Enrollment and Beneficiary Designation Form

Occupational Accident Insurance

Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

MOTOR CARRIER INFORMATION (Please print)	
Name of Motor Carrier: Greentree Transportation Company	Contact Name: Safety
Address: 100 Industry Drive	Telephone: 412-490-6040 Opt. 3
City: Pittsburgh State: PA Zip: 15275	Email Address: intransit-safety@thetii.com
Effective Date of Your Contract:	

INDIVIDUAL DRIVER INFORMATION (Please print)			
Name:		FEIN Number:	☐ None
Address:		CDL Number:	
City:	State: Zip:	Number of Years Experience:	
Date of Birth:	☐ Male ☐ Female	Height:	Weight:
Home Phone:	Cell Phone:	Email Address:	
Beneficiary:			
Relationship to Beneficiary:			

GENERAL INFORMATION

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

1. Do you own and operate your own truck? ☐ Yes ☐ No
2. Do you operate a truck under a lease to purchase plan? ☐ Yes ☐ No
3. Do you operate a truck as a 1099 contract driver, but do not own or lease the truck? ☐ Yes ☐ No
   If Yes, for whom?
4. Do you operate a truck as part of a team or as a co-driver? ☐ Yes ☐ No
   If Yes, with whom?
5. Equipment type: ☐ Box ☐ Flatbed ☐ Intermodal ☐ Tanker ☐ Refrigerated ☐ Dump ☐ Straight Truck
   ☐ Other, please specify:
6. Have you filed a workers' compensation or occupational accident claim in the past 3 years? ☐ Yes ☐ No
   If Yes, please explain:
7. Are you covered under any other medical and/or disability insurance plan? ☐ Yes ☐ No
   If Yes, name of insurance carrier:

INSURANCE FRAUD WARNING

Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading, is guilty of insurance fraud and is subject to criminal and/or civil penalties.

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 actively at work at least 30 hours per week for the Motor Carrier above and meet the eligibility requirements under the Policy. I understand that if I am not eligible, no benefits will be paid and this coverage will be cancelled and premiums returned;
3. 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;
4. 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 Zurich American Insurance Company, the Motor Carrier or the Motor Carrier's designee. A photographic copy of this authorization shall be as valid as the original;
5. I certify to the best of my knowledge and belief that all information on this form is complete and truthful; and
6. I authorize the above named Motor Carrier with whom I have a contract, to take monthly deductions, equal to my premiums, from my settlement account on my behalf, and to remit these funds to Zurich American Insurance Company or its appointed agent. I understand that the cost of the insurance is my sole obligation and responsibility regardless of the above arrangement.

Driver's Signature: _____ Date: _____

Motor Carrier Representative: _____ Phone/Fax Number: _____