9487 Regency Square Blvd.
Jacksonville, FL 32225
Confidential Fax: (904) 805-1629

OWNER OPERATOR'S APPLICATION FOR LEASE

Applicant Name: _____ Date of Application _____
(print)

Terminal / Agent: _____

In compliance with Federal and State equal employment opportunity laws, qualified applicants are considered for all positions without regard to race, color, religion, sex, national origin, age, marital status, veteran status, non-job related disability or any other protected group status.

TO BE READ AND SIGNED BY APPLICANT

I authorize you to make such investigations and inquiries of my personal, employment, financial or medical history and other related matters as may be necessary in arriving at a lease decision. (Generally, inquiries regarding medical history will be made only if and after a conditional offer of lease has been extended.) I hereby release employers, schools, health care providers and other persons from all liability in responding to inquiries and releasing information in connection with my application.
In the event of lease, I understand that false or misleading information given in my application or interview(s) may result in termination of lease. I understand, also, that I am required to abide by all rules and regulations of Customized Trucking Services, Inc. and its agents.
I understand that information I provide regarding current and/or previous employers and/or leases may be used, and those employer(s) and/or agents will be contacted, for the purpose of investigating my safety performance history as required by 49 CFR 391.23(d) and (e). I understand that I have the right to:

- Review information provided by previous employers and/or agents;
- Have errors in the information corrected by previous employers/agents and for those previous employers/agents to re-send the corrected information to Customized Trucking Services, Inc.; and
- Have a rebuttal statement attached to the alleged erroneous information, if the previous employer(s)/agent(s) and I cannot agree on the accuracy of the information.

Signature _____ Date _____

FOR COMPANY USE

PROCESS RECORD

Applicant lease date _____

Applicant rejection date _____ Reason for rejection: _____

TERMINATION OF LEASE

Lease termination date _____ Eligible for re-lease? YES ☐ NO ☐

Terminated ☐ Resigned ☐ Laid Off ☐ Reason: _____

APPLICANT TO COMPLETE

(answer all questions – please print)

Name: _____
Last First Middle

Home Phone: _____ Social Security No.: _____

Cell Phone: _____ Email: _____

List your addresses of residency for the past 7 years.

Current Address: _____
Street City

_____ How long? _____
State Zip Code yr. / mo.

Previous Address: _____
Street City

_____ How long? _____
State Zip Code yr. / mo.

Previous Address: _____
Street City

_____ How long? _____
State Zip Code yr. / mo.

Do you have the right to work in the United States? YES ☐ NO ☐

Date of birth: ____/____/_____ Can you provide proof of age? YES ☐ NO ☐
(Required for Commercial Drivers)

Have you worked for this company before? YES ☐ NO ☐ Where? _____

Dates: From _____ To _____ Location: _____

Reason for leaving: _____

Who referred you? _____

Have you ever been bonded? YES ☐ NO ☐ Name of bonding company: _____

Is there any reason you might be unable to perform the functions of the job for which you are applying?
_____

If yes, explain if you wish. _____

Have you ever been convicted of a criminal offense (felony or misdemeanor)? YES ☐ NO ☐

If yes, please describe the crime - state nature of the crime(s), when and where convicted and disposition of the

Case: _____
(Note: No applicant will be denied a lease solely on the grounds of conviction of a criminal offense. The date of the offense, the nature of the offense, including any significant details that affect the description of the event, and the surrounding circumstances and the relevance of the offense to the position(s) applied for may, however, be considered.)

EMPLOYMENT HISTORY

All driver applicants to drive in interstate commerce must provide the following information on all employers during the preceding 10 years. List complete mailing address, street number, city, state and zip code.
(NOTE: List employers in reverse order starting with the most recent. Add another sheet as necessary.)

CURRENT EMPLOYER		DATE	
Name:		From Mo. Yr.	To Mo. Yr.
Address:		POSITION HELD	
City, State, Zip:		SALARY/WAGE	
Contact Person:	Phone:	REASON FOR LEAVING	
Were you subject to the FMCSRs† while employed? YES ☐ NO ☐			
Was your job designated as a safety-sensitive function in any DOT-regulated mode subject to the drug and alcohol testing requirements of 49 CFR Part 40? YES ☐ NO ☐			
May we contact your current employer? YES ☐ NO ☐			

PREVIOUS EMPLOYER		DATE	
Name:		From Mo. Yr.	To Mo. Yr.
Address:		POSITION HELD	
City, State, Zip:		SALARY/WAGE	
Contact Person:	Phone:	REASON FOR LEAVING	
Were you subject to the FMCSRs† while employed? YES ☐ NO ☐			
Was your job designated as a safety-sensitive function in any DOT-regulated mode subject to the drug and alcohol testing requirements of 49 CFR Part 40? YES ☐ NO ☐			

PREVIOUS EMPLOYER		DATE	
Name:		From Mo. Yr.	To Mo. Yr.
Address:		POSITION HELD	
City, State, Zip:		SALARY/WAGE	
Contact Person:	Phone:	REASON FOR LEAVING	
Were you subject to the FMCSRs† while employed? YES ☐ NO ☐			
Was your job designated as a safety-sensitive function in any DOT-regulated mode subject to the drug and alcohol testing requirements of 49 CFR Part 40? YES ☐ NO ☐			

PREVIOUS EMPLOYER		DATE	
Name:		From Mo. Yr.	To Mo. Yr.
Address:		POSITION HELD	
City, State, Zip:		SALARY/WAGE	
Contact Person:	Phone:	REASON FOR LEAVING	
Were you subject to the FMCSRs† while employed? YES ☐ NO ☐			
Was your job designated as a safety-sensitive function in any DOT-regulated mode subject to the drug and alcohol testing requirements of 49 CFR Part 40? YES ☐ NO ☐			

PREVIOUS EMPLOYER		DATE	
Name:		From Mo. Yr.	To Mo. Yr.
Address:		POSITION HELD	
City, State, Zip:		SALARY/WAGE	
Contact Person:	Phone:	REASON FOR LEAVING	

Were you subject to the FMCSRs† while employed? YES ☐ NO ☐

Was your job designated as a safety-sensitive function in any DOT-regulated mode subject to the drug and alcohol testing requirements of 49 CFR Part 40? YES ☐ NO ☐

PREVIOUS EMPLOYER		DATE	
Name:		From Mo. Yr.	To Mo. Yr.
Address:		POSITION HELD	
City, State, Zip:		SALARY/WAGE	
Contact Person:	Phone:	REASON FOR LEAVING	

Were you subject to the FMCSRs† while employed? YES ☐ NO ☐

Was your job designated as a safety-sensitive function in any DOT-regulated mode subject to the drug and alcohol testing requirements of 49 CFR Part 40? YES ☐ NO ☐

PREVIOUS EMPLOYER		DATE	
Name:		From Mo. Yr.	To Mo. Yr.
Address:		POSITION HELD	
City, State, Zip:		SALARY/WAGE	
Contact Person:	Phone:	REASON FOR LEAVING	

Were you subject to the FMCSRs† while employed? YES ☐ NO ☐

Was your job designated as a safety-sensitive function in any DOT-regulated mode subject to the drug and alcohol testing requirements of 49 CFR Part 40? YES ☐ NO ☐

PREVIOUS EMPLOYER		DATE	
Name:		From Mo. Yr.	To Mo. Yr.
Address:		POSITION HELD	
City, State, Zip:		SALARY/WAGE	
Contact Person:	Phone:	REASON FOR LEAVING	

Were you subject to the FMCSRs† while employed? YES ☐ NO ☐

Was your job designated as a safety-sensitive function in any DOT-regulated mode subject to the drug and alcohol testing requirements of 49 CFR Part 40? YES ☐ NO ☐

† The Federal Motor Carrier Safety Regulations (FMCSRs) apply to anyone operating a motor vehicle on a highway in interstate commerce to transport passengers or property when the vehicle: (1) weighs or has a GVWR of 10,001 pounds or more, (2) is designed or used to transport more than 8 passengers (including the driver), OR (3) is of any size and is used to transport hazardous materials in a quantity requiring placarding.

ACCIDENT RECORD for the past 3 years or more (attach sheet if more space is needed). If none, write **NONE**.

DATES	NATURE OF ACCIDENT (HEAD-ON, REAR-END, UPSET, ETC.)	FATALITIES	INJURIES	HAZARDOUS MATERIAL SPILL
LAST ACCIDENT				
NEXT PREVIOUS				
NEXT PREVIOUS				

TRAFFIC CONVICTIONS and forfeitures for the past 3 years (other than parking violations). If none, write **NONE**.

LOCATION	DATE	CHARGE	PENALTY

(ATTACH SHEET IF MORE SPACE IS NEEDED)

EXPERIENCE AND QUALIFICATIONS – DRIVER

	STATE	LICENSE NO.	CLASS	ENDORSEMENT(S)	EXPIRATION DATE
Driver licenses or permits held in the past 3 years					

A. Have you ever been denied a license, permit or privilege to operate a motor vehicle? YES ☐ NO ☐

B. Has any license, permit or privilege ever been suspended or revoked? YES ☐ NO ☐

If the answer to either A or B is yes, give details: _____

_____

DRIVING EXPERIENCE Check Yes or No

Class of Equipment				Circle Type of Equipment	Dates From (M/Y)	Dates To (M/Y)	Approx. No. of Miles (Total)
Straight Truck	YES ☐	NO ☐		(Van, Tank, Flat, Dump, Refer)			
Tractor & Semi-Trailer	YES ☐	NO ☐		(Van, Tank, Flat, Dump, Refer)			
Tractor – Two Trailers	YES ☐	NO ☐		(Van, Tank, Flat, Dump, Refer)			
Tractor – Three Trailers	YES ☐	NO ☐		(Van, Tank, Flat, Dump, Refer)			
Motorcoach – School Bus	YES ☐	NO ☐	More than 8 passengers				
Motorcoach – School Bus	YES ☐	NO ☐	More than 15 passengers				
Other							

List states operated in for past 5 years: _____

TO BE READ AND SIGNED BY APPLICANT

This certifies that this application was completed by me, and that all entries on it and information in it are true and complete to the best of my knowledge.

Signature: _____ Date: _____

SAFETY PERFORMACE HISTORY RECORDS REQUEST

The individual identified below has indicated that you employ(ed) him/her within the past 3 years in a position that involved the operation of a commercial motor vehicle that was subject to DOT regulated drug and alcohol testing.

In accordance with 49 CFR §§40.25 and 391.23, we are hereby requesting that you supply us with the Safety Performance History of this individual. **Under DOT rule §391.23(g), you *must* respond to this inquiry within 30 days of receipt.**

I, (Print Name) _____ _____
First, M.I., Last — Social Security Number

hereby authorize:

_____
Date of Birth

Previous Employer: _____

Street: _____ _____
Phone

City, State, Zip: _____ _____
Fax

to release and forward the information requested concerning my Alcohol and Controlled Substance Testing records within the previous 3 years from ____/____/_____.

To: **CUSTOMIZED TRUCKING SERVICES, INC.** **DOT# 1938017** **MC# 391357**
Attention: **Qualifications** **Phone: (904) 727-4151**
9487 Regency Square Blvd.
Jacksonville, FL 32225

In compliance with §40.25(g) and 391.23(h), release of this information must be made in a written form that ensures confidentiality, such as fax, email or letter.

Confidential fax number: **(904) 805-1629**

Confidential email address: **CustomizedTrucking@customizedtrucking.com**

_____ _____
Applicant's Signature — Date

EMPLOYMENT VERIFICATION

The applicant named above was or is employed by us. YES ☐ NO ☐

Employed as (job title) _____ from (m/y) _____ to (m/y) _____

D he/she drive a motor vehicle for you? YES ☐ NO ☐ If so, what type? Straight Truck ☐ Bus ☐

Tractor/Trailer ☐ Cargo Tank ☐ Doubles/Triples ☐ Other (specify) _____

Eligible for rehire? YES ☐ NO ☐

Reason for leaving your employ: Discharged ☐ Laid Off ☐ Resigned ☐

	Excellent	Good	Fair	Poor	Very Poor
Quality of work	☐	☐	☐	☐	☐
Cooperation with others	☐	☐	☐	☐	☐
Safety habits	☐	☐	☐	☐	☐
Personal habits	☐	☐	☐	☐	☐
Driving skill	☐	☐	☐	☐	☐
Attitude	☐	☐	☐	☐	☐

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

►START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.
ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	Zip Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	E-mail Address	Telephone Number
	___ - ___ - ___		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents In connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

☐ A citizen of the United States

☐ A noncitizen national of the United States *(See instructions)*

☐ A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) _____. Some aliens may write "N/A" in this field. *(See instructions)*

*For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:*

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (*See instructions*)

3-D Barcode
Do Not Write in This Space

Signature of Employee:	Date *(mm/dd/yyyy):*

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.)*

I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator:		Date *(mm/dd/yyyy):*
Last Name *(Family Name)*	First Name *(Given Name)*	

Address *(Street Number and Name)*	City or Town	State	Zip Code

STOP ***Employer Completes Next Page*** STOP

OneBeacon America Insurance Company

Canton, Massachusetts

DRIVER ENROLLMENT AND BENEFICIARY FORM

TRUCKERS OCCUPATIONAL ACCIDENT INSURANCE

CUSTOMIZED TRUCKING SERVICES, INC. 216-001-014

Please print:

Name: _____ Male: _____ Female:_____

Street Address: _____ City: _____ State: _____ Zip: _____

Social Security Number: _____ Date of Birth: _____ E-Mail Address:_____

Home Telephone Number: _____Cell Telephone Number: _____

Name of Beneficiary:_____ Relationship of Beneficiary: _____

CDL Number:_____ Number of Years Experience: _____

Contracted by (Name of Company): __**Customized Trucking Services**_____ Effective Date of Contract: _____

Street Address: _**9487 Regency Square Blvd.**_____ ___ City: _**Jacksonville** _____ State: _**FL**_____ Zip: _**32225**_____

Motor Carrier Telephone Number: _____ Fax Number: _____

Motor Carrier E-Mail Address: _____

FRAUD STATEMENT

Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or a 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 will also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

In providing this information, I, the undersigned, understand and hereby state that:

1. to the best of my knowledge and belief, all information on this Form is complete and truthful;
2. this coverage being is not a contract for Statutory Workers' Compensation Insurance, and neither I nor my carrier become participants in the Workers' Compensation system by purchasing this insurance; and
3. if, based on the information supplied in this Form, I am not eligible for coverage, premium will be refunded and no claims will be payable.

By my signature below, I, the undersigned, also authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or any other organization, institution or person that has any records, including any medical records, to furnish such information or copies of records to OneBeacon America Insurance Company, the motor carrier or the motor carrier's designee. A photographic copy of this authorization shall be as valid as the original.

IF THE INFORMATION PROVIDED IN THIS FORM IS FRAUDULENT,
THE INSURER HAS THE RIGHT TO RETURN PREMIUM AND CANCEL COVERAGE.

In order to verify the information provided in this Form, I, the undersigned, give the Insurer authority to examine the records that are maintained by the motor carrier.

I certify that I am an independent contractor, paid by a 1099 tax form, not as a W-2 employee.

Driver's Signature: _____ Date: _____

Motor Carrier Representative's Signature: _____

Payment Authorization: I authorize the above named motor carrier, with whom I have a contract, to take monthly deductions, equal to my premiums, from my settlement account on my behalf, and to remit these funds to OneBeacon America Insurance Company.

I UNDERSTAND THAT THE COST OF THE INSURANCE IS MY SOLE OBLIGATION AND RESPONSIBILITY, regardless of the above arrangement of premium payment. I agree that I will forward any amount due and owing to OneBeacon America Insurance Company, upon demand, for any insurance at any time my account remains unpaid.

Signature: _____ Date:_____

FAIR CREDIT REPORTING ACT DISCLOSURE STATEMENT

In accordance with the provisions of Section 604(b)(2)(A) of the Fair Credit Reporting Act, Public Law 91-508, as amended by the Consumer Credit Reporting Act of 1996 (Title II, Subtitle D, Chapter I, of Public Law 104-208), you are being informed that reports verifying your previous employment, previous drug and alcohol test results, and your driving record may be obtained on you for owner operator lease purposes. These reports are required by Sections 382.413, 391.23, and 391.25 of the Federal Motor Carrier Safety Regulations.

_____ _____

Applicant's Signature Date

_____

Print Name

Para información en español, visite www.consumerfinance.gov/learnmore o escribe a la Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.

A Summary of Your Rights Under the Fair Credit Reporting Act

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. **For more information, including information about additional rights, go to www.consumerfinance.gov/learnmore or write to: Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.**

• **You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.

• **You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a consumer reporting agency (your "file disclosure"). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:

- a person has taken adverse action against you because of information in your credit report;
- you are the victim of identify theft and place a fraud alert in your file;
- your file contains inaccurate information as a result of fraud;
- you are on public assistance;
- you are unemployed but expect to apply for employment within 60 days.

In addition, all consumers are entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See www.consumerfinance.gov/learnmore for additional information.

• **You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.

• **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See www.consumerfinance.gov/learnmore for an explanation of dispute procedures.

• **Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information.** Inaccurate, incomplete or unverifiable information must be removed

or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.

• **Consumer reporting agencies may not report outdated negative information.** In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.

• **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need – usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.

• **You must give your consent for reports to be provided to employers.** A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.consumerfinance.gov/learnmore.

• **You may limit "prescreened" offers of credit and insurance you get based on information in your credit report.** Unsolicited "prescreened" offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt-out with the nationwide credit bureaus at 1-888-567-8688.

• **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.

• **Identity theft victims and active duty military personnel have additional rights.** For more information, visit www.consumerfinance.gov/learnmore.

States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. For information about your federal rights, contact:

TYPE OF BUSINESS:	CONTACT:
1.a. Banks, savings associations, and credit unions with total assets of over $10 billion and their affiliates.	a. Consumer Financial Protection Bureau 1700 G Street NW Washington, DC 20552
b. Such affiliates that are not banks, savings associations, or credit unions also should list, in addition to the CFPB:	b. Federal Trade Commission: Consumer Response Center – FCRA Washington, DC 20580 (877) 382-4357
2. To the extent not included in item 1 above:	a. Office of the Comptroller of the Currency Customer Assistance Group 1301 McKinney Street, Suite 3450 Houston, TX 77010-9050
a. National banks, federal savings associations, and federal branches and federal agencies of foreign banks	
b. State member banks, branches and agencies of foreign banks (other than federal branches, federal agencies, and Insured State Branches of Foreign Banks), commercial lending companies owned or controlled by foreign banks, and organizations operating under section 25 or 25A of the Federal Reserve Act	b. Federal Reserve Consumer Help Center P.O. Box 1200 Minneapolis, MN 55480
c. Nonmember Insured Banks, Insured State Branches of Foreign Banks, and insured state savings associations	c. FDIC Consumer Response Center 1100 Walnut Street, Box #11 Kansas City, MO 64106
d. Federal Credit Unions	d. National Credit Union Administration Office of Consumer Protection (OCP) Division of Consumer Compliance and Outreach (DCCO) 1775 Duke Street Alexandria, VA 22314
3. Air carriers	Asst. General Counsel for Aviation Enforcement & Proceedings Aviation Consumer Protection Division Department of Transportation 1200 New Jersey Avenue, SE Washington, DC 20590
4. Creditors Subject to Surface Transportation Board	Office of Proceedings, Surface Transportation Board Department of Transportation 395 E Street S.W. Washington, DC 20423
5. Creditors Subject to Packers and Stockyards Act, 1921	Nearest Packers and Stockyards Administration area supervisor
6. Small Business Investment Companies	Associate Deputy Administrator for Capital Access United States Small Business Administration 409 Third Street, SW, 8th Floor Washington, DC 20416
7. Brokers and Dealers	Securities and Exchange Commission 100 F St NE Washington, DC 20549
8. Federal Land Banks, Federal Land Bank Associations, Federal Intermediate Credit Banks, and Production Credit Associations	Farm Credit Administration 1501 Farm Credit Drive McLean, VA 22102-5090
9. Retailers, Finance Companies, and All Other Creditors Not Listed Above	FTC Regional Office for region in which the creditor operates or Federal Trade Commission: Consumer Response Center – FCRA Washington, DC 20580 (877) 382-4357

REQUEST FOR CHECK OF DRIVING RECORD

I hereby authorize you to release the following information to **Customized Trucking Services, Inc**. for purposes of investigation as required by Sections 391.23 and 391.25 of the Federal Motor Carrier Safety Regulations. You are released from any and all liability which may result from furnishing such information.

_____ _____

(Applicant's signature) (Date)

In accordance with the provisions of Sections 604 and 607 of the Fair Credit Reporting Act, Public Law 91-508, as amended by the Consumer Credit Reporting Act of 1996 (Title II, Subtitle D, Chapter 1, of Public Law 104-208), I hereby certify the following:

1. The consumer (applicant) has authorized in writing the procurement of this report;
2. The consumer (applicant) has been informed in a separate written disclosure that a consumer report may be obtained for lease purposes;
3. The information requested below will be used for a "permissible purpose" (i.e., information for lease purposes) and will be used for no other purpose;
4. The information being obtained will not be used in violation of any federal or state equal opportunity law or regulation; and
5. Before taking any adverse action based in whole or in part on the report the consumer (applicant) will receive a copy of the requested report and the summary of consumer rights as provided with the report by the consumer reporting agency.

I also hereby certify that this report request and the above applicant's release notice meet the definition of "permissible uses" of state motor vehicle records under the provisions of the **Driver's Privacy Protection Act of 1994** (Public Law 103-322, Title XXX, Section 300002(a)).

_____ _____

(Signature of Requestor) (Date)

Dear sir/madam:

The following named person has made application with our company for the position of **OWNER OPERATOR**. In accordance with Section 391.23, Federal Department of Transportation Regulations, please furnish the undersigned with the applicant's driving record for the past three years.

Name: _____
Last First Middle

Current Address: _____
Street City

_____ How long? _____
State Zip Code yr. / mo.

Previous Address: _____
Street City

_____ How long? _____
State Zip Code yr. / mo.

Date of Birth: _____ SSN: _____ License No.: _____

Requested By: **Customized Trucking Services, Inc.**
9487 Regency Square Blvd.
Jacksonville, FL 32225
PH: (904) 727-4151
FAX: (904) 805-1629

HireRight
DAC Trucking

HireRight Customer:

Company Name: CUSTOMIZED TRUCKING SERVICES, INC.

Company Contact Name: Lori Connors

Fax #: (904) 805 - 1629

HireRight Account Code: CTRUCK

TRUCKING INDUSTRY:
DOT D/A Disclosure and Authorization

Send to Fax# (800) 257-8069

PART I – DISCLOSURE AND AUTHORIZATION FOR RELEASE OF INFORMATION FOR EMPLOYMENT PURPOSES – 49 CFR PART 391.23, DOT DRUG AND ALCOHOL TESTING

In accordance with DOT Regulation 49 CFR Part 391.23, I hereby authorize release of my DOT-regulated drug and alcohol testing records by the DOT-regulated employer(s) listed below to HireRight for the purpose of HireRight transmitting such records to the HireRight customer listed above. I understand that information/documents released pursuant to this Part I is limited to the following DOT-regulated testing items, including pre-employment testing results, occurring during the previous **three (3) years**: (i) alcohol tests with a result of 0.04 or higher; (ii) verified positive drug tests; (iii) refusals to be tested (including adulterated and/or substituted tests); (iv) other violations of DOT drug and alcohol testing regulations (i.e., violations of 49 CFR 382 Subpart B); (v) information obtained from previous employers of a drug and alcohol rule violation; and (vi) any documentation of completion of the return-to-duty process following a rule violation.

If any company listed below furnishes HireRight with information concerning items (i) through (vi) above, I also authorize such company to furnish the following information to HireRight, if applicable: (i) dates of my negative drug and/or alcohol tests and/or tests with results below 0.04 during the previous **three (3) years**; and (ii) the name and phone number of any substance abuse professional who evaluated me during the previous **three (3) years**.

List all DOT-regulated employers you have applied with and/or worked for in a safety-sensitive function during the previous **three (3) years**. If necessary, attach additional pages, including the date, your name, social security number and signature.

Previous DOT-Regulated Employer	City	State	Phone Number
			( ) -
			( ) -
			( ) -
			( ) -
			( ) -
			( ) -

By signing below, I certify that: (i) all information provided herein is complete and accurate; (ii) I have read and fully understand this Part I disclosure and authorization for release as well as the attached FMCSA Notification of Driver Rights and any applicable state law notices; (iii) prior to signing I was given an opportunity to ask questions and to have those questions answered to my satisfaction; (iv) I execute this authorization voluntarily and with the knowledge that the information obtained pursuant to this authorization could affect my eligibility for employment, promotion, retention or other lawful purpose; (v) I understand I may review this document with legal counsel prior to signing; and (vi) facsimile or photographic copies of this authorization are as valid as an original.

Print Applicant Name: _____ Social Security #: _____

Applicant Signature: _____ Date: _____

Part 2 - FMCSA Notification of Driver Rights

In compliance with 49 CFR Part 40 §391.23 you have certain rights regarding the safety performance history information that will be provided to prospective employers. I) You have the right to review information provided by previous employers. II) You have the right to have errors in the information corrected by the previous employer and for that previous employer to re-send the corrected information to prospective employers. III) You have the right to have a rebuttal statement attached to the alleged erroneous information, if the previous employer and the driver cannot agree on the accuracy of the information. (2) Drivers who have previous DOT regulated employment history in the preceding three years and wish to review previous employer-provided investigative information must submit a written request to prospective employers. This may be done at any time, including when applying, or as late as 30 days after being employed or being notified of denial of employment. Prospective employers must provide this information within five business days of receiving the written request. If prospective employers have not yet received the requested information from the previous employer, then the five day deadline will begin when the requested safety performance history information is received. If you have not arranged to pick up or receive the requested records within 30 days of prospective employers making them available, the prospective employers may consider you to have waived your request to review the record.

MOTOR VEHICLE DRIVER'S
Certification of Violations/Annual Review of Driving Record

MOTOR CARRIER INSTRUCTIONS: Each motor carriers shall at lease once every 12 months, require each driver it leases to prepare and furnish it with a list of all violations of motor vehicle traffic laws and ordinances (other than violations involving only parking) of which the driver has been convicted, or on account of which he/she has forfeited bond or collateral during the preceding 12 months (Section 391.27). Drivers who have provided information required by Section 383.31 need not repeat that information on this form.

DRIVER REQUIREMENTS: Each driver shall furnish the list as required by the motor carrier above. If the driver has not been convicted of, or forfeited bond or collateral on account of any violation which must be listed, he/she shall so certify (Section 391.27).

COMPLETED BY DRIVER – CERTIFICATION OF VIOLATIONS

NAME OF DRIVER: (PRINT)	DRIVER CODE		DATE OF LEASE
HOME TERMINAL	CDL #	STATE	EXPIRATION DATE

I certify that the following is a true and complete list of traffic violations required to be listed (other than those I have provided under Part 383) for which I have been convicted or forfeited bond or collateral during the past 12 months.

(If you have had no violations, check the following box - ☐ None.)

DATE	OFFENSE	LOCATION	TYPE OF VEHICLE OPERATED

If NO violations are listed above, I certify that I have not been convicted or forfeited bond or collateral on account of any violation (other than those I have provided under Part 383) required to be listed during the past 12 months.

Date _____ Driver's Signature _____

COMPLETED BY MOTOR CARRIER – ANNUAL REVIEW OF DRIVING RECORD

MOTOR CARRIER INSTRUCTIONS: Review the Certification of violations listed above and other information described in Section 391.25 of the Federal Motor Carrier Safety Regulations. Complete the information requested below:

I have hereby review the driving record of the above named driver in accordance with Section 391.25 and find that he/she (check one):

☐ Meets minimum requirements for safe driving ☐ Is disqualified to drive a motor vehicle pursuant to Section 391.15

☐ Does not adequately meet satisfactory safe driving performance

Action taken with driver: _____

_____

Reviewed By: _____ _____
Signature Date

_____ _____
Printed Name Title

9487 Regency Square Blvd.
Jacksonville, FL 32225

PREVIOUS PRE-EMPLOYMENT EMPLOYEE ALCOHOL AND DRUG TEST STATEMENT

Sec. 40.25(j) As the employer, you must also ask the employee whether he or she has tested positive, or refused to test, on any pre-employment drug or alcohol test administered by an employer to which the employee applied for, but did not obtain, safety-sensitive transportation work cover by DOT agency drug and alcohol testing rules during the past two years. If the employee admits that he or she had a positive test or a refusal to test, you must not use the employee to perform safety-sensitive functions for you, until and unless the employee documents the successful completion of the return-to-duty process. (see Sec. 40.25(b)(5) and (e))

Prospective Owner Operator/Driver Name: _____
(Print)

The prospective owner operator/driver is required by Sec. 40.25(j) to respond to the following questions.

1. Have you tested positive, or refused to test, on any pre-employment drug or alcohol test administered by an employer to which you applied for, but did not obtain, safety-sensitive transportation work covered by DOT agency drug and alcohol testing rules during the past two years?

   Check one: ☐ Yes ☐ No

2. If you answered yes, can you provide/obtain proof that you've successfully completed the DOT return-to-duty requirements?

   Check one: ☐ Yes ☐ No

I certify that the information provided on this document is true and correct.

Prospective Owner Operator/Driver Signature: _____

Witnessed By: _____ Date: _____

Alcohol And Drug Employee's Certified Receipt

Owner Operator's Name

Customized Trucking Services, Inc.

Company/Department

This is to certify that I have been provided educational materials required by §382.601 and my employer's policies and procedures with respect to meeting the Part 382 requirements. The materials include detailed discussion of the following checked (✓) items:

_____ 1. The designated person to answer questions about the materials.

_____ 2. The categories of drivers subject to Part 382.

_____ 3. The safety-sensitive functions and periods of the workday for which compliance is required.

_____ 4. Specific information concerning prohibited driver conduct.

_____ 5. Circumstances under which a driver will be tested.

_____ 6. Test procedures, driver protection and integrity of the testing processes, and safeguarding the validity of the test.

_____ 7. The requirement that drivers submit to tests administered in accordance with Part 382.

_____ 8. An explanation of what will be considered a refusal to submit to a test and the consequences.

_____ 9. The consequences for Part 382, Subpart B violations, including removal from safety-sensitive functions, and Part 40, Subpart O procedures.

_____ 10. The consequences for drivers found to have an alcohol concentration of 0.02 or greater but less than 0.04.

_____ 11. Information on:

- the effects of alcohol and controlled substances use on an individual's health, work or personal life
- signs and symptoms of a problem
- available methods of intervening when a problem is suspected (confrontation, referral, etc.)

_____ 12. Optional information:

_____

_____

_____

_____

_____ _____

Owner Operator's Signature Date

_____ _____

Authorized Carrier Representative Date

ORIGINAL - RETAIN IN EMPLOYEE'S CONFIDENTIAL FILE

872-FS-C2 6793
(Rev. 2/07)

THE BELOW DISCLOSURE AND AUTHORIZATION LANGUAGE IS FOR MANDATORY USE BY ALL ACCOUNT HOLDERS

IMPORTANT DISCLOSURE
REGARDING BACKGROUND REPORTS FROM THE *PSP Online Service*

In connection with your application for employment with _____("Prospective Employer"), Prospective Employer, its employees, agents or contractors may obtain one or more reports regarding your driving, and safety inspection history from the Federal Motor Carrier Safety Administration (FMCSA).

When the application for employment is submitted in person, if the Prospective Employer uses any information it obtains from FMCSA in a decision to not hire you or to make any other adverse employment decision regarding you, the Prospective Employer will provide you with a copy of the report upon which its decision was based and a written summary of your rights under the Fair Credit Reporting Act before taking any final adverse action. If any final adverse action is taken against you based upon your driving history or safety report, the Prospective Employer will notify you that the action has been taken and that the action was based in part or in whole on this report.

When the application for employment is submitted by mail, telephone, computer, or other similar means, if the Prospective Employer uses any information it obtains from FMCSA in a decision to not hire you or to make any other adverse employment decision regarding you, the Prospective Employer must provide you within three business days of taking adverse action oral, written or electronic notification: that adverse action has been taken based in whole or in part on information obtained from FMCSA; the name, address, and the toll free telephone number of FMCSA; that the FMCSA did not make the decision to take the adverse action and is unable to provide you the specific reasons why the adverse action was taken; and that you may, upon providing proper identification, request a free copy of the report and may dispute with the FMCSA the accuracy or completeness of any information or report. If you request a copy of a driver record from the Prospective Employer who procured the report, then, within 3 business days of receiving your request, together with proper identification, the Prospective Employer must send or provide to you a copy of your report and a summary of your rights under the Fair Credit Reporting Act.

Neither the Prospective Employer nor the FMCSA contractor supplying the crash and safety information has the capability to correct any safety data that appears to be incorrect. You may challenge the accuracy of the data by submitting a request to https://dataqs.fmcsa.dot.gov. If you challenge crash or inspection information reported by a State, FMCSA cannot change or correct this data. Your request will be forwarded by the DataQs system to the appropriate State for adjudication.

Any crash or inspection in which you were involved will display on your PSP report. Since the PSP report does not report, or assign, or imply fault, it will include all Commercial Motor Vehicle (CMV) crashes where you were a driver or co-driver and where those crashes were reported to FMCSA, regardless of fault. Similarly, all inspections, with or without violations, appear on the PSP report. State citations associated with Federal Motor Carrier Safety Regulations (FMCSR) violations that have been adjudicated by a court of law will also appear, and remain, on a PSP report.

The Prospective Employer cannot obtain background reports from FMCSA without your authorization.

AUTHORIZATION

If you agree that the Prospective Employer may obtain such background reports, please read the following and sign below:

I authorize _____ ("Prospective Employer") to access the FMCSA Pre-Employment Screening Program (PSP) system to seek information regarding my commercial driving safety record and information regarding my safety inspection history. I understand that I am authorizing the release of safety performance information including crash data from the previous five (5) years and inspection history from the previous three (3) years. I understand and acknowledge that this release of information may assist the Prospective Employer to make a determination regarding my suitability as an employee.

I further understand that neither the Prospective Employer nor the FMCSA contractor supplying the crash and safety information has the capability to correct any safety data that appears to be incorrect. I understand I may challenge the accuracy of the data by submitting a request to https://dataqs.fmcsa.dot.gov. If I challenge crash or inspection information reported by a State, FMCSA cannot change or correct this data. I understand my request will be forwarded by the DataQs system to the appropriate State for adjudication.

I understand that any crash or inspection in which I was involved will display on my PSP report. Since the PSP report does not report, or assign, or imply fault, I acknowledge it will include all CMV crashes where I was a driver or co-driver and where those crashes were reported to FMCSA, regardless of fault. Similarly, I understand all inspections, with or without violations, will appear

on my PSP report, and State citations associated with FMCSR violations that have been adjudicated by a court of law will also appear, and remain, on my PSP report. I have read the above Disclosure Regarding Background Reports provided to me by Prospective Employer and I understand that if I sign this Disclosure and Authorization, Prospective Employer may obtain a report of my crash and inspection history. I hereby authorize Prospective Employer and its employees, authorized agents, and/or affiliates to obtain the information authorized above.

Date: _____ _____

Signature

_____

Name (Please Print)

NOTICE: This form is made available to monthly account holders by NIC on behalf of the U.S. Department of Transportation, Federal Motor Carrier Safety Administration (FMCSA). Account holders are required by federal law to obtain an Applicant's written or electronic consent prior to accessing the Applicant's PSP report. Further, account holders are required by FMCSA to use the language contained in this Disclosure and Authorization form to obtain an Applicant's consent. The language must be used in whole, exactly as provided. Further, the language on this form must exist as one stand-alone document. The language may NOT be included with other consent forms or any other language.

LAST UPDATED 12/22/2015

Direct Deposit Sign-up/Authorization Form

- When completing new Banking/Financial information:
  - For checking, attach a personal check to the form and print "void" across the face of the check.
  - For savings, attach a deposit slip and print "void" across the face of the deposit slip.
- Make sure this form is completely filled out and a check or deposit slip is attached, *incomplete forms will be rejected* and may cause delays in receiving funds via the direct deposit process.

Name: _____

Driver Code: _____

Phone number: _____

E-mail address: _____

Name of Bank: _____

Branch Name (if applicable): _____

Address of Bank: _____

Account Number: _____ **Account Type:** _____

Routing number (ABA) – Please obtain this from Bank: _____

Authorization Date: _____

Authorization signature of Account Holder: _____

Maintenance Escrow Authorization

Driver Name: _____

Owner Name: _____

Unit Number: _____

_____ I DO NOT wish to have Customized Trucking Services, Inc. deduct funds from my settlement for the “maintenance escrow” account.

_____ I hereby authorize Customized Trucking Services, Inc. to deduct $50.00 per week from my settlement to be placed into a “maintenance escrow” account on my behalf. The limit for the maintenance account will be $2,000.00. Any contractor, who participates in this program, may withdraw any amount up to the total balance of the account at the time of the withdrawal.

_____ _____

Print Date

_____

Signature

CTSI 2-25-13

Overweight Permits Deduction Authorization

Driver Name: _____

Owner Name: _____

Unit Number: _____

☐ I DO NOT wish to have Customized Trucking Services, Inc. to order or obtain any oversize permits on my behalf.

☐ I hereby authorize Customized Trucking Services, Inc. to order the permits checked below on my behalf. In addition, by my signature, I authorize Customized Trucking Services, Inc. to deduct the total cost of said permit (s) plus an administrative fee of 15% from my settlement in the amount of $50.00 per week until deducted in full.***

☐ FL
☐ AL
☐ SC
☐ GA
☐ NC
☐ Other _____

_____ _____

Print Date

_____

Signature

*** Please note if your lease agreement is canceled by either party, prior to full collection of the various permits ordered on your behalf, Customized Trucking Services, Inc. will collect all remaining balances from your settlement in full.

IFTA Permit Deduction Authorization

Driver Name: _____

Owner Name: _____

Unit Number: _____

☐ I DO NOT wish to have Customized Trucking Services, Inc. order or obtain an IFTA on my behalf due to the fact that I: *(Circle One)*

Have my Own IFTA *(Please Provide Copy)* Am a Florida Only Driver

☐ I herby authorize Customized Trucking Services, Inc. to order an IFTA permit on my behalf. In addition, by my signature, I authorize Customized Trucking Services, Inc. to deduct $ **0.01** per mile from my weekly settlement.

_____ _____

Print Date

_____

Signature

Form **W-9**
(Rev. January 2011)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification (required): ☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶

☐ Other (see instructions) ▶

☐ Exempt payee

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

			–		–				

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here **Signature of U.S. person ▶** **Date ▶**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

INDEPENDENT CONTRACTOR NON-TRUCKING LIABILITY ENROLLMENT FORM

Gallagher Transportation Services
Arthur J. Gallagher Risk Management Services, Inc.
2345 Grand Boulevard Suite 400
Kansas City, Missouri 64108

As an Independent Contractor, you can voluntarily elect to participate in the Bobtail/Non-Trucking Insurance Program developed by Gallagher Transportation Services ("Gallagher") for Independent Contractors. Coverage includes liability insurance while Bobtailing or Non-Trucking (which means in a non business mode) designed for Independent Contractors. By providing the information requested below and submitting it to Gallagher, coverage will become effective upon acceptance by Gallagher. Notification of acceptance will be mailed to the mailing address shown on this enrollment form.

Tractor/Power unit to be insured

_____ _____
Year & Make Unit Number

_____
Serial Number

Independent Contractor Information:

Name: _____
Street: _____
City/State/Zip: _____
Telephone: _____

Motor Carrier (Facilitating Motor Carrier):

Customized Trucking Services, Inc.

Effective Date Requested:

Effective Date: _____

THE FOLLOWING TERMS AND CONDITIONS WILL APPLY TO THE BOBTAIL/NON-TRUCKING LIABILITY COVERAGE PROVIDED TO THE INDEPENDENT CONTRACTORS OF SPONSORING MOTOR CARRIERS

Effective Date: Coverage will become effective on the date your Enrollment Form is accepted by Gallagher.

Termination: In the event your independent contractor operating agreement with the facilitating motor carrier is terminated, settlement deduction will automatically cease and your coverage will automatically terminate within the terms and conditions of the policy or as soon as allowed by law. When this happens, you should make arrangements to replace your Non-Trucking Liability insurance coverage immediately.

If you wish to voluntarily cancel coverage, written notification must be given to the insurance underwriter of your intent. Such written notification may be given to the Gallagher Administrative Office.

The insurance underwriter retains the right to cancel the insurance coverage in accordance with policy terms and conditions. You will be given a minimum of 15 days notice of cancellation.

Policy Terms and Conditions: You will receive from Gallagher a certificate of insurance. A copy of the certificate will become an Addendum to your independent contractor operating agreement with the facilitating motor carrier for purposes of cost disclosure. Please review the certificate carefully to be certain that it is correct. A copy of the policy is available upon written request to the facilitating motor carrier and/or Gallagher during normal business hours.

Cost and Consent to Rate: You accept and acknowledge that your insurance cost, as explained more fully in this Enrollment Form, may include premium, taxes, fees, and/or administrative expenses of the facilitating motor carrier, association, and/or Gallagher. Further, the underwriters retain the right to change the insurance cost or terms and conditions of the coverage by giving thirty days notice to you of a change. You may elect to continue coverage under the revised terms and conditions or choose to replace coverage with a different insurance policy. In such event, the underwriters will issue a notice acknowledging your cancellation or a replacement certificate reflecting the revised cost to you. A copy of the certificate will become an Addendum to your independent contractor operating agreement with the facilitating motor carrier for purposes of cost disclosure.

Authorization of Settlement Deduction: In accordance with your independent contractor operating agreement, and as an Addendum thereto, you authorize the facilitating motor carrier to periodically deduct your insurance costs from your settlement payments. If such settlements (or other monies due you) are not sufficient to cover your insurance cost, you will be asked to remit by certified check or money order the outstanding insurance cost to Gallagher Transportation Services, 2345 Grand, Suite 400, Kansas City, MO 64108 within a ten (10) day period. Otherwise, the insurance underwriters may cancel this insurance coverage in accordance with the policy terms and conditions. Coverage will not automatically be reinstated if cancellation is processed.

Certification

I certify that all information in this Enrollment Form and other enrollment documents is true and correct to the best of my knowledge and that the equipment to be insured, and the driver of the equipment to be insured, meets the safety requirements of the facilitating motor carrier and the Department of Transportation. I understand and acknowledge that Arthur J. Gallagher Risk Management Services, Inc. ("AJG") is the insurance agent with limited authority to procure the insurance coverage referred to in this Enrollment Form. I acknowledge that I have not sought or received insurance advice from Gallagher or AJG regarding the referenced insurance coverage as it applies to me, my business and/or equipment. Further, I have read, understand and agree to the terms and conditions, which apply to this coverage as stated on the backside of this Enrollment Form. I also agree that the Certificate of Insurance evidencing this coverage shall constitute a properly executed and effective Addendum to the independent contractor operating agreement between the undersigned and the facilitating motor carrier. Coverage is subject to all policy terms, conditions and exclusions.

Signed _____ Date _____
Owner or Authorized Representative

Edition 11.2015

Gallagher Transportation Services
Arthur J. Gallagher Risk Management Services, Inc.
2345 Grand Boulevard Suite 900
Kansas City, Missouri 64108

STATE MINIMUM UNINSURED AND UNDERINSURED LIMITS

STATE	MINIMUM COVERAGE	STATE	MINIMUM COVERAGE
Arizona	Policy Limits	**Maryland**	Policy Limits
Connecticut	Policy Limits	**New Hampshire**	Policy Limits
Florida	Policy Limits	**Oregon**	Policy Limits
Louisiana	Policy Limits	**South Carolina**	Policy Limits
Maine	Policy Limits	**Utah**	Policy Limits

PLEASE NOTE THAT NO COVERAGE IS PROVIDED UNLESS YOU ARE UNDER A LONG TERM LEASE TO THE FACILITATING MOTOR CARRIER.

Arthur J. Gallagher Risk Management Services, Inc.
Gallagher Transportation Services
2345 Grand, Suite 900
Kansas City, MO 64108

INDEPENDENT CONTRACTOR PHYSICAL DAMAGE ENROLLMENT FORM

Gallagher Transportation Services
Arthur J. Gallagher Risk Management Services, Inc.
2345 Grand Boulevard Suite 900
Kansas City, Missouri 64108

As an Independent Contractor, you can voluntarily elect to participate in the Physical Damage Insurance Program developed by Gallagher Transportation Services ("Gallagher") for Independent Contractors. Coverage includes comprehensive and collision insurance coverage designed for Independent Contractors. By providing the information requested below and submitting it to Gallagher, coverage will become effective upon acceptance by Gallagher. Notification of acceptance will be mailed to the mailing address shown on this Enrollment Form.

[For Gallagher Use Only]

Effective Date: _____

Received By:

Independent Contractor Information:

Name: _____

Street: _____

City/State/Zip: _____

Telephone: _____

Email Address: _____

Facilitating Motor Carrier: Customized Trucking Services Inc.

Terminal: _____

Comprehensive and Collision Coverage Deductible: $1,000

TRACTOR/POWER UNIT TO BE INSURED

Unit No.	Year & Make	Serial Number	Amount Insured (ACV)

Lienholder

Street

City	State	Zip

TRAILER (S) TO BE INSURED

Unit No.	Year & Make	Serial Number	Amount Insured (ACV)

Lienholder

Street

City	State	Zip

CERTIFICATION

I certify that all information in this Enrollment Form and other enrollment documents is true and correct to the best of my knowledge and that the equipment to be insured, and the driver of the equipment to be insured, meets the safety requirements of the facilitating motor carrier and the Department of Transportation. I understand and acknowledge that Arthur J. Gallagher Risk Management Services, Inc. ("AJG") is the insurance agent with limited authority to procure the insurance coverage referred to in this Enrollment Form. I acknowledge that I have not sought or received insurance advice from Gallagher or AJG regarding the referenced insurance coverage as it applies to me, my business and/or equipment. Further, I have read, understand and agree to the terms and conditions, which apply to this coverage as stated on the backside of this Enrollment Form. I also agree that the Certificate of Insurance evidencing this coverage shall constitute a properly executed and effective Addendum to the independent contractor operating agreement between the undersigned and the facilitating motor carrier.

Signed _____ Date: _____

Owner or Authorized Representative

TERMS AND CONDITIONS – PLEASE READ CAREFULLY

It is further understood and agreed:

ACTUAL CASH VALUE (ACV)
Your equipment is insured against covered losses for its actual cash value at the time of loss or cost of repair, whichever is less. Actual Cash Value means the cost to purchase similar equipment (year, make, model, equipment, etc.). If you over–estimate your equipment's value, you will receive only the actual cash value at the time of loss. On the other hand, if you under–estimate your equipment's value, the maximum amount, which would be paid, will be the insurable value on which you have paid your cost of insurance. Therefore, it is important that you properly value your equipment. You should check with a dealer to determine the actual cash value of your equipment.

EFFECTIVE DATE
Coverage will become effective on the date your Enrollment Form is accepted by Gallagher.

TERMINATION
In the event your independent contractor operating agreement with the facilitating motor carrier is terminated, settlement deduction will automatically cease and your coverage will automatically terminate within the terms and conditions of the policy or as soon as allowed by law. When this happens, you should make arrangements to replace your physical damage insurance coverage immediately.

If you wish to voluntarily cancel coverage, written notification must be given to the insurance underwriter of your intent. Such written notification may be given to the Gallagher Administrative Office.

The insurance underwriter retains the right to cancel the insurance coverage in accordance with policy terms and conditions. You will be given a minimum of 15 days notice of cancellation.

LIENHOLDER
If you have specified a lienholder on the Enrollment Form, notification of coverage will be sent to the lienholder at the address you provide. You acknowledge and agree that the insurance underwriter is obligated to include the lienholder's name, as well as your own on all claim payment checks.

POLICY TERMS AND CONDITIONS
You will receive from Gallagher a certificate of insurance. A copy of the certificate will become an Addendum to your independent contractor operating agreement with the facilitating motor carrier for purposes of cost disclosure. Please review the certificate carefully to be certain that it is correct. A copy of the policy is available upon written request to the facilitating motor carrier and/or Gallagher during normal business hours.

Upon your written notice to the Gallagher Administrative Office, you can request changes to the equipment, lienholder, and other information on this Enrollment Form.

COST AND CONSENT TO RATE
You accept and acknowledge that your insurance cost, as explained more fully in this Enrollment Form, may include premium, taxes, fees, and/or administrative expenses of the facilitating motor carrier, association, and/or Gallagher. Further, the underwriters retain the right to change the insurance cost or terms and conditions of the coverage by giving thirty days notice to you of a change. You may elect to continue coverage under the revised terms and conditions or choose to replace coverage with a different insurance policy. In such event, the underwriters will issue a notice acknowledging your cancellation or a replacement certificate reflecting the revised cost to you. A copy of the certificate will become an Addendum to your independent contractor operating agreement with the facilitating motor carrier for purposes of cost disclosure.

DISCLOSURE
By signing this Enrollment Form, you understand and acknowledge that Arthur J. Gallagher Risk Management Services, Inc. ("AJG") is the authorized insurance agent with the limited authority to for procure the insurance. You also hereby agree that you have not received any advice, counsel, direction or any representation from Gallagher or AJG as to the propriety of the insurance coverage as it may relate to your business, equipment individual insurance needs or specialized needs; nor have you relied on any statements or actions made by Gallagher to evaluate your operations as an individual insurance risk.

AUTHORIZATION OF SETTLEMENT DEDUCTION
In accordance with your independent contractor operating agreement, and as an Addendum thereto, you authorize the facilitating motor carrier to periodically deduct your insurance costs from your settlement payments. If such settlements (or other monies due you) are not sufficient to cover your insurance cost, you will be asked to remit by certified check or money order the outstanding insurance cost to Gallagher Transportation Services, 2345 Grand, Suite 900, Kansas City, MO 64108 within a ten (10) day period. Otherwise, the insurance underwriters may cancel this insurance coverage in accordance with the policy terms and conditions. Coverage will not automatically be reinstated if cancellation is processed.

PLEASE READ ALL INFORMATION CAREFULLY BEFORE SIGNING THE APPLICATION ON THE REVERSE SIDE

Gallagher Transportation Services
Arthur J. Gallagher Risk Management Services, Inc.
Administrative Office:
2345 Grand, Suite 900
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