



Motor Carrier Short Form Application

This short form application will give us a starting point to offering you the most competitive quote on your workers' compensation coverage. Fax completed form to 334-834-7931. Please call 334-834-7911 with any questions.

| Motor Carrier Information | | | |
|--|--------------------------|--------------------------------|-----------------------------|
| Company Name: | | | |
| Company Contact: | | | |
| Street Address: | | | |
| City: | State: | Zip Code: | |
| Phone Number: | Fax Number: | | |
| E-Mail Address: | | | |
| Federal ID: | | | |
| Current Experience Modification: | | How long in business? | |
| How many terminals/locations? | | List all States as Applicable: | |
| Do you currently have worker's compensation insurance? | <input type="checkbox"/> | Yes | <input type="checkbox"/> No |
| If Yes: | Agency Name: | | |
| Agency Contact Information: | | | |

| Operating Information | |
|--|--|
| Average length of haul (miles): | Maximum length of haul (miles): |
| Do you pay per diem? <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have a Safety Program? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Brief Description of Operations/Include Type of Cargo Hauled (attach separate sheet if more spaced is needed): | |
| | |

| Payroll Audit/Accounting Information | | |
|---|-------------------|----------------|
| Contact Name: | | Email Address: |
| Total Drivers: | Owners/Operators: | Employees: |
| Complete the below table. Attach separate sheet if more space is needed. | | |
| Class Code | # Employees | Payroll |
| | | |
| | | |
| | | |

**Fax completed form and any attachments to 334-834-7931.
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