



Hire Date: _____

Full (Legal) Name: _____

Phone Number: _____

Email Address: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Social Security Number: _____

Date of Birth: _____

Emergency Contact: _____

Phone Number: _____

Relationship: _____

Truck Value: _____

Years of Experience: _____

****COMPLETED APPLICATIONS MUST BE EMAILED TO****

will@swivelogistics.com

Dear Applicant:

Please complete the attached Driver Application in its entirety and include the following:

- 1) Copy of COL - FRONT & BACK
- 2) Copy of social security card
- 3) Copy of Medical exam card
- 4) Copy of TWIC

Please pay special attention to the Employment History section and provide all of the required information for each previous employer, including:

- 1) Name
- 2) Address
- 3) Contact name
- 4) Contact telephone number
- 5) Employment start and end dates
- 6) Positions/duties

Please note, incomplete applications will not be processed until all of the required information is provided.

Thank you

DRIVER INFORMATION

NAME: _____

ADDRESS: _____

CELLPHONE#: _____

CDL STATE: _____

CDL#: _____

CDL EXPIRATION DATE: _____

SS#: _____

DATE OF BIRTH: _____

EMAIL: _____

DO YOU HAVE AN FMSCA DRUG AND ALCOHOL CLEARINGHOUSE ACCOUNT? YES NO

Owner Operator will provide the following:

License Plate:	Yes	No	(if yes, Plate# _____ State _____)
IFTA Fuel Decal:	Yes	No	
Fuel Tax:	Yes	No	
2290:	Yes	No	
Bobtail/Physical Damage ins:	Yes	No	
Occ Acc/Work Comp:	Yes	No	
FEIN or SS# for tax purposes:	Yes	No	

Name of LLC or company (if applicable): _____

FEIN# (if applicable): _____

Pre-Qualification Questionnaire

- | | | |
|--|-----|----|
| 1. Are you at least 23 years old? | Yes | No |
| 2. Are you presently qualified to operate a commercial motor vehicle Per CFR49 Part 391.11? | Yes | No |
| 3. Do you have at least two (2) years verifiable driving experience as a Class A Commercial driver? | Yes | No |
| 4. Are you able to pass a DOT road test in a combination tractor/trailer? | Yes | No |
| 5. Can you supply a complete work history for the past three (3) years?
Note, this list must include employer name, supervisor name, contact number and employment start & end dates and MUST be correct. | Yes | No |
| 6. Has your CDL ever been suspended or revoked?
If Yes, provide details: | Yes | No |
| 7. Have you ever been charged and/or convicted of any of the following offenses: | | |
| a. Reckless driving | Yes | No |
| b. Driving on wrong side of road | Yes | No |
| c. Hit and run | Yes | No |
| d. Leaving the scene of an accident | Yes | No |
| e. Causing a fatality through the negligent operation of a CMV | Yes | No |
| f. Driving while intoxicated (DWI) | Yes | No |
| g. Driving under the influence (DUI) of alcohol or other controlled substances | Yes | No |
| If Yes to any of the above questions, please provide details: _____ | | |
| _____ | | |
| 8. Have you ever been charged or convicted of a felony?
If so please provide details: | Yes | No |
| _____ | | |
| 9. Have you ever refused or failed a drug or alcohol test? | Yes | No |
| 10. Have you been convicted of: | | |
| a. More than one (1) moving violation in the past twelve (12) months? | Yes | No |
| b. More than three (3) moving violations in the past three (3) years? | Yes | No |
| 11. Have you been involved in a DOT preventable accident in the past three (3) years? | Yes | No |

I certify this information is true and correct and I understand and agree Eagle Truck Lines LLC believing this information to be true and correct, shall act upon it accordingly. Any facsimile copy, Photostat or carbon copy of this declaration shall be treated as the original. Any falsification of this document or the application shall preclude my employment with Eagle Truck Lines LLC.

Applicant Name (print)

Date

Applicant Signature

Personal Biography

7. Traffic Violations Last 3 Years

Date	Location	Charge	Type of Vehicle

8. Accidents Last 3 Years

Date	Location	Description	Type of Vehicle

9. Driver's Licenses Held in Last 3 Years

State of License _____	License# _____	Exp. Date _____
State of License _____	License# _____	Exp. Date _____
State of License _____	License# _____	Exp. Date _____

10. Has your license ever been suspended or revoked? _____ If yes, When? _____

For What reason? _____

11. Have you ever been convicted of a felony? _____ If yes, date and nature of offense. _____

12. List all Schools or training related to trucking that you have attended.

13. Highest educational level completed? _____

14. Have you ever served in the armed forces? _____ If yes, did you receive an honorable discharge? _____

15. Are you a US citizen? _____ If foreign national, do you have a valid green card? _____

16. List states operated in at least three years _____

Personal Biography

List all employment and driving history during the last 10 years

A. Company _____
Address _____
Phone _____ Dates employed from _____ To _____
Position _____ Reason for Leaving _____
Designated Sensitive Function: Yes No Subject to FMSCR: Yes No

B. Company _____
Address _____
Phone _____ Dates employed from _____ To _____
Position _____ Reason for Leaving _____
Designated Sensitive Function: Yes No Subject to FMSCR: Yes No

C. Company _____
Address _____
Phone _____ Dates employed from _____ To _____
Position _____ Reason for Leaving _____
Designated Sensitive Function: Yes No Subject to FMSCR: Yes No

D. Company _____
Address _____
Phone _____ Dates employed from _____ To _____
Position _____ Reason for Leaving _____
Designated Sensitive Function: Yes No Subject to FMSCR: Yes No

E. Company _____
Address _____
Phone _____ Dates employed from _____ To _____
Position _____ Reason for Leaving _____
Designated Sensitive Function: Yes No Subject to FMSCR: Yes No

TO BE READ AND SIGNED BY APPLICANT

This certifies that I completed this application, and that all entries, and information documented by me are true and complete to the best of my knowledge. By my signature heretofore, I acknowledge having been given by this carrier which has presented me with this application, a statement of my right to due process as outlined by all parts of 49 CFR Part 391.23 of the Federal Motor Carrier Safety Regulations effective October 29, 2004.

Having made this acknowledgment, I therefore authorize you to make such previous employment and background investigations and inquiries of my personal, employment, financial or medical history, and other related matters as may be necessary to arrive at a possible employment decision. (Generally, inquiries regarding medical history will be made only if and after a conditional offer of employment has been extended.) I understand that false or misleading information given in my application or interviews may result in discharge. I understand, also, that I am required to abide by all rules and regulations of the company.

Date: _____

Applicant's Signature: _____

CERTIFICATION OF COMPLIANCE WITH DRIVER LICENSE REQUIREMENTS

Motor Carrier Instructions:

The requirements in Part 383 apply to every driver who operates in intrastate, interstate or foreign commerce and operates a vehicle weighing 26,001 pounds or more, can transport more than 9 people, or transports hazardous materials that require placarding.

The requirements in **Part 391** apply to every driver who operates in intrastate commerce and operates a vehicle weighing 10,001 pounds or more, can transport more than 9 people, or transports hazardous materials that require placarding.

Driver Requirements:

Parts 383 and 391 of the Federal Motor Carrier Safety (FMCSA) Regulations contain some requirements that you as a driver must comply with. These requirements were effective on July 1, 1987. They are as follows:

1) **Possess Only One License:**

You, as a commercial vehicle driver, may not possess more than one motor vehicle operator's license.

2) **Notification of License Suspension, Revocation, or Cancellation:**

Section 391.15 (b) (2) and 383.33 of the FMCSA regulations require that you notify your employer the next business day of any revocation or suspension of your driver's license. In addition, Section 383.31 requires that any time you violate a state or local traffic law (other than parking), you must report it within 30 days to: 1) your employing motor carrier, and 2) the state that issued your license (if the violation occurs in a state other than the one which issued your license). The notification to both the employer and state must be in writing.

3) **The following license is the only one I will possess:**

Driver's License Number: _____ State: _____ Expiration Date: _____

Driver Certification: I certify that I have read and understand the above requirements.

Driver's Name (printed): _____

Driver's Signature: _____ Date: _____

**DRIVER'S STATEMENT OF
ON-DUTY-HOURS**
(For first time or intermittent drivers)

Motor Carrier Instructions:

When using a driver for the first time or intermittently, a signed statement must be obtained, giving the total time on duty (driving and on duty) during the immediate preceding seven days and the time at which the driver was last released from duty prior to beginning work.

Name (please print): _____
Last
First
Middle

(seven previous days)

Date	Today							
Hours Worked								

Total Hours: _____

I hereby certify that the information provided above is true and correct to the best of my knowledge and belief, and that I was last relieved from work at:

Time: _____ AM/PM Date: _____

Driver's Signature: _____ Date: _____

Federal Motor Carrier Safety Administration (FMCSA)
Drug and Alcohol Clearinghouse

I, _____, hereby provide consent to MLM Transport (the Company) to conduct queries of the FMCSA Commercial Driver's License Drug and Alcohol Clearinghouse (Clearinghouse) to determine whether drug or alcohol violation information about me exists in the Clearinghouse.

I understand that if the queries conducted by the Company indicate that drug or alcohol violation information about me exists in the Clearinghouse, FMCSA will not disclose that information to the Company without first obtaining consent from me.

I further understand that if I refuse to provide consent for the Company to conduct a query of the Clearinghouse, the Company must prohibit me from performing safety-sensitive functions, including driving a commercial motor vehicle, as required by FMCSA's drug and alcohol program regulations.

This authorization will remain in effect until cancelled by me in writing or upon termination of my employment with the Company.

Employee Signature: _____

Date: _____

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 MLM Transport ("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 MLM Transport ("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 that 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.

NOTICE: The prospective employment concept referenced in this form contemplates the definition of "employee" contained at 49 C.F.R. 383.5.

LA.ST UPDA.TBD 2/11/2016

DISCLOSURE STATEMENT

PURSUANT TO FAIR CREDIT REPORTING ACT (FCRA}

By this document Eagle Transportation discloses to you that a consumer report regarding your credit history, criminal history and other background information and/or an investigative consumer report containing information as to your character general reputation, personal characteristics and/or mode of living may be obtained from consumer reporting agencies, personal interviews or other sources in connection with your application for employment or any time during your employment (including independent contractor assignments, as applicable). The information obtained shall be used solely for the purpose of evaluating you for employment, promotion, reassignment, or retention as an employee or independent contractor.

All terms are used as defined in the FCRA, 15 U.S.C. § 1681et seq.

AUTHORIZATION TO PROCURE A CONSUMER REPORT OR INVESTIGATIVE CONSUMER REPORT

HEREBY authorize Eagle Transportation or those authorized by them, including Vintage Services LLC, to procure consumer reports and/or investigative consumer reports on me in connection with my application for employment or any time during my employment, which shall be used solely for the purpose of evaluating me for employment, promotion, reassignment, or retention as an employee or as an independent contractor. I understand that reports may include information about my prior employment, D.O.T. commercial driver experience as outlined in Parts 382.413, 391.23 and 391.25 of the Federal Motor Carrier Safety Regulations (FMCSRs), driving records, military record, education, credit worthiness and history, character, general reputation, criminal record, and mode of living, residency, general reputation, personal characteristics, performance, experience, reasons for termination of past employment and other qualities pertinent to my qualifications for employment.

I understand that this information may be obtained through a variety of sources, including, but not limited to, public records, educational institutions, financial institutions, credit bureaus, consumer reporting agencies, and personal interviews with my current and former employers, friends, neighbors and associates. I understand that upon written request to Eagle Transportation, I will be informed whether an investigative consumer report was requested and given information as to the nature and scope of the investigation requested. I understand that upon written request to Eagle Transportation, a copy of this Authorization will be provided to me.

_____ Date: _____ Time: _____

Print Name:

Signature: _____

CALIFORNIA, MINNESOTA AND OKLAHOMA RESIDENTS ONLY:

I wish to receive a free copy of any Consumer Report and/or Investigative Consumer Report concerning me that is requested.



Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No.1615-0047
Expires 07/31/2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the [Instructions](#).

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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 (if any)	Other Last Names Used (if any)	
Address (Street Number and Name)			Apt. Number (if any)	City or Town		State ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number		Employee's Email Address		Employee's Telephone Number	
<p>I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.</p>		Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):				
		<input type="checkbox"/> 1. A citizen of the United States				
		<input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions.)				
		<input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.)				
<input type="checkbox"/> 4. A noncitizen (other than Item Numbers 2. and 3. above) authorized to work until (exp. date, if any)						
If you check Item Number 4. , enter one of these:						
USCIS A-Number		OR	Form I-94 Admission Number		OR	Foreign Passport Number and Country of Issuance
Signature of Employee				Today's Date (mm/dd/yyyy)		

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the [Preparer and/or Translator Certification](#) on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign **Section 2** within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)	<p>Additional Information</p>				
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)	<p><input type="checkbox"/> Check here if you used an alternative procedure authorized by DHS to examine documents.</p>				
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

<p>Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.</p>		First Day of Employment (mm/dd/yyyy):
Last Name, First Name and Title of Employer or Authorized Representative		Signature of Employer or Authorized Representative
		Today's Date (mm/dd/yyyy)
Employer's Business or Organization Name		Employer's Business or Organization Address, City or Town, State, ZIP Code

For reverification or rehire, complete [Supplement B, Reverification and Rehire](#) on Page 4.

Request for Taxpayer Identification Number and Certification

Go to www.irs.gov/FormW9 for instructions and the latest information.

**Give form to the
 requester. Do not
 send to the IRS.**

Before you begin. For guidance related to the purpose of Form W-9, see *Purpose of Form*, below.

Print or type. See Specific Instructions on page 3.	1	Name of entity/individual. An entry is required. (For a sole proprietor or disregarded entity, enter the owner's name on line 1, and enter the business/disregarded entity's name on line 2.)		
	2	Business name/disregarded entity name, if different from above.		
	3a	Check the appropriate box for federal tax classification of the entity/individual whose name is entered on line 1. Check only one of the following seven boxes. <input type="checkbox"/> Individual/sole proprietor <input type="checkbox"/> C corporation <input type="checkbox"/> S corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate <input type="checkbox"/> LLC. Enter the tax classification (C = C corporation, S = S corporation, P = Partnership) _____ Note: Check the "LLC" box above and, in the entry space, enter the appropriate code (C, S, or P) for the tax classification of the LLC, unless it is a disregarded entity. A disregarded entity should instead check the appropriate box for the tax classification of its owner. <input type="checkbox"/> Other (see instructions) _____	4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3): Exempt payee code (if any) _____ Exemption from Foreign Account Tax Compliance Act (FATCA) reporting code (if any) _____ <i>(Applies to accounts maintained outside the United States.)</i>	
	3b	If on line 3a you checked "Partnership" or "Trust/estate," or checked "LLC" and entered "P" as its tax classification, and you are providing this form to a partnership, trust, or estate in which you have an ownership interest, check this box if you have any foreign partners, owners, or beneficiaries. See instructions _____ <input type="checkbox"/>		
	5	Address (number, street, and apt. or suite no.). See instructions.	Requester's name and address (optional)	
	6	City, state, and ZIP code		
	7	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 line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Social security number									
				-					
or									
Employer identification number									

Note: If the account is in more than one name, see the instructions for line 1. See also *What Name and Number To Give the Requester* for guidelines on whose number to enter.

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); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

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 for Part II, later.

Sign Here	Signature of U.S. person	Date
------------------	--------------------------	------

General Instructions

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

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to www.irs.gov/FormW9.

What's New

Line 3a has been modified to clarify how a disregarded entity completes this line. An LLC that is a disregarded entity should check the appropriate box for the tax classification of its owner. Otherwise, it should check the "LLC" box and enter its appropriate tax classification.

New line 3b has been added to this form. A flow-through entity is required to complete this line to indicate that it has direct or indirect foreign partners, owners, or beneficiaries when it provides the Form W-9 to another flow-through entity in which it has an ownership interest. This change is intended to provide a flow-through entity with information regarding the status of its indirect foreign partners, owners, or beneficiaries, so that it can satisfy any applicable reporting requirements. For example, a partnership that has any indirect foreign partners may be required to complete Schedules K-2 and K-3. See the Partnership Instructions for Schedules K-2 and K-3 (Form 1065).

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS is giving you this form because they



I hereby authorize {MLM Transport LLC} to directly deposit my pay in the bank account(s) listed below in the percentages or flat dollar amount specified. I **have attached a voided personalized check (checking accounts) or deposit slip (savings accounts) for each account specified below. Letter from bank is also accepted.** No more than two accounts may be designated. This authorization is to remain in force until the Company has received written authorization from me of its termination or change. Also, I hereby grant {MLM Transport LLC} the right to correct any such electronic funds transfer resulting from an erroneous overpayment by debiting my account to the extent of such overpayment.

Name (PRINT): _____

Signature: _____ Date: _____

Account #1 (Check only one)

Checking (attached voided check)

Savings (attach deposit slip and obtain ABA routing number from your bank)

Account Number: _____

Routing Number: _____

Financial Institution: _____

Street Address: _____

City, State and Zip Code: _____

Telephone: (____) _____

Amount of pay to be deposited into this account:

\$_____ or _____%

Account #2 (Check only one)

Checking (attached voided check)

Savings (attach deposit slip and obtain ABA routing number from your bank)

Account Number: _____

Routing Number: _____

Financial Institution: _____

Street Address: _____

City, State and Zip Code: _____

Telephone: (____) _____

Amount of pay to be deposited into this account:

\$_____ or _____%

WESCO INSURANCE COMPANY

215 Little Falls Drive
Wilmington, DE 19808

REQUEST FOR INSURANCE ENROLLMENT FORM

X Driver Enrollment Date: _____

X Motor Carrier: MLM Transport Services LLC

Policy Number: _____

X Covered Driver: _____
(Name) (Date of Birth)

X _____
(Address)

X _____
(CDL#/State) (e-mail address)

X _____
(Beneficiary Name) (Relationship) (Contact Info)

By signing this Request for Insurance Enrollment Form I agree to all of the following:

- I certify that I am an Owner Operator paid on a 1099 performing contracted services pursuant to written agreement, in a position to incur profit or loss, and determine the method, manner and means to perform my work assignment.
- I shall make such premium payments as may be required for the program for which I am enrolling.
- That all of the statements made in this Request are, to the best of my knowledge and belief, true and accurate.

(OR)

- I certify that I am a Contract Driver paid on a 1099 performing contracted services pursuant to written agreement, in a position to incur profit or loss, and determine the method, manner and means to perform my work assignment.
- I shall make such premium payments as may be required for the program for which I am enrolling.
- That all of the statements made in this Request are, to the best of my knowledge and belief, true and accurate.

AMOUNTS OF INSURANCE requested are listed on the Certificate of Insurance provided upon enrollment in the program. A full copy of the Occupational Accident policy is available upon request.

EFFECTIVE DATE OF INSURANCE is the date on file with the administrator of this program provided this request has been approved by Wesco Insurance Company or its authorized representative, and the proper premium has been paid.

FRAUD WARNINGS

For residents of Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines or confinement in prison, or any combination thereof.

For residents of Alaska: A person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

WESCO INSURANCE COMPANY

215 Little Falls Drive
Wilmington, DE 19808

For residents of Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

For residents of Arkansas, Louisiana, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For residents of Delaware: Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

For residents of the District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

For residents of Kansas: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by the Company, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of this policy, or a claim for payment or other benefit pursuant to this policy which the Insured knows to contain materially false information concerning any fact material thereto, or conceals, for the purpose of misleading, information concerning any fact material thereto.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

For residents of Maine and Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines or denial of insurance benefits.

For residents of Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of Massachusetts: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of New Hampshire: A person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

For residents of New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For residents of New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

WESCO INSURANCE COMPANY

215 Little Falls Drive
Wilmington, DE 19808

For residents of Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For residents of Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For residents of Oregon: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

For residents of Pennsylvania: 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 fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

For residents of Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

For residents of Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

For all other states: 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 may be guilty of committing a fraudulent insurance act, which is a crime.

For residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For residents of New York: 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 fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

I hereby elect to participate in the Occupational Accident program set forth above. I declare and acknowledge that I am an **INDEPENDENT CONTRACTOR**, and that as such, the cost of this program and insurance are my sole obligation and responsibility. By enrolling for this insurance coverage, I hereby acknowledge and agree that I meet the eligibility requirements of this coverage, and that I am not an employee of any company for which I perform services. I further understand and acknowledge that this is **NOT WORKERS' COMPENSATION INSURANCE**.

X Signed _____
(Signature of Covered Driver)

Date _____