____ Mobile Home Toter _____ Driveaway _____ Double Trailer Hauler _____ Other _____

Are any of the following commodities hauled?

☐ Yes ☐ No Hazardous Materials Requiring 1,000,000 Liability Limits or Less
☐ Yes ☐ No Hazardous Materials Requiring 5,000,000 Liability Limits
☐ Yes ☐ No Refuse/Waste/Garbage
☐ Yes ☐ No Explosives

If yes, please provide details.

Commodities Transported (Please be specific - general freight and miscellaneous is not acceptable)

%	Type	%	Type

9. *COVERAGE SELECTION*

It is only necessary to complete sections for desired coverage. If a coverage section is left blank it will be understood that no coverage is desired.

9. *AUTO LIABILITY*

Commercial Vehicles

Combined Single Limit - each accident

$ _____

Taxicabs Only

Bodily Injury - each person / Bodily Injury - each accident / Property Damage - each accident

$ _____ / $ _____ / $ _____

Please indicate the desired radius restriction if less than an unlimited radius is desired.

☐ **150** ☐ **300** ☐ **200 (FL and CT only)**

For an unlimited radius please indicate the percentage of trips by radius from the physical address.

Percentage of Trips by Radius		
0-150	**151-300**	**Over 300**

Additional/Designated Insureds

Name	Mailing Address	*Type of Additional Insured

*Please enter each desired additional/designated insured by entering the corresponding number: 1. Designated Additional Insured, 2. Intermodal, 3. Additional Insured Waiver Rights Recovery, 4. Additional Insured Hired/Non-Owned

9. *AUTO PHYSICAL DAMAGE*

Please complete for all units that desire physical damage coverage.

Unit No.	Physical Damage Limit	Name of Loss Payee	Loss Payee Complete Address

_____
Applicant's Initials

AUTO PHYSICAL DAMAGE (continued)

Deductible Desired- Please select one

☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000 (submit for approval)

CANAL Canal Commercial Combination Insurance Application

Coverage Desired

☐ Collision and Specified Causes of Loss
☐ Collision and Comprehensive (not available in all states)

Additional Coverages Desired

☐ Additional Towing Limit $ _____ (in the event of a total loss to the described unit) $2,500 included

☐ Trailer Interchange Limit $ _____ Minus $1,000 Deductible (UIIA container haulers)

☐ Non-Owned Trailer Limit $ _____ Minus $1,000 Deductible (coverage applies only while attached to a scheduled power unit)

Please list the name and address of owners of Non-Owned trailers

Name of Owner	Address of Owner

9. *MOTOR TRUCK CARGO*

Coverage for cargo in trailers applies ONLY while trailer is attached to a scheduled power unit.

Limit Desired
Per Vehicle $ _____

Units that require specific limits other than above, please indicate below.

Unit No.	Desired Limit	Unit No.	Desired Limit
	$		$

Deductible Desired- Please select one

☐ $500 (available only on limits up to $25,000) ☐ $1,000 ☐ $2,500 ☐ $5,000 (submit for approval)

Additional Coverages Desired

☐ Refrigeration Breakdown - $2,500 minimum deductible required

☐ Poultry Cages

☐ Water Damage - $2,500 minimum deductible required

☐ Earned Freight Increase to $ _____ $1,000 included

☐ Debris Removal Increase to $ _____ $10,000 included

9. *TRUCKERS GENERAL LIABILITY*

This application is for General Liability Coverage on businesses solely involved in "for-hire" transportation of property.

Desired Limits

General Aggregate - please select one ☐ $1,000,000 ☐ $2,000,000
Each Occurrence $1,000,000 (included)

Employers Liability (Stop Gap) Coverage

Applicable only in ND, OH, WA and WY. Please select either yes or no.

		Limits	
☐ Yes	☐ No	$1,000,000	Bodily Injury by Accident - each accident
		$1,000,000	Bodily Injury by Disease - each employee
		$1,000,000	Bodily Injury by Disease - each policy

☐ Yes ☐ No Do you haul bulk fuel? If yes, a $1,000 deductible applies. If desired, please indicate an optional higher deductible $ _____
☐ Yes ☐ No Do you repair or service vehicles of others?
☐ Yes ☐ No Do you have dogs at premises? (see exclusion endorsement)
☐ Yes ☐ No Do you carry a firearm? (see exclusion endorsement)
☐ Yes ☐ No Do you generate income from other activities besides the operation of the trucks?

Please explain all "Yes" answers
Please list all mobile equipment owned by the applicant, if any (i.e. forklift, backhoe, mobile crane, etc.)

_____
Applicant's Initials

TRUCKERS GENERAL LIABILITY (continued)

Please list all premises owned or rented

Street Address

City	State	Zip Code	County
Street Address			
City	State	Zip Code	County
Street Address			
City	State	Zip Code	County

Additional/Designated Insureds

Name	Mailing Address	*Type of Additional Insured

*Please enter each desired additional/designated insured by entering the corresponding number: 1. Controlling Interest, 2. Designated Person or Organization, 3. Managers or Lessors of Premises, 4. Mortgagee, 5. Owners, Lessees or Contractors, 6. Co-Owner of Insured Premises, 7. Vicarious Liability for Owners, Lessees or Contractors

10. *CERTIFICATES OF INSURANCE*

Name	Mailing Address

11. *MVR AND CREDIT REPORT ACKNOWLEDGEMENT*

I authorize Canal Insurance Company to obtain a copy of any Motor Vehicle Report for rating/underwriting the insurance for which I have applied. I also understand that a routine inquiry may be made providing information concerning my character, general reputation, personal characteristics and mode of living. Upon written request, information as to the nature and scope of the report will be provided to me.

Disclosure: In connection with this application for commercial automobile insurance, we may review a credit report or obtain or use a credit-based insurance score based on the information contained in that credit report. We may use a third party in connection with the development of the insurance score. Your credit report/credit-based insurance score will not be used for any purpose other than the underwriting of the commercial automobile insurance policy for which you have applied.

Under no circumstances can the credit-based insurance score, the lack thereof, or the refusal to authorize the obtaining of a credit report or a credit-based insurance score be a factor in determining your eligibility for commercial automobile insurance, including cancellation or nonrenewal, if a policy is ultimately issued.

I authorize Canal Insurance Company to obtain a credit report, including but not limited to a credit-based insurance score based on personal information provided. This authorization is valid for future reports obtained for renewal policies with Canal Insurance Company.

Applicant's Signature _____ Date _____

12. *ACKNOWLEDGEMENT AND SIGNATURE*

I hereby certify that the information contained in this application is true and agree that a misrepresentation of any of the facts by me will constitute reason for the company to void or cancel any policy issued on the basis of this application, and will hold the company harmless for the action taken. I also agree that if a policy is issued pursuant to this application, the application and any elections or rejections, which are included with the application and signed by me, may be relied upon by the company as accurate and shall become a part of the policy.

I recognize that all or parts of my operations are under the Department of Transportation oversight requiring me to adhere to their rules and regulations. I acknowledge that DOT rules and regulations are understood by me, and I will adhere to the rules and regulations including, but not limited to, driver hiring, vehicle inspection, maintenance and hours of service.

PENNSYLVANIA FRAUD WARNING

WARNING: Any person who knowingly and with intent to defraud any insurance company or other 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.

Signature of **APPLICANT** **X** _____

Type or Print Applicant Name _____

Title or Relationship to Applicant _____

Date Application Completed _____

Signature of **AGENT** of the Applicant **X** _____

Agency Name _____

Address of Agency _____

Premium Calculations (agent use only)

Coverage	Premium
Auto Liability	
Auto Physical Damage	
Motor Truck Cargo	
Truckers General Liability	
Total	

Deposit or Down Payment	Number of Installments	Amount Enclosed

CANAL

☐ INSURANCE COMPANY

☐ INDEMNITY COMPANY

PENNSYLVANIA SUPPLEMENTAL APPLICATION

MUST be completed in conjunction with Form A-101 PA only if Auto Liability Coverage is requested

1. Applicant Name

2. DBA, if any

PENNSYLVANIA FRAUD WARNING

WARNING: Any person who knowingly and with intent to defraud any insurance company or other 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.

IMPORTANT NOTICE

Insurance companies operating in the Commonwealth of Pennsylvania are required by law to make available for purchase the following benefits for you, your spouse or other relatives or minors in your custody or in the custody of your relatives, residing in your household, occupants of your motor vehicle or persons struck by your motor vehicle:

(1) Medical benefits, up to at least $100,000.

(1.1) Extraordinary medical benefits, from $100,000 to $1,100,000 which may be offered in increments of $100,000.

(2) Income loss benefits, up to at least $2,500 per month up to a maximum benefit of at least $50,000.

(3) Accidental death benefits, up to at least $25,000.

(4) Funeral benefits, $2,500.

(5) As an alternative to paragraph (1), (2), (3) and (4), a combination benefit, up to at least $177,500 of benefits in the aggregate or benefits payable up to three years from the date of the accident, whichever occurs first, subject to a limit on accidental death benefit of up to $25,000 and a limit on funeral benefit of $2,500, provided that nothing contained in this subsection shall be construed to limit, reduce, modify or change the provisions of section 1715(d) (relating to availability of adequate limits).

(6) Uninsured, underinsured and bodily injury liability coverage up to at least $100,000 because of injury to one person in any one accident and up to at least $300,000 because of injury to two or more persons in any one accident or, at the option of the insurer, up to at least $300,000 in a single limit for these coverages, except for policies issued under the Assigned Risk Plan. Also, at least $5,000 for damage to property of others in any one accident under the liability coverage.

Additionally, insurers may offer higher benefit levels than those enumerated above as well as additional benefits. However, an insured may elect to purchase lower benefit levels than those enumerated above.

Your signature on this notice or your payment of any renewal premium evidences your actual knowledge and understanding of the availability of these benefits and limits as well as the benefits and limits you have selected.

If you have any questions or you do not understand all of the various options available to you, contact your agent or company.

If you do not understand any of the provisions contained in this notice, contact your agent or company before you sign.

Date Application Completed _____ Signature of Agent of Applicant _____

Signature of Applicant _____ **X** Address of Agent _____

_____

THIS IS NOT A BINDER THIS IS NOT A BINDER THIS IS NOT A BINDER THIS IS NOT A BINDER

UNINSURED MOTORIST COVERAGE

Step A - Reject UM Coverage

REJECTION OF UNINSURED MOTORIST PROTECTION

By signing this waiver I am rejecting uninsured motorist coverage under the policy, for myself and all relatives residing in my household. Uninsured coverage protects me and relatives living in my household for losses and damages suffered if injury is caused by negligence of a driver who does not have any insurance to pay for losses and damages.
I knowingly and voluntarily reject this coverage.

X _____ _____

Signature of First Named Insured | Date

If you signed the above rejection, proceed to Step A of next page. If you did not sign the above rejection, proceed to Step B.

Step B - Select limit of liability if UM Coverage is desired.

You have the right to purchase limits equal to but not greater than your bodily injury liability limits. Coverage cannot be purchased for less than financial responsibility limits of $15,000 per person, $30,000 each accident or $30,000 combined single limit. Indicate your desired limit in the space below:

_____ per person _____ each accident **or** _____ combined single limit

X _____ _____

Signature of First Named Insured | Date

If you selected UM coverage, proceed to Step C if you desire to reject stacking of limits.

Step C - Reject stacking of limits for premium reduction

REJECTION OF STACKED UNINSURED MOTORIST PROTECTION

By signing this waiver, I am rejecting stacked limits of uninsured motorist coverage under the policy for myself and all relatives residing in my household under which the limits of coverage available would be the sum of limits for each motor vehicle insured under the policy. Instead, the limits of coverage that I am purchasing shall be reduced to the limits stated in the policy. I knowingly and voluntarily reject the stacked limits of coverage. I understand that my premium will be reduced if I reject this coverage.

X _____ _____

Signature of First Named Insured | Date

Proceed to Step A of the next page.

UNDERINSURED MOTORIST COVERAGE

Step A - Reject UIM Coverage

REJECTION OF UNDERINSURED MOTORIST PROTECTION

By signing this waiver I am rejecting underinsured motorist coverage under the policy, for myself and all relatives residing in my household. Underinsured coverage protects me and relatives living in my household for losses and damages suffered if injury is caused by negligence of a driver who does not have enough insurance to pay for all losses and damages. I knowingly and voluntarily reject this coverage.

X _____ _____

Signature of First Named lnsured | Date

If you signed the above rejection, proceed to next page. If you did not sign the above rejection, proceed to Step B.

Step B - Select limit of liability if UIM Coverage is desired

You have the right to purchase limits equal to but not greater than your bodily injury liability limits. Coverage cannot be purchased for less than financial responsibility limits of $15,000 per person, $30,000 each accident or $30,000 combined single limit. Indicate your desired limit in the space below:

_____ per person _____ each accident **or** _____ combined single limit

X _____ _____

Signature of First Named lnsured | Date

If you selected UIM Coverage, proceed to Step C if you desire to reject stacking of limits.

Step C - Reject stacking of UIM limits for premium reduction

REJECTION OF STACKED UNDERINSURED MOTORIST PROTECTION

By signing this waiver, l am rejecting stacked limits of underinsured motorist coverage under the policy for myself and all relatives residing in my household under which the limits of coverage available would be the sum of limits for each motor vehicle insured under the policy. Instead, the limits of coverage that I am purchasing shall be reduced to the limits stated in the policy. I knowingly and voluntarily reject the stacked limits of coverage. I understand that my premium will be reduced if I reject this coverage.

X _____ _____

Signature of First Named lnsured | Date

Proceed to next page.

ADDED FIRST PARTY BENEFITS

Basic No-Fault Coverage of $5,000 is included in your premium and cannot be rejected.

☐ I reject additional No-Fault benefits listed below.

☐ I wish to select the additional No-Fault benefits listed below.

(Make your choice by marking one box for each of options A-D or one box for Option E).

A. MEDICAL EXPENSES: (X) Indicates your choice.

☐ None ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ $100,000

B. INCOME LOSS: (X) Indicates your choice - per month/total limit.

☐ None ☐ $1,000/$5,000 ☐ $1,000/$15,000

☐ $1,500/$25,000 ☐ $2,500/$50,000

C. ACCIDENTAL DEATH: (X) Indicates your choice.

☐ None ☐ $5,000 ☐ $10,000 ☐ $25,000

D. FUNERAL EXPENSE: (X) Indicates your choice.

☐ None ☐ $1,500 ☐ $2,500

OR

E. COMBINATION FIRST PARTY BENEFITS

☐ $50,000 ($2,500 Funeral and $10,000 Accidental Death Benefits)

☐ $100,000 ($2,500 Funeral and $10,000 Accidental Death Benefits)

☐ $177,500 ($2,500 Funeral and $25,000 Accidental Death Benefits)

AND

F. EXTRAORDINARY MEDICAL BENEFIT (EMB): (X) Indicates your choice.

☐ I do not wish to purchase EMB Coverage.

☐ I wish to purchase EMB Coverage at the following limit:

☐ $100,000 ☐ $300,000 ☐ $500,000 ☐ $1,000,000

I have had the coverages, benefit levels and options, as set out above, fully explained to me and have indicated my choices as shown.

X _____ _____

Signature of First Named Insured | Date

THIS IS NOT A BINDER THIS IS NOT A BINDER THIS IS NOT A BINDER THIS IS NOT A BINDER