Occupational Insurance Coverage Application

1st Guard Corporation

APPLICANT INFORMATION: Please complete ALL questions. Incomplete forms will be rejected and coverage declined.

1. _____
(First Name) (Middle Initial) (Last Name)

2. _____ _____
(Street Address) **(Effective Date)**

_____ **3.** _____
(City) (State) (Zip) (Date of Birth)

4. Soc Sec #: _____ **5.** Home Phone: _____ **6.** Cell # : _____

7. Equipment Used:

Trailer Type	Intermodal	Dry Van	Refrigerated	Dump Truck	Tanker	Flatbed	Auto Hauler
% Utilized							

DESCRIBE OTHER IF NOT SPECIFIED ABOVE: _____

8. Do you load or unload your cargo? No ☐ Yes ☐ If "Yes", what percentage? ____%

9. Do you transport HazMat ? No ☐ Yes ☐ If "Yes", what percentage? ____%

10. BENEFICIARY DESIGNATION:

I name the following Person as Beneficiary for Any Accidental Death Benefits Payable under the Group Master Policy.

Name: Relationship to me:

PLAN MAXIMUM LIMITS REQUESTED: ☐ $500,000 ☐ $1,000,000

I understand that the Maximum Limit requested is the Maximum the policy will pay for Covered Loss but that other sub limits and exclusions apply subject to policy terms and conditions. The definitions, exclusions, provisions, terms and conditions of the policy govern the limits that are payable.

ACCEPTANCE AND UNDERSTANDINGS:

I hereby apply for insurance coverage under an Occupational Accident Group Master Policy issued by U.S. Specialty Insurance Company (hereafter referred to as USSIC).

THIS POLICY IS NOT WORKERS' COMPENSATION and does not satisfy the Workers' Compensation insurance requirements imposed on me by a State for anyone who may be employed by me, and for whom I may become obligated to provide Workers' Compensation benefits. I understand that if I become eligible for Workers' Compensation benefits, I will not be paid any amounts under this insurance and will have to reimburse U.S. Specialty Insurance Company for any amount received under such coverage, up to the amount paid by U.S. Specialty Insurance Company under this insurance.

To verify eligibility as an Independent Contractor driver, I certify that items A) through J) below to be true and accurate statements about me:

A. I am actively at work at least 30 hours per week as an Independent Contract Truck Driver;

B. I am the sole or primary operator of a power unit under a long-term lease contract with a Motor Carrier;

C. The Motor Carrier does not own the power unit that I drive nor do I lease purchase it from them;

D. I am not an employee of the Motor Carrier;

E. 1 am not eligible for coverage under any Workers' Compensation or similar law;

F. I am not required by the Motor Carrier to drive over regular scheduled routes;

G. I am paid on a 1099 and not a W2;

H. I have a written contract with the Motor Carrier that states I am an Independent Contractor and not an employee for the purposes of Workers' Compensation;

I. I am at risk for the profit or loss of my business; and

J. I pay all expenses relating to the operation of the power unit and determine the method and means of completing the work that I perform under contract.

This application is not a binder of insurance and coverage is subject to acceptability by U.S. Specialty Insurance Company based on the application. Coverage is not in effect until this application and premium is received and approved by USSIC or its designated administrator. I authorize the designated administrator and/or USSIC to make deductions from my account for insurance premiums. I understand that this application is attached to the policy and constitutes part of the Policy(ies) when issued. Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or who files a statement of application or claim containing any false, incomplete, or misleading information may be guilty of a violation of state criminal law. I further understand that this coverage is provided only while I am working under a long-term lease contract with a Motor Carrier. **I understand that this policy does NOT cover any sickness, disease, or illness and that other Exclusions also apply. Non-payment of Premium and/or reaching age 70 will result in termination of the policy.** By signing below, I certify that I have read and understand the terms and conditions and that the information I have provided is true and accurate.

_____
(Signature of Applicant) (Date)