



Workers Compensation Fund
Trucking Questionnaire

Please Print or Type

Policyholder Name	Policy Number
-------------------	---------------

2 INFORMATION

1 In what state do you regularly operate?

2 Is the radius of your operations more or less than 200 miles from point of principal garaging?

More than 200 miles from point of principal garaging Less than 200 miles from point of principal garaging

3 Are all employees residents of Utah? If no, list all other states in which your employees reside.

4 Are all employees hired in Utah? If no, list all other states in which your employees are hired.

5 In which states do you have workers' compensation policies?

6 Do you own / operate terminals? If yes, list locations.

Signature and Title of Owner, Partner, Member or Corporate Officer	Date
--	------

Please return a completed signed application to:

Workers Compensation Fund
Attn. Underwriting Department
100 West Towne Rldge Parkway
Sandy, Utah 84070

If you have any questions, please call 385.351.8020
or 800.446.2667 ext. 8020

Fax: 385.351.8554

For your protection, Utah law requires the following to appear on this form:
Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in the state prison.