OneBeacon INSURANCE

Independent Contractor Trust

OCCUPATIONAL ACCIDENT ENROLLMENT AND BENEFICIARY DESIGNATION FORM

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** ☐ **Plan 3** ☐

Individual Driver Information

Name[/Member #]: _____
Address: _____
City: _____
State: _____ Zip: _____
Social Security Number: _____
Date of Birth: _____
Home Telephone Number: _____
Cell Phone Number: _____
E-mail Address: _____
Beneficiary: _____
Relationship to Beneficiary: _____
Address of Beneficiary: _____
_____

ICC Number: _____
CDL Number: _____
Number of Years Experience: _____
Contracted By (Name of Company): _____
_____
Address: _____
City: _____
State: _____ Zip: _____
Effective Date of Contract: _____
Motor Carrier Phone Number: _____
Motor Carrier Fax Number: _____
Motor Carrier E-mail Address: _____
_____

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 OneBeacon America Insurance Company, or 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 in the Independent Contractor Trust and that I must abide by the terms and conditions of the Trust. A copy of the Trust Agreement will be provided at the Enrollee's request. Please write to: OneBeacon America Insurance Company at 1000 Woodbury Road, Woodbury, NY 11797, Attn: John Ruvolo.

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

NON-OCCUPATIONAL ACCIDENT BENEFITS	**1**	**2**	3
ACCIDENTAL DEATH			
Principal Sum	$ 10,000	$ 10,000	$ 10,000
Accident Commencement Period	365 days	365 days	365 days
ACCIDENTAL DISMEMBERMENT			
% of Principal Sum of	$ 10,000	$ 10,000	$ 10,000
Accident Commencement Period	365 days	365 days	365 days
ACCIDENT MEDICAL EXPENSE			
Medical Commencement Period	90 days	90 days	90 days
Deductible Amount	$ 0	$ 0	$ 0
Maximum Benefit Period	52 wks	52 wks	52 wks
Dental Maximum per Accident	$ 1,000	$ 1,000	$ 1,000
Maximum Benefit Amt per Accident	5,000	5,000	5,000
Lifetime Maximum Benefit	10,000	10,000	10,000
LIMITS OF LIABILITY			
OCCUPATIONAL COVERAGE:			
Combined Single Limit	$1,000,000	$500,000	$300,000
Aggregate Limit of Liability (applicable to all covered losses with respect to any one accident)	2,000,000	1,000,000	600,000
NON-OCCUPATIONAL COVERAGE:			
Combined Single Limit	$ 15,000	$ 15,000	$ 15,000
Aggregate Limit of Liability (applicable to all covered losses with respect to any one accident)	30,000	30,000	30,000

MONTHLY RATE PER DRIVER**:** **PLAN 1**: $146.00 **PLAN 2**: $136.00 **PLAN 3**: $125.00