Company Name _____ **Coverage Period** _____

YES / NO Have all employees been classified correctly by name and earnings for each class code represented? If no, please explain.

YES / NO Have officers/principals been correctly classified and included/excluded based on policy endorsements?

NA How many trucks/equipment did your company ***own*** during the coverage period? _____
NA How many of these were ***utilized*** on a regular basis during the coverage period? _____

YES / NO Does your company use any owner/operators (drivers that drive their own equipment)? ***(ALL owner/operators must be identified by detailed name, age, compensation paid during the ATA Fund coverage period, and number of weeks worked for the Fund Member during the coverage period.)*** If yes, a copy of the Non Trucking Liability/Physical Damage Report must be attached. Is this attached?
IF YES, PLEASE FILL OUT THE ATTACHED SUPPLEMENTAL APPLICATION.
If Yes, please have the member fill out the supplemental questionnaire regarding owner/operators.

YES / NO Does your company use any laborers (other than owner/operators) that are paid by 1099, cash, or any other means that is not reported in the company's quarterly state and federal payroll tax returns? ***If yes, these laborers must be identified by detailed name and compensation paid during the ATA Fund coverage period.***

YES / NO Does your company have any brokerage, agent, or freight forwarding operations? *If yes, please fille out the attached supplemental application..*
If Yes, please have the member fill out the owner/operator questionnaire.

YES / NO Does your company pay driver per diems? If yes, on what basis does your company pay per diems? _____
If yes, each driver's per diem amount must be separated out and listed for each.

YES / NO / NA If yes, are the per diems *excluded* from your quarterly payroll tax returns? How many of your drivers are paid per diems? _____
What is the total per diem amount paid to your drivers during the coverage period? _____

YES / NO Does your company have more than one location? ***If yes, a complete listing of locations with physical addresses must be provided.***

YES / NO Does your company have facilities or employees with workers' compensation exposure in other states? ***If yes, please list these states:***

YES / NO Does your company have more than one entity?
YES / NO ***If yes, has each entity been included on this audit? If no, please explain.***

YES / NO Does your company have a **401k Plan**? ***If yes, what is the total amount of compensation deferred in the 401k Plan?*** _____

YES / NO / NA If your company does have a **401k Plan**, is this compensation ***included*** in your quarterly State tax returns?
YES / NO / NA If your company does have a **401k Plan**, is this compensation ***included*** in your quarterly Federal tax returns?

YES / NO Does your company have a **Cafeteria Plan*****? If yes, what is the total amount of compensation deferred in the Cafeteria Plan?*** _____

YES / NO / NA If your company does have a **Cafeteria Plan**, is this compensation ***included*** in your quarterly State tax returns?
YES / NO / NA If your company does have a **Cafeteria Plan**, is this compensation ***included*** in your quarterly Federal tax returns?

YES / NO Do any of your company's officers have ownership in any other companies? ***If yes, what are the names of these companies and the nature of their business? Certificates of Workers Comp Insurance must be provided for each.***
_____

YES / NO Was this audit conducted at your company's location? ***If no, please explain.***

This form must be completed and attached to all audits without exception. Any audit submitted without this form will be considered unproductive which is subject to a 150% force billing enforced by legal action.

****Signature** _____ **Title** _____
*(must be signed by **an officer of the company**)*

***** By signing this form, I declare that all questions above have been answered correctly, and that I agree with the payrolls and classification of all employees.***

ATA COMP FUND

PROTECTION | PERFORMANCE | DRIVEN

Owner Operator/Lease Purchase Operator/Contract or Otherwise Engaged Driver Supplemental Audit Schedule

YES / NO Does your company (fund member) use any owner/operators, lease purchase operators, or contract or otherwise engaged drivers (driver classification)? ***ALL such operators or drivers must be identified by driver classification, detailed company name, driver name, date of birth, state of residence, amounts paid during the policy term, and number of calendar weeks (Monday – Sunday) worked for the fund member during the policy term (One week can be from one to seven days).*** If yes, a copy of the Non-Trucking Liability/Physical Damage Report must be attached. Is this attached?

YES / NO If you answered yes to the above question, are these operators or drivers under contract to drive solely for the fund member?

YES / NO Are these operators or drivers operating under their own authority at any time?

YES / NO If No, are they operating under the authority of the fund member?

YES / NO Do any of your owner operators/drivers provide their own workers' compensation coverage?

YES / NO / NA If yes, does the fund member maintain records of Certificates of Insurance for ***workers' compensation coverage*** on file for these operators or drivers for the entire policy term?
If yes, copies of the policy for operators and/or drivers must be attached.

YES / NO / NA If the fund member does not maintain records of worker's compensation coverage, does the fund member carry occupational accident coverage on their operators or drivers? ***If yes, a copy of the policy must be attached. We will not accept a Certificate of Insurance only as we request the occupational accident policy to review the coverage verbiage.***

YES / NO / NA Does the fund member carry and maintain approved supplemental contingent liability coverage on their operators or drivers specifically extending coverage and linked to this occupational accident coverage? ***If yes, a copy of the policy must be attached. We will not accept a Certificate of Insurance showing coverage as we request the contingent liability policy to review the coverage verbiage.***

YES / NO / NA If the fund member does not carry coverage for their operators or drivers, do these operators or drivers carry occupational accident coverage themselves? ***If yes, copies of the policy(ies) must be attached. We will not accept a Certificate of Insurance only as we request the occupational accident policy to review the coverage verbiage.***

YES / NO / NA Is any of the equipment used by these operators or drivers obtained by a lease/purchase agreement or by ANY form of financing or lien holding provided by the fund member or any other commonly owned or controlled company? ***If yes, how many? These drivers must be specifically identified separately by detailed company name, driver name, date of birth, state of residence, amounts paid during the policy term, and number of calendar weeks (Monday – Sunday) worked for the fund member during the policy term (On week can be from one to seven days).***

YES / NO Does your company broker or sub-contract any freight/loads?

YES / NO If yes, is there a contract in place between the shipper/manufacturer and the fund member for any of the freight/loads hauled by these companies, operators, or drivers?

YES / NO Is any of the freight/loads hauled by these companies, operators, or drivers under their own authority?

YES / NO Is any of the freight/loads brokered or sub-contracted through a non-owned third-party company/agent/broker?

YES / NO Does your company have any commonly owned or controlled brokerage, agent, or freight forwarding operations? *If yes, provide a detailed written explanation.*

YES / NO If yes, does your company have a brokerage license for these operations? *If yes, a copy of this license must be attached.*

Please describe any situation not addressed in the above questions that may provide additional clarification:

_____

_____

_____

_____

_____

Driver/Per Diem Audit Worksheet

**If your company has more drivers that receive per diems than there is room to list on one sheet, please make additional copies.
If your company does not pay per diems, please write "NONE" on this form and sign.

Fund Member ____

Driver's Name	Wages Paid during coverage period	Per Diem Paid during coverage period	# of Nights spent over the road	Rate paid per night

**Signature ____ Title ______________________
(must be signed by an officer of the company)

Lease Purchase Operator/Contract Driver Audit Worksheet

**If your company has more lease purchase operators than there is room to list on one sheet, please make additional copies.
If your company does not use lease purchase operators, please write "NONE" on this form and sign.

Fund Member ____

Lease Purchase Operator's Name	Age of Driver	Amount Paid during coverage period	# of weeks worked during coverage period

**Signature ____________________________________ Title ______________________

(must be signed by an officer of the company)

Fund Member_____

As of December 31, 2021:

Class Code	# of employees

The purpose of this sheet is to know how many employees you typically have in each class code.

**Signature _____ Title _____

(must be signed by an officer of the company)

Owner Operator/Contract Driver Audit Worksheet

**If your company has more owner operators than there is room to list on one sheet, please make additional copies.
If your company does not use owner operators, please write "NONE" on this form and sign.

EACH INDIVIDUAL DRIVER MUST BE LISTED OF SMALL FLEET OWNERS.

Fund Member ____

Owner Operator's Name	# of drivers	Age of Driver	Amount Paid during coverage period	# of weeks worked during coverage period

**Signature ____ Title ________________________
(must be signed by an officer of the company)

1099 or Cash Laborer Worksheet
(Other than Owner Operators / Lease Purchase Operators)

**If your company has more laborers than there is room to list on one sheet, please make additional copies. If your company does not use 1099 or cash paid laborers, please write "NONE" on this form and sign.

Fund Member _____

Laborer's Name	Laborer's Job Description	Wages Paid during coverage period	Laborer's WC Coverage? (Y/N) Provide COI

**Signature _____ Title _____

(must be signed by an officer of the company)