

U.S. Risk, LLC | 14241 Dallas Parkway, Suite 850, Dallas, Texas 75254

HIRED AND NON-OWNED AUTO SUPPLEMENTAL APPLICATION FOR MISCELLANEOUS HEALTHCARE OPERATIONS

Submit with [Miscellaneous Healthcare General Liability and Professional Liability Application](#)

Each question must be fully answered. If not applicable, please enter "N/A."

GENERAL INFORMATION

1. Name of Applicant: _____
Address: _____
City: _____ State: _____ County: _____ ZIP: _____
2. Number of owned automobiles: _____
3. Do you have automobile liability coverage for your owned autos? Yes No
4. Is non-owned automobile liability covered under the owned auto policy? Yes No
5. Why is hired and non-ownership liability coverage being requested?

DESCRIPTION OF USE

Hired Automobile Coverage Section

1. Do any of your employees, agents, independent contractors or volunteers lease automobiles in your name? Yes No
If yes, please explain: _____
2. Types of automobiles hired: _____
3. What is the maximum passenger capacity of hired automobiles? _____
4. Are any hired automobiles leased? Yes No
What are the average terms of the lease? _____
5. Are the same automobiles leased or does it vary? Same automobiles Varies
If same, explain why the automobiles cannot be scheduled on the policy: _____
6. Do you provide drivers to operate hired automobiles? Yes No
If no, are the drivers required to provide a Certificate of Insurance? Yes No
What are the **minimum** liability limits required by the leasee (you)? _____
7. Is there a written lease agreement? Yes No
If yes, please attach a copy.
8. Will you be named as an additional insured on the lessor's policy? Yes No
9. Do you lease, hire, rent or borrow any auto(s) (other than private passenger type) owned or leased by your employees, partners or members of their households? Yes No
If yes, provide details and how many: _____
10. Do you own or control any subsidiary or are you affiliated with any other corporation? Yes No
If yes, what is the business or affiliate? _____



Non-Owned Automobile Coverage Section

1. How many employees, independent contractors or volunteers drive their personal automobiles in connection with your business? _____
How many of these are part-time? 15–45 hours per week: _____ Under 15 hours per week: _____
How will they be used?

If persons other than employees use their personal automobiles in connection with your business, please provide full description and number:

2. Do you require employees or others to provide transportation for patients/clients in their personal automobiles? Yes No
If yes, under what circumstances and how often?

3. What is the maximum distance which a non-owned auto may be driven from your premises? _____

4. Total number of employees, independent contractors or volunteers: _____

5. Total number of non-owned autos used in your business: _____

6. Do your employees lease automobiles on your behalf? Yes No

7. What is the estimated annual mileage for use on all non-owned automobiles? _____

8. Do you require employees or contracted personnel to have their own insurance? Yes No

If yes, what are the minimum limits required? _____

9. Do you require evidence of insurance? Yes No

10. Do you check MVRs annually? Yes No

11. Will you use non-owned automobiles other than those owned by your employees? Yes No

If yes, describe relationship:

12. Do you have volunteers at your operation? Yes No

If yes, indicate the total number of volunteers furnishing automobiles in your operation: _____

Maximum number of volunteers at any one time: _____

13. Do you have current non owned coverage? Yes No

If yes, who is the insurance carrier? _____

What are the current limits of liability? _____

CLAIMS HISTORY

1. During the past five (5) years, have any claims for hired or non-owned automobile liability been presented to your current or prior insurance carrier(s) or to you? Yes No

2. Are you, or any other person for whom insurance is being requested, aware of any fact(s), incident(s), act(s), event(s), circumstance(s) or occurrence(s) that may result in a claim(s) being made against you? Yes No

If yes, provide full details:

APPLICANT SIGNATURE PANEL

THE APPLICANT DECLARES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE INCEPTION DATE OF THE POLICY PERIOD, IT WILL IMMEDIATELY NOTIFY THE UNDERWRITERS OF SUCH CHANGE. SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERWRITERS TO OFFER, NOR THE APPLICANT TO ACCEPT, INSURANCE; BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE INSURANCE AND MADE A PART OF THE POLICY SHOULD A POLICY BE ISSUED.

Notice applicable in most states: 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 material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

I/We hereby declare that the above statements and particulars are true and I/we agree that this application shall be the basis of the contract with the insurance company.

Authorized signature

Date

Typed or printed name: _____

Title: _____