## Filing at a Glance

Company: Vanliner Insurance Company

| | | |
|---|---|---|
| Product Name: Non-Trucking Application and Renewal Questionnaire | SERFF Tr Num: VANL-125349478 | State: Arkansas |
| TOI: 20.0 Commercial Auto | SERFF Status: Closed | State Tr Num: EFT $50 |
| Sub-TOI: 20.0001 Business Auto | Co Tr Num: | State Status: Fees verified and received |
| Filing Type: Form | Co Status: | Reviewer(s): Betty Montesi, Llyweyia Rawlins, Brittany Yielding |
| | Author: Tina Kampwerth | Disposition Date: 11/08/2007 |
| | Date Submitted: 11/06/2007 | Disposition Status: Approved |
| Effective Date Requested (New): 12/01/2007 | | Effective Date (New): 12/01/2007 |
| Effective Date Requested (Renewal): 12/01/2007 | | Effective Date (Renewal): 12/01/2007 |

## General Information

| | |
|---|---|
| Project Name: Non-Trucking Application and Renewal Questionnaire | Status of Filing in Domicile: |
| Project Number: DISC072007AP 08 07/DISC072007RQ 08 07 | Domicile Status Comments: |
| Reference Organization: | Reference Number: |
| Reference Title: | Advisory Org. Circular: |
| Filing Status Changed: 11/08/2007 | |
| State Status Changed: 11/08/2007 | Deemer Date: |
| Corresponding Filing Tracking Number: | |

Filing Description:

Vanliner Insurance Company is seeking approval of the enclosed Application and Renewal Questionnaire. Vanliner's goal is to obtain a generic form approved in all states.

## Company and Contact

**Filing Contact Information**

| | |
|---|---|
| Tina Kampwerth, Senior Compliance | Tina_Kampwerth@Vanliner.com |

Coordinator


One Premier Drive
St. Louis, MO 63026

(800) 325-3619 [Phone]
(636) 305-4270[FAX]


**Filing Company Information**


Vanliner Insurance Company
One Premier Drive
St Louis, MO  63026
(636) 343-9889 ext. [Phone]

CoCode: 21172
Group Code: -99
Group Name:
FEIN Number: 86-0114294

State of Domicile: Arizona
Company Type:
State ID Number:


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# Filing Fees

| | |
|---|---|
| Fee Required? | Yes |
| Fee Amount: | $50.00 |
| Retaliatory? | Yes |
| Fee Explanation: | $50/filing - Missouri |
| Per Company: | No |

| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|---|---|---|---|
| Vanliner Insurance Company | $50.00 | 11/06/2007 | 16506247 |

# Correspondence Summary

## Dispositions

| Status | Created By | Created On | Date Submitted |
|---|---|---|---|
| Approved | Llyweyia Rawlins | 11/08/2007 | 11/08/2007 |

# Disposition

Disposition Date: 11/08/2007

Effective Date (New): 12/01/2007

Effective Date (Renewal): 12/01/2007

Status: Approved

Comment:

Rate data does NOT apply to filing.

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *VANL-125349478* | *State:* | *Arkansas* |
| *Filing Company:* | *Vanliner Insurance Company* | *State Tracking Number:* | *EFT $50* |
| *Company Tracking Number:* | | | |
| *TOI:* | *20.0 Commercial Auto* | *Sub-TOI:* | *20.0001 Business Auto* |
| *Product Name:* | *Non-Trucking Application and Renewal Questionnaire* | | |
| *Project Name/Number:* | *Non-Trucking Application and Renewal Questionnaire/DISC072007AP 08 07/DISC072007RQ 08 07* | | |

| Item Type | Item Name | Item Status | Public Access |
|---|---|---|---|
| **Supporting Document** | Uniform Transmittal Document-Property & Casualty | Approved | Yes |
| **Form** | Commercial Auto Non Trucking Application | Approved | Yes |
| **Form** | Renewal Questionnaire | Approved | Yes |

# Form Schedule

| Review Status | Form Name | Form # | Edition Date | Form Type | Action | Action Specific Data | Readability | Attachment |
|---|---|---|---|---|---|---|---|---|
| Approved | Commercial Auto Non Trucking Application | DISC072007AP | 08 07 | Other | New | | 0.00 | DISC072007AP.pdf |
| Approved | Renewal Questionnaire | DISC072007RQ | 08 07 | Other | New | | 0.00 | DIS072007RQ.pdf |

# VANLINER INSURANCE COMPANY
# INSURANCE APPLICATION FOR INDEPENDENT OWNER OPERATOR COVERAGES

VAN LINES NAME: _____ CITY/ST: _____
(qualified with)
TRUCKING CO NAME: _____ CITY/ST: _____
(contracted with)

## APPLICANT INFORMATION (Please Print)

NAME: _____ DBA: _____

Date of Hire: _____ Date of Birth: _____ Height _____ Weight _____

ADDRESS: _____ FEIN #: _____ UNEMP #: _____

CITY: _____ ST: _____ ZIP: _____

PH#: _____ SSN#_____ CDL#: _____

COVERAGES BEING REQUESTED : PROPOSED EFF. DATE: _____

____ WORKERS' COMPENSATION (Complete Sections 1 & 2) ____ NON-TRUCKING LIABILITY (BOBTAIL) (Complete Sections 1 & 3) ____ PHYSICAL DAMAGE (Complete Sections 1 & 3)

## SECTION 1: GENERAL INFORMATION

1. Are you a: ( ) Sole Proprietor/Individual ( ) Corporation ( ) Co-Subcontractor/partnership or joint venture ( ) Other (describe) _____.
2. Please classify yourself as one of the following: ( ) Owner/Operator ( ) Local Contractor ( ) Contract Packer ( ) Other (describe) _____.
3. You are primarily a: ( ) Household Goods Mover ( ) Car Carrier ( ) Special Commodity ( ) Electronics/Exhibitor ( ) General Merchandise ( ) Other (describe) _____.
4. Are you contracted with another company other than the trucking company indicated above? ___ YES __ NO. If yes, please give the name of the trucking company and explain your relationship: _____.
5. Are you involved in any other business endeavors other than trucking? ____ YES ____ NO. If yes, please describe: _____.
6. What is the percentage of your work performed? Local ____ % Intrastate ____ % Interstate _____ %.
7. List the states in which you primarily operate: _____.
8. How many commercial vehicles do you own? _____.
9. Are you qualified or going to be qualified with the Van Lines listed above? ____ YES ____ NO. *If no, please attach a copy of a recent MVR and DOT physical.*

I represent the above information to be complete and accurate to the best of my knowledge. I hereby acknowledge that (a) I am the sole or primary operator of a power unit, under a permanent or long-term lease contract with the Van Lines noted above; (b) I am not an employee of the Van Line.
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 METERIAL THERETO, COMMITS A FRAUDLENT 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, TN, or VT; in DC, LA, ME, & VA, insurance benefits may also be denied).

X _____ X _____
Signature of Applicant Date Signature of Insurance Producer Date

APPLICATION WILL NOT BE ACCEPTED WITHOUT APPLICANT'S SIGNATURE. IF BOUND, COVERAGE WILL BE WRITTEN BASED ON SECTIONS COMPLETED.

## SECTION 2: WORKERS' COMPENSATION INFORMATION

1. Do you currently have other Workers' Compensation coverage: ( ) YES ( ) NO If yes, please provide a certificate of insurance.
2. How are you paid? ( ) 1099 Form ( ) W-2 Form
3. Do you reside or conduct the majority of your business in North Dakota, Ohio, Washington, or Wyoming? ( ) Yes ( ) No. If yes, do you have sole proprietor coverage for yourself and for your employees under that state's fund? ( ) Yes ( ) No. If yes, please provide a certificate of insurance.
4. Do you use subcontractors, whom you pay by 1099? ( ) Yes ( ) No. If yes, are you electing to provide Workers' Compensation coverage for these subcontractors? ( ) Yes ( ) No If yes, please list them below in Question #6.
5. Are you requesting Worker's Compensation coverage on yourself? ( ) Yes ( ) No. If yes, please provide a copy of your last 1099 statement and include yourself on Question #6. If no, please submit a signed statement opting out of Workers' Compensation coverage.
6. List any full time or part time labor you use on a regular basis (include yourself, your spouse, & subcontractors paid by 1099).
**Effective 01/01/06, employers can require employees to be treated through a certified health care network for Work Comp claims filed in Texas.**

| Name | SS # | Duties | Annual Salary | F/T P/T | Paid by W/2 or 1099 |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

7. Do you occasionally hire help to assist you in the loading/unloading of freight/household goods? ( ) Yes ( ) No.
8. How do you pay your helpers? ( ) 1099 Form ( ) W-2 Form ( ) Cash Receipt
9. Have you or any employees/helpers been compensated (medical or indemnity) for an on-the-job injury within the last 5 years? ( ) Yes ( ) No. If yes, please explain the injury. _____

_____

**Circle "Y" for "YES" or "N" for "NO" for each question listed below:**

Y N 1. Arthritis; Specify type and joints affected.
Y N 2. Any disease or disorder of the back, spine, bone, joints or muscles.
Y N 3. Gout or rheumatism.
Y N 4. High Blood Pressure, if yes give most recent reading ____/____
Y N 5. Chest pain, shortness of breath, heart murmur, or disorder. of the heart or circulatory system.
Y N 6. Nephritis, kidney stones, or any other diseases of bladder /kidney.
Y N 7. Tumor or disease of the prostate, testes, breast, uterus, ovaries, complications of pregnancy, or venereal disease.
Y N 8. Varicose veins, phlebitis, or any type of hernia.
Y N 9. Any injury or disorder to the back, knees or shoulders.
Y N 10. Any type of cancer, tumor, or cyst.
Y N 11. Any disease or disorder of the eyes, ears, nose, or throat.
Y N 12. Anemia, hemophilia, goiter or other disease of the blood or glands.
Y N 13. Diabetes or sugar, albumin or blood in the urine.
Y N 14. Dizziness, fainting spells, epilepsy, mental ornervous condition, severe headaches, or any other disease or disorder of the brain or nervous system.
Y N 15. Asthma, or chronic cough.
Y N 16. Any disease or disorder for the stomach, intestines, bowels, rectum, appendix, liver or gall bladder, including weight reduction surgery.
Y N 17 Any type of surgery within the last 2 years.
Y N 18. Any other abnormality, deformity, or disease not listed above.

**PLEASE GIVE COMPLETE DETAILS OF EACH ITEM ABOVE CHECKED "YES". (Enclose a separate sheet if additional space is required).**

| Ques. No. | Person Affected | Type of Aliment or Disease | Onset Date | Date of Last Treatment/Surgery | Prescription Drugs being Taken | Name & Address of Physicians/Practioner |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |

### AUTHORIZATION TO RELEASE AND FURNISH MEDICAL RECORDS

**Physicians, hospitals, and other providers are hereby authorized and have my consent to release, disclose, and furnish to the Insurance Company for their review and retention in connection with my application any and all information, records or copies of records relating to my medical history and conditions. This includes but is not limited to diagnosis, treatment, care, surgery, and the date thereof. I understand that my medical records will be maintained with strict confidentiality by the Insurance Company. I understand and agree that any errors, omissions, or misstatements in this application my result in the Insurance Company either declining to write the coverage applied for, or canceling coverage already extended to me. I also understand that the information that I have provided in this application is subject to verification by the Insurance Company.**

_____ _____
APPLICANT'S SIGNATURE DATE

## SECTION 3: NON-TRUCKING LIABILITY (BOBTAIL)/PHYSICAL DAMAGE

1. Do you drive a commercial vehicle yourself? ( ) Yes ( ) No.
2. Does anyone regularly share driving responsibility with you? ( ) Yes ( ) No If yes, how many days per year will another person drive your vehicle? _____ # of days.
3. Please list your vehicle information below; attach a list if you have more than one vehicle to be insured. Please include a copy of your vehicle(s) Department of Motor Vehicle Registration (DMV).

**( ) Tractor ( ) Straight Truck ( ) Pack Van ( ) Trailer ( ) Car Carrier ( ) Other** _____

**GVW** _____ **YR** _____ **MAKE** _____ **VIN #** _____

**Registration State** _____ **Cost New $** _____ **Stated Value $** _____

**Comprehensive Deductible: * $** _____ **Collision Deductible: * $** _____

***(*subject to minimum amount based on underwriting standards)***

4. Do you require any filings or certificates with the DMV? ( ) Yes ( ) No If yes, describe _____.
5. Are you the registered owner of the vehicle(s) to be insured? ( ) Yes ( ) No. If no, explain _____.

_____.

***(Required for a financed purchase)***

Lienholder's Name _____

Address _____

_____

***(Required for a lease)***

Lessor's Name _____

Address _____

_____

6. Is there a generator installed? ( ) Yes ( ) No.
7. Do you want comprehensive and collision coverage on the generator listed above? ( ) Yes ( ) No. If yes, please provide the following information: YR _____ MAKE _____ SERIAL # _____

VALUE $_____ **AND** select a Deductible Option of: ( ) $100 **OR** ( ) $1,000 per occurrence.

PRIVACY POLICY

**At Vanliner, we strive to meet you expectations for privacy while still managing information to properly conduct our business and to serve you to our fullest potential. There are occasions when information must be disclosed to fulfill your requests, to deliver products and services, to administer and update policies and to comply with laws and regulations. Keep in mind, that information sharing can be very important for meeting your needs and providing you with excellent and consistent quality service. A complete copy of our privacy policy will be issued with your policy(s).**

**Return this application to:**
**Vanliner Insurance Company**
**One Premier Drive**
**P O Box 26342**
**Fenton MO 63026-1542**
**Phone # (800) 325-3619**
**Fax # (636) 349-3846**

**Insurance Producer Name** _____

**Address** _____

**City/State/Zip** _____

**Phone No.** _____

# Vanliner Owner-Operator Renewal Questionnaire

**Name** _____ **Van Lines Agency Name** _____

**Address:** _____ **SS#:** _____

**City, State:** _____ **FEIN#:** _____

**Existing Policy Number** _____ **Existing Certificate Number** _____

1). What is your legal status? ___ Individual __ Corporation __ Partnership ___ Other

2). What is your job classification? ____ Household Goods ____ General Merchandise ____ Car Carrier
____ Special Commodities ____ Electronics/Exhibitor ____ Other (*describe* _____)

3). How many commercial vehicles do you own or lease? _____ **(Please attach a list of units; include YR, MAKE,VIN, & GVW) (*If changing or adding vehicles, please submit a copy of the vehicle registration.)**

4). Are you currently qualified with the Van Lines listed above? ____ YES ____ NO.
Are you qualified with any other Van Lines ____ ____ YES ____ NO. If so, whom _____

5). List the states in which you primarily operate. _____
_____

6). What is the percentage of your work performed? Local _____% Intrastate _____% Interstate _____%

7). Are you contracted with other trucking carriers/companies? ___ YES ___NO. If yes, give name of company and relationship _____

8). How are you paid? _____ 1099 ____ W2

9). Are you electing to provide coverage on yourself? ____ YES ____ NO

10). Do you use subcontractors whom you pay by 1099? ____ Yes ____ No.
If yes, are you electing to provide Workers' Compensation coverage for them? ____ Yes ____ No. *(If yes, please include their information on question number 11).*

11). Please attach a list of any full-time or part-time employees you use on a regular basis (include yourself, your spouse, and subcontractors paid by 1099). Please include their name, estimated annual salary, and how paid (1099, W2 or Cash). **Effective 1/1/06, employers can require employees to be treated through a certified health care network for WC claims filed in Texas.**

I represent the above information to be complete and accurate to the best of my knowledge. I hereby acknowledge that (a) I am the sole or primary operator of a power unit, under a permanent or long-term lease contract with the Van Lines noted above; (b) I am not an employee of the Van Line.
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 METERIAL THERETO, COMMITS A FRAUDLENT 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, TN, or VT; in DC, LA, ME, & VA, insurance benefits may also be denied).

X _____ X _____
**Signature of Applicant** **Date** **Signature of Insurance Producer** **Date**

***Renewal Questionnaire will not be accepted without applicant's and producer's signature.***

# Rate Information

Rate data does NOT apply to filing.

# Supporting Document Schedules

| | | **Review Status:** | |
|---|---|---|---|
| **Satisfied -Name:** | Uniform Transmittal Document-Property & Casualty | Approved | 11/08/2007 |

**Comments:**

Vanliner Insurance Company is seeking approval of the enclosed Application and Renewal Questionnaire. Vanliner's goal is to obtain a generic form approved in all states.

**Attachments:**

AR filing docs.pdf

AR ltr.pdf

Effective January 1, 2006

# Property & Casualty Transmittal Document (Revised 1/1/06)

| 1. Reserved for Insurance Dept. Use Only |
|---|
| |

| 2. Insurance Department Use only | |
|---|---|
| a. Date the filing is received: | |
| b. Analyst: | |
| c. Disposition: | |
| d. Date of disposition of the filing: | |
| e. Effective date of filing: | |
| New Business | |
| Renewal Business | |
| f. State Filing #: | |
| g. SERFF Filing #: | |
| h. Subject Codes | |

| 3. | Group Name | Group NAIC # |
|---|---|---|
| | | |

| 4. | Company Name(s) | Domicile | NAIC # | FEIN # |
|---|---|---|---|---|
| | Vanliner Insurance Company | MO | 21172 | 86-0114294 |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

| 5. | Company Tracking Number | DISC072007AP 08 07/DISC072007RQ 08 07 |
|---|---|---|

**Contact Info of Filer(s) or Corporate Officer(s)** [include toll-free number]

| 6. | Name and address | Title | Telephone #s | Fax # | e-mail |
|---|---|---|---|---|---|
| | Vanliner Insurance Company Tina Kampwerth | Senior Compliance Coordinator | 800-325-3619 | 636-305-4270 | Tina_Kampwerth@Vanliner.com |
| | | | | | |
| 7. | Signature of authorized filer | | Tina Kampwerth | | |
| 8. | Please print name of authorized filer | | Tina Kampwerth | | |

**Filing information** (see General Instructions for descriptions of these fields)

| | | |
|---|---|---|
| 9. | **Type of Insurance (TOI)** | 20.0000 |
| 10. | **Sub-Type of Insurance (Sub-TOI)** | **20.0001** |
| 11. | **State Specific Product code(s)**(if applicable)[See State Specific Requirements] | |
| 12. | **Company Program Title** (Marketing title) | **Non Trucking Application and Renewal Questionnaire** |
| 13. | **Filing Type** | ☐ Rate/Loss Cost ☐ Rules ☐ Rates/Rules<br>☒ Forms ☐ Combination Rates/Rules/Forms<br>☐ Withdrawal ☐ Other |
| 14 | **Effective Date(s) Requested** | New: 12/01/2007 Renewal: 12/1/2007 |
| 15. | **Reference Filing?** | ☐ Yes ☒ No |
| 16. | **Reference Organization** (if applicable) | |
| 17. | **Reference Organization # & Title** | |
| 18. | **Company's Date of Filing** | 11/6/2007 |
| 19. | **Status of filing in domicile** | ☐ Not Filed ☐ Pending ☒ Authorized ☐ Disapproved |

# Property & Casualty Transmittal Document---

| 20. | **This filing transmittal is part of Company Tracking #** | Non Trucking Application and Renewal Questionnaire |
|---|---|---|

| 21. | **Filing Description** [This area can be used in lieu of a cover letter or filing memorandum and is free-form text] |
|---|---|

Vanliner Insurance Company is seeking approval of the enclosed Application and Renewal Questionnaire.

| 22. | **Filing Fees** (Filer must provide check # and fee amount if applicable)<br>[If a state requires you to show how you calculated your filing fees, place that calculation below] |
|---|---|

**Check #:** EFT
**Amount:**

**Refer to each state's checklist for additional state specific requirements or instructions on calculating fees.**

*****Refer to each state's checklist for additional state specific requirements (i.e. # of additional copies required, other state specific forms, etc.)**

# FORM FILING SCHEDULE

(This form must be provided ONLY when making a filing that includes forms)

**(Do not refer to the body of the filing for the forms listing, unless allowed by state.)**

| | | |
|---|---|---|
| 1. | **This filing transmittal is part of Company Tracking #** | Non Trucking App and Questionnaire |
| 2. | **This filing corresponds to rate/rule filing number** (Company tracking number of rate/rule filing, if applicable) | |

| 3. | **Form Name /Description/Synopsis** | **Form # Include edition date** | **Replacement Or withdrawn?** | **If replacement, give form # it replaces** | **Previous state filing number,** if required by state |
|---|---|---|---|---|---|
| 01 | Non Trucking Application | DISC072007AP 08 07 | ☒ New<br>☐ Replacement<br>☐ Withdrawn | | |
| 02 | Renewal Questionnaire | DISC072007RQ 08 07 | ☒ New<br>☐ Replacement<br>☐ Withdrawn | | |
| 03 | | | ☐ New<br>☐ Replacement<br>☐ Withdrawn | | |
| 04 | | | ☐ New<br>☐ Replacement<br>☐ Withdrawn | | |
| 05 | | | ☐ New<br>☐ Replacement<br>☐ Withdrawn | | |
| 06 | | | ☐ New<br>☐ Replacement<br>☐ Withdrawn | | |
| 07 | | | ☐ New<br>☐ Replacement<br>☐ Withdrawn | | |
| 08 | | | ☐ New<br>☐ Replacement<br>☐ Withdrawn | | |
| 09 | | | ☐ New<br>☐ Replacement<br>☐ Withdrawn | | |
| 10 | | | ☐ New<br>☐ Replacement<br>☐ Withdrawn | | |

VANLINER
INSURANCE COMPANY

November 6, 2007

Commissioner Julie Benafield Bowman
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201

RE: Vanliner Insurance Company
NAIC: 000-21172
Federal Employer ID #86-0114294
Commercial Auto Non Trucking Application and Renewal Questionnaire
Form Number DISC072007AP 08 07/DISC072007RQ 08 07
Effective 12/1/07

Dear Ms. Bowman:

Vanliner Insurance Company is seeking approval of the enclosed Application and Renewal Questionnaire. Vanliner's goal is to obtain a generic form approved in all states.

Should you have any questions or require additional information, please call me at 800-325-3619 extension 4609 or email me at Tina_Kampwerth@Vanliner.com.

Sincerely,

Tina Kampwerth
Sr. Compliance Coordinator

Enc.

*Vanliner Insurance Company • One Premier Drive • St Louis, Missouri 63026*
*636-343-9889 • FAX 636-326-0403 • 800-325-3619*