Truckers Occupational Accident Application

INDIVIDUAL

YOU ARE NOT ELEIBLE FOR COVERAGE IF YOU ARE AN EMPLOYEE DRIVER

MOTOR CARRIER INFORMATION

Legal name: _____ Address:_____
City: _____ State: _____Zip:_____
Telephone:_____Email Address: _____
Effective Date of Contract:_____

INDIVIDUAL DRIVER INFORMATION

Name: _____ Date of Birth: _____
Address:_____ City: _____
State: _____Zip:_____ Telephone:_____
Email Address: _____

GENERAL INFORMATION

List all commodities hauled and the percentage for the year:

_____ ___% _____ ___% _____ ___%
_____ ___% _____ ___% _____ ___%

Does the account haul:

Hazardous Waste Material	Yes ☐	No ☐		Logging	Yes ☐	No ☐	
Explosives	Yes ☐	No ☐		Flammables	Yes ☐	No ☐	
Refuse	Yes ☐	No ☐		Radioactive Cargo	Yes ☐	No ☐	

Do you own and operate your own truck? Yes ☐ No ☐

Do you operate as a 1099 contract driver, but do not own or lease the truck? Yes ☐ No ☐

Have you filed a workers' compensation or occupational accident claim in the past 3 years?

Yes ☐ No ☐ If yes please provide details below.

Please provide loss information in the grid provided below and attach loss runs:

Policy Term	Carrier	Loss Description	Loss Payout

Occupational Accident Coverage requested:

Accidental Death & Dismemberment	Benefit: $250,000
Accidental Medical Benefit:	1,000,000 104 incurral period
Temporary Total Disability Benefit:	75% of SAWW up to $500
Permanent Total Disability:	75% of SAWW up to age 70, $500
Combined Single Limit	$1,000,000

Non-Occupational Accident Coverage requested:

Accidental Death & Dismemberment	$10,000
Accidental Medical Benefit:	$5,000
Incurral period:	52 weeks

I understand and hereby acknowledge the following:

1. The Occupational Accident coverage provided is not a contract for Statutory Workers' Compensation Insurance and neither I nor the Motor Carrier above can become participants in the Workers' Compensation system by purchasing this insurance;
2. I certify that I am an independent contractor and receive a 1099 tax form. I further certify that I am not an employee and do not receive a W-2 tax form. I understand coverage will be terminated and no benefits paid if I am an employee;
3. I certify to the best of my knowledge and belief that all information on this form is complete and truthful.

Driver's Signature: _____ **Date:** _____

Motor Carrier Representative: _____ **Date:** _____