AMERICAN ASSOCIATION OF INDEPENDENT CONTRACTORS

OCCUPATIONAL ACCIDENT ENROLLMENT AND BENEFICIARY DESIGNATION FORM

Underwriters at Lloyd's of London

This form must be complete, signed and dated before it can be processed and coverage can be put into effect.

Please indicate which Plan you are enrolling in: **Plan 1** ☐ **Plan 2** ☐

Individual Driver Information

Name/Member: _____ ICC Number: _____

Address: _____ CDL Number: _____

City: _____ Number of Years Experience: _____

State: _____ Zip: _____ Contracted By (Name of Company): _____

Social Security Number: _____ _____

Date of Birth: _____ Address: _____

Home Telephone Number: _____ City: _____

Cell Phone Number: _____ State: _____ Zip: _____

E-mail Address: _____ Effective Date of Contract: _____

Beneficiary: _____ Motor Carrier Phone Number: _____

Relationship to Beneficiary: _____ Motor Carrier Fax Number: _____

Address of Beneficiary: _____ Motor Carrier E-mail Address: _____

_____ _____

Do you have any DWI's in the last five years? Yes ☐ No ☐

Do you have any license suspensions in the last three years? Yes ☐ No ☐

Do you have more than tree moving violations in the last three years (with no more than two in the last 12 months)? Yes ☐ No ☐

If you answered yes to any of the above please attach details of the occurrence(s), including offense dates, to this form.

General Information:

Are you an Owner/Operator with your own authority? Yes ☐ No ☐ Leased to a Motor Carrier? Yes ☐ No ☐

If no to both of the above, are you a: Co-Driver ☐ Contract Driver ☐ (and you receive a Form 1099) Employee Driver ☐ (and you receive a Form W-2)

Are you a team driver? Yes ☐ No ☐

Trailer Type Used: Dry Van ☐ Refer ☐ Box ☐ Flat Bed ☐ Other_____

Years Experience Hauling the Above Type Trailer?_____

Do you haul any Oversize or Overweight loads, or pull any double trailers?Yes ☐ No ☐ If so, which?_____

Type of Carriage? Truckload ☐ LTL ☐

Do you load/unload? Yes ☐ No ☐

If yes, what is the average weight you lift: _____

Do you attach and detach the trailer? Yes ☐ No ☐

Do you tarp? Yes ☐ No ☐ Do you strap? Yes ☐ No ☐

What do you haul? _____

What other duties do you perform? _____

Are you covered under any medical plan? Yes ☐ No ☐

If yes, please provide name of carrier: _____

I hereby authorize the Program Administrator to bill the following selected party for my Occupational Accident coverage:

☐ Self ☐ Motor Carrier, as listed on the front of this Form

☐ Other: _____

Name

_____

Street/PO Box

_____

City State Zip

I understand that the cost of the insurance is my sole obligation and responsibility. I agree that I will forward any amount due to the Program Administrator upon demand, for any insurance at any time my account remains unpaid.

I understand and hereby state:

1. The Occupational Accident coverage provided is not a contract for Statutory Workers' Compensation Insurance and neither the carrier above nor I become participants in the Workers' Compensation system by purchasing this insurance.
2. I certify to the best of my knowledge and belief that all information on this form is complete and truthful.
3. I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or any other organization, institution or person that has any records, including any medical records to furnish such information or copies of records to the Program Administrator or its designated representative. A photographic copy of this authorization shall be as valid as the original.
4. I am 18 years of age or older and I am under dispatch an average of 30 hours each week.
5. I am an independent contractor and receive a 1099 tax form, not a W-2 tax form for an employee. Or I am an employee, and I receive a W-2 form, but I am exempt from Workers' Compensation insurance; I understand that my employer and I must sign a certificate of exemption form to substantiate this.

PARTICIPATION IN TRUST

I understand and acknowledge that by enrolling for insurance coverage I will become a Participant Trucking National Transport Association, Inc.

FRAUD STATEMENT

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.

IF THE INFORMATION YOU HAVE PROVIDED IS FRAUDULENT,
WE MAY HAVE THE RIGHT TO RETURN PREMIUM AND CANCEL COVERAGE.

In order to verify the information you have provided, you are giving us authority to examine the records that are maintained by the motor carrier and the Program Administrator.

Enrollee's Signature: _____ Date: _____

Agent/Producer Signature: _____ Date: _____

Agent/Producer Code (if known): _____

Note: The information below is only a brief description of the coverage provided under this group program. Refer to the Policy which provides the contract of insurance for a description of benefits, limitations and exclusions.

OCCUPATIONAL ACCIDENT BENEFITS	1	2
ACCIDENTAL DEATH		
Principal Sum	$50,000	$25,000
Survivor's Benefit	$200,000	$125,000
Accident Commencement Period	365 days	365 days
ACCIDENTAL DISMEMBERMENT		
% of Principal Sum of	$250,000	$150,000
Monthly Benefit	$2,500	$1,500
Paralysis Benefit	$250,000	$150,000
Accident Commencement Period	365 days	365 days
TEMPORARY TOTAL DISABILITY		
Disability Commencement Period	90 days	90 days
Waiting Period	7 days	7 days
Benefit Percentage	70%	70%
Maximum Weekly Benefit Amount	$500	$400
Maximum Benefit Period	104 wks	52 wks
CONTINUOUS TOTAL DISABILITY		
Waiting Period	104 wks	52 wks
Benefit Percentage	70%	70%
Maximum Weekly Benefit Amount	$500	$400
Maximum Benefit Amount	$400,000	$200,000
Maximum Benefit Period	to age 70	to age 70
ACCIDENT MEDICAL EXPENSE		
Medical Commencement Period	90 days	90 days
Deductible Amount	$0	$0
Maximum Benefit Period	104 wks	52 wks
Dental Maximum per Accident	$3,600	$3,600
Maximum Benefit Amt per Accident	$1,000,000	$300,000
Lifetime Maximum Benefit	$1,000,000	$300,000

NON-OCCUPATIONAL ACCIDENT BENEFITS	1	2
ACCIDENTAL DEATH		
Principal Sum	$10,000	$10,000
Accident Commencement Period	365 days	365 days
ACCIDENTAL DISMEMBERMENT		
% of Principal Sum of	$10,000	$10,000
Accident Commencement Period	365 days	365 days
ACCIDENT MEDICAL EXPENSE		
Medical Commencement Period	90 days	90 days
Deductible Amount	$ 0	$ 0
Maximum Benefit Period	52 wks	52 wks
Dental Maximum per Accident	$1,000	$1,000
Maximum Benefit Amt per Accident	$5,000	$5,000
Lifetime Maximum Benefit	$10,000	$10,000
LIMITS OF LIABILITY		
OCCUPATIONAL COVERAGE:		
Combined Single Limit	$1,000,000	$300,000
Aggregate Limit of Liability (applicable to all covered losses with respect to any one accident)	$2,000,000	$600,000
NON-OCCUPATIONAL COVERAGE:		
Combined Single Limit	$10,000	$10,000
Aggregate Limit of Liability (applicable to all covered losses with respect to any one accident)	$20,000	$20,000

Lloyd's of London MONTHLY RATE PER DRIVER**:** Plan 1 Plan 2

Tier 1 **$137.99*** **$119.99***
All Trucking (including couriers) not named below

Tier 2 **$146.99*** **$131.99***
Bulk Carrier or Tank Operators
Oilfield Equipment Haulers
Heavy Machinery Haulers

Tier 3 **$166.99*** **$149.99***
Livestock Haulers
Sand, Gravel or any type of aggregate haulers
Dump truck Operations

Tier 4 **$201.99*** **$181.99***
Hazardous Material Haulers
Auto Haulers

Excluded
Moving & Storage
Logging and lumbering operations

*Rates include an AAIC Association Member Fee