Occupational Accident Enrollment Form

NOTE – Occupational Accident Insurance is charged by the month & is not prorated

DRIVER INFORMATION SHEET

Individual Driver Information: *(please print)*
Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Social Security Number: _____
Date of Birth: _____
Male: ☐ Female: ☐
Home Telephone Number: _____
Cell Phone Number: _____
E-Mail Address: _____
Beneficiary: _____
Relationship to Beneficiary: _____

CDL Number:
_____
Number of years Experience:
_____
Contracted by *(Name of Company)*:
_____
Effective Date of Contract:
_____
Address:
_____
City: _____ State: _____ Zip:
_____
Motor Carrier Phone Number:
_____
Motor Carrier Fax Number:
_____
Motor Carrier E-Mail Address:
_____

General Information:

Are you an Owner/Operator? ☐ If yes, is the Certificate of Title in your name? _____ Yes _____ No If no, are you a:
Co-Owner ☐ Leased Driver ☐ Contract Driver ☐ Team Driver ☐ Employee ☐

Do you drive for another person? Yes ☐ No ☐
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 ☐
What type of transmission do you drive? Automatic ☐ Shift ☐
Do you drive? Long Haul (> 200 miles/trip ☐ Short Haul (< 200 miles/trip) ☐

What other duties do you perform?
_____
_____

Are you covered under any medical plan? Yes ☐ No ☐ If yes, please state:
_____
_____

As a participant in the Occupational Accident Program, I understand and hereby state:

1. The Occupational Accident coverage provided is not a contract for Statutory Workers' Compensation Insurance and neither my carrier 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 motor carrier or the motor carrier's designee. A photographic copy of this authorization shall be as valid as the original.
4. I am an independent contractor paid by a 1099 tax form not as a W-2 employee.
5. A 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 the Occupational Accident Company or its appointed agent.

Drivers Signature: _____ Date: _____

Motor Carrier Representative: _____ Phone/Fax Number: _____

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: _____

_____ _____