Worldwide Outfitters & Guides

A S S O C I A T I O N

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON, FILES AN APPLICATION FOR INSURANCE CONTAINING ANY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

INDIVIDUAL NAMED OPERATOR DISCOVERY QUESTIONNAIRE

THIS IS FOR QUOTATION PURPOSES ONLY – THIS IS NOT A BINDER

PROPOSED EFFECTIVE DATE: _____

General Information

1. Applicant (as it would appear on the coverage contract): _____
2. Doing Business As: _____
3. Mailing Address: _____

   City: _____ State: _____ Zip: _____
4. Contact Person: _____ Years Experience: _____

   Contact Person is: ☐ Owner ☐ Manager ☐ Promoter ☐ Management ☐ Other: _____
5. Day Phone: _____ Evening Phone: _____ Fax Number: _____
6. Web Address: _____

Insurance History

7. Who was your last or is your current insurance carrier? _____
8. What is or was your annual premium? _____
9. Describe your claims and loss history: _____

   _____

Operator Questionnaire

Any operator that will be employed, or contracted by the Participating Member, which is furnished with any vehicles and/or equipment, owned or furnished by the Participating Member, for use directly associated with the exclusive commercial business use of said insured vehicles and/or equipment, must be approved and names in the coverage contract issued to the Participating Member as a Named Operator. To approve a Named Operator, that individual must have an acceptable driving record and a recent employment physical exam or medical evaluation. Personal use of any vehicle, including driving to and from work, is specifically excluded.

1. Name of Operator to be insured: _____
2. Present address: _____

   City: _____ State: _____ Zip: _____
3. How long at this address? _____ If less than two years, please note last address where the operator resided, for at least two years: _____
4. In case of emergency, contact: _____

   Phone: _____ Relationship to Named Operator: _____

   Address: _____
5. Date of birth: _____ Weight: _____ Height: _____ Glasses? ☐ Yes ☐ No
6. Social Security #: _____ Driver's License #: _____ State issued: _____

7. Married? ☐ Yes ☐ No List number of children, if applicable: _____

8. Describe any physical handicap: _____

9. Number of years experience with equipment to be operated: _____

10. Explain past experience and type of equipment used: _____

_____

11. Note two most recent prior employers:

    a. _____

    Years employed: _____ Phone: _____ Person to contact: _____

    b. _____

    Years employed: _____ Phone: _____ Person to contact: _____

12. Identify and explain any prior accidents or claims you have been involved in: _____

_____

    a. Give employer and year accident occurred: _____

    b. Provide claims settlement made, if known: _____

13. If less than two years licensed to drive in the state you will be employed, please provide a list of states where you have had a license in the past 5 years, and the name in which the license was issued: _____

_____

14. Has your driver's license ever been suspended or revoked in the past 5 years, in any state? ☐ Yes ☐ No If yes, identify the state and reason for action: _____

15. Have you been issued a moving violation in the past five years? ☐ Yes ☐ No If yes, please list dates and type of violation charged: _____

Note: Each operator must obtain a doctor's medical exam certificate, which certifies that the doctor examined the operator, in accordance with Section 391.43 of the Motor Carrier Safety Regulations of the Federal Highway Administration, and that all physical examination procedures were adhered to. The doctor must state that he finds the operator qualified under the rules of the FMCSR. Both the physical exam and eyesight requirements of Section 391.43 of the FMCSR must be met prior to any individual operator being insured under the coverage issued. The Questionnaire and Doctor's Certificate must be returned with the signed coverage receipt form, within 10 days of receiving the coverage contract issued to the Participating Member by the Association and its Insurer.

REPRESENTATIONS AND WARRANTIES

The "Applicant" is the party to be named as the "Insured" in any insuring contract if issued. By signing this Discovery Questionnaire, the Applicant for insurance hereby represents and warrants that the information provided in the Discovery Questionnaire, together with all supplemental information and documents provided in conjunction with the Discovery Questionnaire, is true, correct, inclusive of all relevant and material information necessary for the Association to accurately and completely assess the Discovery Questionnaire, and is not misleading in any way. The Applicant further represents that the Applicant understands and agrees as follows: (i) the Association can and will rely upon the Discovery Questionnaire and supplemental information provided by the Applicant, and any other relevant information, to assess the Applicant's request for insurance coverage and to quote and potentially bind, price, and provide coverage; (ii) the Discovery Questionnaire and all supplemental information and documents provided in conjunction with the Discovery Questionnaire are warranties that will become a part of any coverage contract that may be issued; (iii) the submission of a Discovery Questionnaire or the payment of any premium does not obligate the Association or any Insurer to quote, bind, or provide insurance coverage; and (iv) in the event the Applicant has or does provide any false, misleading, or incomplete information in conjunction with the Discovery Questionnaire, any coverage provided will be deemed void from initial issuance.

The Applicant hereby authorizes the Association, and its agents, to gather any additional information the Association deems necessary to process the Discovery Questionnaire for quoting, binding, pricing, and providing insurance coverage including,

but not limited to, gathering information from federal, state, and industry regulatory authorities, insurers, creditors, customers, financial institutions, and credit rating agencies. The Association has no obligation to gather any information nor verify any information received from the Applicant or any other person or entity. The Applicant expressly authorizes the release of information regarding the Applicant's losses, financial information, or any regulatory compliance issues to this Association in conjunction with consideration of the Discovery Questionnaire.

The Applicant further represents that the Applicant understands and agrees the Association: (i) may present a quote with a sub-limit of liability for certain exposures, (ii) may quote certain coverages with certain activities, events, services, or waivers excluded from the quote, (iii) will rate each quotation in the best interest of each Association member to the extent possible to meet the overall intent of the Association's program of insurance for all members, and (iv) offer several optional quotes for consideration by the Applicant for insurance coverage. In the event coverage is offered, such coverage will not become effective until the Association's accounting office receives the required premium payment, and the Applicant signs and returns the appropriate "Acknowledgement and Coverage Contract Receipt" form within 10 days of receiving an insurance coverage contract.

The Applicant agrees that the Association and any party from whom the Association may request information in conjunction with the Discovery Questionnaire may treat the Applicant's facsimile signature on the Discovery Questionnaire as an original signature for all purposes.

IMPORTANT: Each accepted Applicant is provided insurance as a participating member under a Master Group Policy of Insurance issued on behalf of the Worldwide Outfitter and Guides Association, a qualified "Purchasing Group" under the Risk Retention Act of 1986—Public Law 97-45. Master Group Policies have been issued to the Association, formed and governed by the laws, rules, and regulations of the State of Utah, to which members will be added as "Participating Members." The Association's program of insurance is a fully insured plan with an insurer permitted to provide insurance in each Association member's state of residence.

All coverage contract charges and service provider fees are minimum and fully earned as of the effective date of coverage. Membership in the Association is restricted to those whose business or activities are similar with respect to liability to which members are exposed by virtue of any common business, act, product, service, premises, or operations. The Applicant represents that the Applicant understands and agrees: (i) the Applicant's request for the Association to quote or otherwise effect coverage for the Applicant is without undue influence or incentive, (ii) the Applicant is individually procuring any insurance that may be provided as a participant in a Master Group Policy, where the benefits and coverage have already been approved by the Association's Purchasing Group, (iii) any coverage that may be provided will be provided under a Master Coverage Contract has been effected in the State of Utah as the state in which the Purchasing Group is organized and domiciled, and where the Association's Purchasing Group's principal office is located, (iv) all rules and regulations applicable to the individual or self-procurement of insurance will govern any coverage provided, and (v) the Applicant is individually responsible for the direct payment of taxes related to coverage provided in the Applicant's state of residence. Should taxes be made a part of any quotation provided by the Purchasing Group to the Applicant, the Association may, as an accommodation and convenience to the Applicant, collect and remit any tax collected to the tax collection agency in the member's state of residence.

Dated: _____

Applicant:

_____
Signature

_____
Print Name