

**CAPACITY COVERAGE COMPANY
COURIER PROGRAM INSURANCE APPLICATION**

APPLICANT INFORMATION

Named Insured _____	Phone _____
_____	Fax _____
Mailing Address _____	E-Mail address _____
_____	Federal Tax ID # _____
Street Address _____	Years in Business _____

Proposed Effective Date: _____	(If less than two years attach outline of prior experience) Contact Person/Title _____

DESCRIPTION OF OPERATIONS

TYPE OF WORK

MILEAGE RADIUS

Rush: 2 Hours or Less _____ %	0 – 50 miles _____ %
Route _____ %	51 – 100 miles _____ %
Other _____ %	101 – 300 miles _____ %
On Demand* _____ %	Over 300 miles _____ %
Residential: _____ % Commercial _____ %	Largest City Entered _____
*One shot deliveries with no specific time constraints	Are you a licensed Freight Broker: _____

TYPE OF MESSENGERS

Gross Vehicle Weight	Drivers Using Their Own Vehicles						Bikers			Walkers	
	< 10,000		10,001-26,000		> 26,000		# of Bicycles	# of Mopeds	# of Motor-cycles	Number	
	PART TIME*	FULL TIME	PART TIME*	FULL TIME	PART TIME*	FULL TIME				PART TIME*	FULL TIME
Independent Contractors											
Employee Drivers											

DO YOU HAVE CONTRACTS WITH YOUR INDEPENDENT CONTRACTORS? YES _____ NO _____

* P-T - Part time is 20 hours or less per week on average or drivers earning 50% or less of average full-time driver.

GROSS ESTIMATED ANNUAL REVENUE

Last fiscal year: _____	\$ _____
Current fiscal year (estimate): _____	\$ _____

OPERATING AUTHORITY

FHAFMCSA Authority Yes _____ No _____ MC Docket Number _____/USDOT # _____
(Please provide copies of current filings)
PUC Authority States: _____

Completed by _____ (Type or Print Name and Title)

Signature _____ Title _____ Date _____

CURRENT INSURANCE INFORMATION

COVERAGE	CURRENT CARRIER	PREMIUM	EXPIRATION DATE
Property			
General Liability			
Automobile (Owned Veh.)			
Hired & Non-Owned Auto			
Cargo			
Crime			
Workers' Compensation			
Umbrella			
Other (list)			

Please provide copies of the above policies. We can often obtain additional information from policies that is helpful in putting together our quotation.

In addition to the completed application, we require the following items:

- "Loss Runs" for all lines of coverage being quoted for the last Five (5) years.
- Your Bill of Lading or other shipping receipt AND A COPY OF ALL CONTRACTS
- Sample of Independent Contractor Agreement (if applicable).
- Copies of current filings (if applicable).

In the following specific coverage sections of the application, many limits will already be filled in. These are automatically included within the standard coverage(s). If you require different limits, please indicate those in the 'requested' column.

New Jersey law requires us to notify you of the following: "Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, is guilty of insurance fraud."

CAPACITY COVERAGE COMPANY

PROPERTY APPLICATION

COVERAGE	REQUESTED LIMITS (100% Replacement Cost Values)
Building	\$
Contents (including Leasehold Improvements)	\$
Personal Property of Others	<i>Covered On our Cargo Policy Complete attached Warehouse Supplemental</i>
Loss of Income / Extra Expense	\$
Electronic Data Processing (EDP)	\$
Hardware and Software	
Accounts Receivable	\$
Valuable Papers	\$
Other Coverages - Describe	\$
Other Coverages – Describe	\$
Deductible (\$1,000 minimum)	\$

UNDERWRITING INFORMATION

Type of Building (Office, Warehouse, etc.)		Year Built	
Total Square Feet of Building		Square Feet you occupy	
Wall Construction	Masonry _____	Brick Veneer _____	Frame _____ Metal _____
Roof Construction	Wood Deck _____	Metal Deck _____	
Number of Stories	Basement	Yes _____	No _____
Describe Other Occupants if Multi-Tenant Building (professional, manufacturing, etc.) _____ _____			
Fire Protection (Check all that apply)	Sprinklers	Extinguishers	Standpipe
	Central Station Alarm	Local Alarm	Other

GENERAL LIABILITY APPLICATION

COVERAGE	LIMITS	
	Standard	Requested
Annual General Aggregate	\$ 2,000,000	\$
Each Occurrence	\$ 1,000,000	\$
Products and Completed Operations Aggregate	\$ 1,000,000	\$
Personal and Advertising Injury	\$ 1,000,000	\$
Fire Damage Legal Liability	\$ 100,000	\$
Medical Expense (any one person)	\$ 5,000	\$

RATING INFORMATION

1. Warehouse/Terminal Payroll – Per Location	\$
2. Dispatch Employee Payroll ONLY – Per location	\$
2. Administration/Clerical Payroll – Total	\$

MISCELLANEOUS UNDERWRITING INFORMATION

(Explain any "Yes" Response)

1. Any Medical Facilities provided?
2. Any operations sold, acquired or discontinued in the last five years?
3. Any watercraft owned, hired or leased?
4. Any aircraft owned, hired or leased?
5. Sponsor any athletic teams?
Details of "Yes" Answers: _____
UMBRELLA/EXCESS LIABILITY REQUESTED? Yes _____ No _____ Limit Required \$ _____

CARGO APPLICATION

	LIMITS	
	Standard	Requested
Any One Loss, Disaster or Casualty-Any One Occurrence	\$ 25,000	\$
Sub-limits for General Cargo: (Excluding Bank Work)		
1. In or on any one cargo conveyance	\$ 25,000	\$
2. Loss of market; loss of use or delay, per occurrence	\$ 5,000	\$
3. In or at any one unscheduled terminal, per occurrence	\$ 25,000	\$
Deductible Requested	\$2,000 (minimum)	\$
<u>SPECIFIC WAREHOUSE:</u> (complete Warehouse Supplemental Attached)		
<u>BANK WORK:</u> (Reconstruction & Face Value-Complete <u>Attached Supplemental</u> in full with limits needed		
<u>EMPLOYEE DISHONESTY:</u> (Complete attached Crime Section Supplemental		

Any special coverages needed? (Explain) _____

Do you do any work on behalf of Banks or other Financial Institutions? _____ (if yes “Reconstruction/Face Value” supplement must be completed in full).

Cargo Claim history past 5 years (attach loss runs, if none, write none) _____

Do you use a B.O.L. (or any shipping receipt) specifying a “Limit of Liability”? _____ Yes _____ No

If Yes, what is the limitation? \$ _____ If No-Why Not? _____

COMMODITIES CARRIED	PERCENT OF REVENUE	MAX VALUE PER VEHICLE
Cash and/or Negotiable Documents		
Non-Negotiable Financial Documents – (Complete Reconstruction/Face Value Supplemental attached)		
Jewelry/Precious Metals		
Pharmaceuticals: (Complete Supplemental Attached)		
Perishables		
Electronics including Mobile Phones & Related Accessories		
Fine Arts		
Other (Miscellaneous Small Packages and Envelopes not otherwise classified)		

WAREHOUSING SUPPLEMENT

(This must be completed if you have any kind of warehousing operation)

Address of Warehouse:		
Total Area (in cubic capacity or # of storage lots) of premises available for storage listed above:		
Total Area of Building:	Area you occupy:	
If multi tenant, describe other occupancies:		
Building Description: # Stories	Basement?	Exterior Wall Construction:
YEAR BUILT _____	Roof Type _____	Floor Type _____
Premises Protection: Sprinklered?	Yes // No	
Central Station Alarm?	Yes / No ///	Burglary Included? Yes / No ///
Motion Detector? Yes / No		
Estimated total values in storage during the previous year (20____):		
Maximum at any one time:	Average at any one time:	
Do you issue a 'warehouse receipt'?	Yes No	(if so, attach a copy)
If not, do you have any form of written agreement with customers as to who is responsible, for what and how much? Yes No (If so, attach a copy or describe in detail how you limit your liability)		
How often do stored commodities turnover? (List by commodity)		
Gross Receipts (from warehousing only):		
Last complete fiscal year (20____) \$	Estimated for current year (20____) \$	

	AVERAGE \$ VALUE	MAXIMUM \$ VALUE
Food/Perishables – Describe!	\$	\$
Furniture	\$	\$
Electronics	\$	\$
a. TV, Radio/Stereo, etc.	\$	\$
b. Computer Equipment/Parts	\$	\$
c. Mobile Phones and/or SIM Cards	\$	\$
Office Products (other than computer)	\$	\$
Appliances (other than TV/Radio, etc.)	\$	\$
Chemicals or Liquids of any kind – <i>Describe In Detail</i>	\$	\$
Pharmaceuticals – <i>Describe and also Narcotics %</i>	\$	\$
Liquor, Wine, Spirits	\$	\$
Auto Parts	\$	\$
Other (Describe)	\$	\$

**RECONSTRUCTION and/or FACE VALUE INSURANCE
SUPPLEMENTAL APPLICATION**

(PLEASE COMPLETE ONE FORM FOR EACH BANK)

Bank or Financial Institution Name: _____

Cities/States Involved: _____

1. LIMITS OF LIABILITY REQUIRED - per Occurrence:	INDICATE BELOW	
a) Document Reconstruction Limit Only (no face value)	\$ _____	
b) Face Value Limit Only (no reconstruction)	\$ _____	
c) Document Reconstruction & Face Value-Combined Limit	\$ _____	
d) Third Party Employee Dishonesty to be Included ??	Yes or No	
Deductible desired:	\$ _____	
2. <u>Branch Information:</u>		
a. Number of branches:		
b. Number of daily pickups:		
c. Number of branches any one vehicle visits before proceeding to Data Processing Center:		
d. Number of days per week:		
e. Number of "On Us" items per route:	Average: _____	Max.: _____
f. Average Face Value (per item):	Average: _____	Max.: _____
g. Any checks photocopied or microfilmed prior to transit?	Yes: _____	No: _____
1. If so, is there a minimum amount that triggers this?		
h. Average # of items per route/per day:		
3. Are routes for this Bank dedicated?:	Yes: _____	No: _____
a. If not, how many banks are "co-mingled"?		
4. Fire proof/resistant bags used?		
5. How are bags labeled?		
6. How many total vehicles are used for this contract?	# _____	
7. Describe Security of Vehicles Used on Route -		

8. Are drivers educated with the fact that there is nothing in the bags of intrinsic value?	Yes: _____	No: _____
9. Is your liability addressed in a contract with the Bank?	Yes: _____	No: _____
Please attach a copy of page(s) in contract outlining Courier Company's liability.		

RECONSTRUCTION and/or FACE VALUE INSURANCE APPLICATION

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10. Does the bank have a check reconstruction procedure?

Yes:

No:

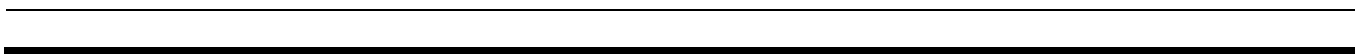
a. Briefly describe:

11. How and when does the bank make the determination that a destroyed/lost item(s) can't be reconstructed and must be deemed a "face value" claim?

THIS QUESTION MUST BE ANSWERED

12. Annual Gross Revenue Derived from this Bank Contract:

\$ _____



PHARMACEUTICAL SUPPLEMENT

(This must be completed if you carry any kind of Pharmaceuticals)
COMPLETE SEPARATE FORM FOR EACH CUSTOMER CONTRACT

1. Proposed total annual revenue from the Pharmaceutical contract \$ _____

Name of Customer: _____

Limit of Liability Required By Contract-Any One Occurrence: \$ _____

Revenue breakout for each contract and between any line hauls and route trucks.

2. Line haul Revenue: \$ _____

3. # daily linehauls: _____

4. Route Revenue: \$ _____

5. # daily routes (non-linehauls): _____

6. Average per truck value –route: \$ _____

7. Maximum per truck value– route: \$ _____

8. Average value per truck- line haul: \$ _____

9. Maximum per truck value- line haul: \$ _____

10. Total # of line hauls and/or route trucks on the road at any one time: _____

11. Vehicle security and any other security measures: _____

12. One man or two man crews? _____

13. The percentage of narcotics on each shipment: _____%

14. Describe how pharmaceuticals are wrapped and secured in truck: _____

CRIME APPLICATION

COVERAGE	REQUESTED LIMITS	DEDUCTIBLE (\$2,000 minimum)
Employee Dishonesty	\$	\$
Forgery or Alteration	\$	\$

EMPLOYEE/INDEPENDENT CONTRACTOR CENSUS

(Indicate number of each)

Employee Drivers _____
Independent Contractor Drivers _____
Clerical Employees _____
Other (exclude Owners/officers) _____
TOTAL _____

MISCELLANEOUS UNDERWRITING INFORMATION

1. Is a countersignature required on all checks?	Yes	No
2. If "No", what check amount requires countersignature?	\$	
3. Can the person who reconciles bank statements, also deposit and/or withdraw money?	Yes	No
4. Are financial audits performed? How often?	Yes	No
5. To your knowledge, do you transport money, negotiable securities, jewelry or precious metals? If "Yes", explain: _____	Yes	No

BUSINESS AUTO APPLICATION

AUTOMOBILE COVERAGE OPTIONS:

#1) **NON-OWNED/HIRED AUTO LIABILITY OVER IC LIMITS OF \$100,000/\$300,000** (we must receive copies of Declarations Pages of all drivers evidencing these limits prior to binding coverage)

#2) **NON-OWNED/HIRED AUTO LIABILITY OVER STATE MINIMUM LIMITS** (we must receive copies of Declarations Pages of all drivers evidencing these limits prior to binding coverage)

#3 **OWNED / SCHEDULED AUTOS:** Complete attached auto schedule

INDICATE WHICH OPTIONS YOU DESIRE _____

LIABILITY

COVERAGE	LIMITS REQUESTED
Bodily Injury/Property Damage (Owned & Non-Owned)	\$ 1,000,000
* Personal Injury Protection (PIP)	Statutory
* Additional Personal Injury Protection (PIP)	\$
* Medical Payments	\$
* Uninsured/Underinsured Motorists	\$

PHYSICAL DAMAGE *

Deductibles	Comprehensive \$	Collision \$
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OTHER COVERAGES OR ENDORSEMENTS

**** Drive Other Car Liability and Physical Damage** **Yes** **No**

List Individuals to be Covered:

Hired Car Physical Damage Limit _____ **Comp Deductible** **\$1,000 min.** **Coll Deductible** **\$1,000 min.**

Underwriting Information: States: **# Days:** **# Vehicles:**

Estimated Annual Cost of Vehicle Rentals (30 Days or Less each time):

* This applies to company owned vehicles only

** This applies to anyone (officer, employee, or independent contractor) driving company-owned vehicles who does not have their own personal auto policy. Please call us if there are any questions as to whom this may apply.

BUSINESS AUTO APPLICATION (CONT.)
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Miscellaneous Underwriting Information

(Explain any "Yes" responses)

I. VEHICLES (Company Owned Only)

1. Company owned vehicles customized or altered? Special Equipment Installed? If so, specify	Yes	No
2. Company owned vehicles kept at drivers' homes?	Yes	No
3. Is there a preventative maintenance program for company owned vehicles? If so, briefly describe. _____	Yes	No
4. Regular Vehicle Inspections of company owned vehicles? Frequency?	Yes	No

II. DRIVERS

1. Dress Code for Drivers? If so, what _____	Yes	No
2. If drivers (employees or independent contractors) are using their own vehicles, what do you require as evidence of their insurance and how do you monitor this? Certificate _____ Copy of Policy _____ Other _____		
3. What limits are drivers using their own vehicles required to carry? 50/100/25 _____ 100CSL _____ 100/300/50 _____ 300 CSL _____ State Minimum _____ Other _____		
4. Do drivers operate same vehicle each day?	Yes	No
5. Any Drivers under 21? (not eligible for insurance)	Yes	No
6. What is annual driver turnover? _____ _____		

BUSINESS AUTO APPLICATION (CONT.)
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III. DRIVER SELECTION

1. Written Application Required?	Yes	No
2. Interview by Management?	Yes	No
3. Road Test Required?	Yes	No
4. Written Test Required?	Yes	No
5. References Checked?	Yes	No
6. Police Record Checked?	Yes	No
7. Require 2 or more years driving experience in U.S.?	Yes	No
8. MVR's ordered on all prospective employees?	Yes	No
9. Are above items completed prior to employee being allowed to drive?	Yes	No

IV. SAFETY & COMPLIANCE

1. Safety Coordinator Appointed?	Yes	No
2. Driver Training Provided?	Yes	No
3. Accident Register Maintained?	Yes	No
4. Accident Review Committee	Yes	No
5. Driver Safety Meetings? (If so, how often _____)	Yes	No

V. MISC.

1. Hours of Operation? _____		
2. Vehicles leased to or from others?	Yes	No
3. Employees or Passengers Transported?	Yes	No
4. Personal Use of Company Owned Vehicles Permitted?	Yes	No
5. Describe type of dispatch system used.		

SCHEDULE A

**CAPACITY COVERAGE COMPANY
DRIVER SCHEDULE
(DRIVERS MUST BE AT LEAST 21 YEARS OF AGE)**

#	NAME	BIRTH DATE	DRIVER'S LICENSE NO.	SOCIAL SECURITY NO.	STATE OF ISSUANCE
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					
25					

**CAPACITY COVERAGE COMPANY
OWNED VEHICLE FLEET SCHEDULE**

Yr.	Make	Model	Vehicle Identification Number	Garage Location City, State, Zip	Value	Comp Y/N	Coll Y/N	Radius	GVW*	80% of Usage

* Gross Vehicle Weight - required only for vehicles in excess of 10,000 pounds

Indicate any Additional Insured's or Loss Payee's

WORKERS' COMPENSATION APPLICATION

STATE	CLASS CODE	DUTIES/JOB DESCRIPTION	NUMBER OF EMPLOYEES	ESTIMATED PAYROLL
				\$
				\$
				\$
				\$
				\$
				\$
				\$

Current Experience Modification _____

Federal Employer Identification Number _____

Are partners, Owners, Officers to be Included? _____ Excluded? _____

List each partner/owner/officer, including birth date, duties and payroll:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Current Workers Compensation Policy Information (Please complete even if we are not quoting Workers Comp):

Insurance Carrier: _____

Policy Number: _____

Policy Period: _____

Employer's Liability Limits: _____

WORKERS' COMPENSATION APPLICATION (CONT.)

GENERAL INFORMATION

(Please provide all required details for "Yes" responses in the space provided below)

	Yes	No
(1) Does Applicant own, operate or lease aircraft/watercraft?		
(2) Any exposure to flammables, explosives, caustics, fumes?		
(3) Any exposure to radioactive material?		
(4) Any work performed underground or above 15 feet?		
(5) Any work performed on barges, vessels, docks, bridge over water?		
(6) Is Applicant engaged in any other type of business?		
(7) Are subcontractors used?		
(8) Any work sublet without certificates of insurance?		
(9) Is a formal safety program in operation?		
(10) Any group transportation provided?		
(11) Any employees under 16 or over 60 years of age?		
(12) Any part-time or seasonal employees?		
(13) Is there any volunteer or donated labor?		
(14) Are there any employees with physical disabilities?		
(15) Do employees travel out of state?		
(16) Are athletic teams sponsored?		
(17) Are physicals required after employment offers are made?		
(18) Any other insurance with this insurer?		
(19) Any prior coverage declined/canceled/non-renewed (last 3 years)?		
(20) Are employee health plans provided:		
(21) Is there a labor interchange with any other business or subsidiary?		
(22) Do you lease employees to or from other employers?		
(23) Do any employees predominantly work at home?		

INSURANCE CHECKLIST

Below is a list of usually available coverages (not all-inclusive), some of which will be quoted to you per the application(s) completed:

- | | | | |
|-------|-------------------------------|-------|---|
| _____ | Property (Building & Contents | _____ | Automobile |
| _____ | Business Income | _____ | Employee Dishonesty |
| _____ | Extra Expense | _____ | Money & Securities |
| _____ | Flood | _____ | Depositor's Forgery |
| _____ | Earthquake | _____ | General Liability |
| _____ | Electronic Data Processing | _____ | Fiduciary Liability |
| _____ | Signs | _____ | Employee Benefits Liability |
| _____ | Plate Glass | _____ | Stop Gap Liability |
| _____ | Cargo Liability | _____ | Workers' Compensation/Employers Liability |
| _____ | Transportation | _____ | Umbrella/Excess Liability |
| _____ | Ocean Cargo | _____ | Directors & Officers Liability |
| _____ | Valuable Papers | _____ | Employment Practices Liability |
| _____ | Accounts Receivable | | |

If you are interested in any additional coverages, either in terms of a further explanation and/or a quotation, please call or write us with your request.
