GREAT AMERICAN INSURANCE GROUP

TRUCKING PROGRAM

Great American Insurance Company
580 Walnut Street
Cincinnati, OH 45202
513.369.5000

OCCUPATIONAL ACCIDENT INSURANCE INDIVIDUAL OWNER-OPERATOR APPLICATION

1. SCHEDULE OF BENEFITS : PLAN D

DESCRIPTION OF BENEFITS	OCCUPATIONAL	NON-OCCUPATIONAL	PASSENGER
ACCIDENTAL DEATH (MAXIMUM)	$250,000 PRINCIPAL SUM	$15,000 PRINCIPAL SUM	$50,000 PRINCIPAL SUM
SURVIVOR'S BENEFIT (LUMP SUM)	($50,000 +$1000/MTH UP TO 200 MTHS)	($500 PER MONTH UP TO 30 MTHS)	($12,500+$500/MTH 25 MTHS)
ACCIDENTAL DISMEMBERMENT INCLUDING PARALYSIS, AND SEVERE BURN BENEFITS INCURRAL PERIOD	104 WEEKS	104 WEEKS	104 WEEKS
ACCIDENTAL MEDICAL EXPENSE	$1,000,000 MAXIMUM BENEFIT AMOUNT	$10,000 MAXIMUM BENEFIT AMOUNT	$50,000 MAXIMUM BENEFIT
ACCIDENTAL DENTAL BENEFIT	$1000 PER INJURY/ $10,000 LIFETIME	NOT COVERED	NOT COVERED
DEDUCTIBLE	0	0	$100
INCURRAL PERIOD	104 WEEKS	104 WEEKS	104 WEEKS
RIDER LIMIT FOR: HERNIA OR HEMORRHOID OR OCCUPATIONAL DISEASE OR OCCUPATIONAL CUMULATIVE TRAUMA HERNIA OR HEMORRHOID MAX BENEFIT PERIOD	$7,500 PER ACCIDENT OR INJURY SUBJECT TO A $15,000 LIFETIME MAXIMUM 10 WEEKS	NOT COVERED	NOT COVERED
TEMPORARY TOTAL DISABILITY	$700 WEEKLY MAXIMUM	NOT COVERED	NOT COVERED
WAITING PERIOD	7 DAYS		
DURATION-MAXIMUM BENEFIT PERIOD	104 WEEKS		
RIDER LIMIT FOR: HERNIA OR HEMORRHOID OR OCCUPATIONAL DISEASE OR OCCUPATIONAL CUMULATIVE TRAUMA HERNIA OR HEMORRHOID MAX BENEFIT PERIOD	10 WEEKS		
CONTINUOUS TOTAL DISABILITY	$700 WEEKLY MAXIMUM	NOT COVERED	NOT COVERED
WAITING PERIOD	104 WEEKS		
POLICY AGGREGATE AND COMBINED SINGLE LIMIT ANY ONE ACCIDENT	**$1,000,000**		

This coverage is not Workers' Compensation Insurance or for any other purpose except occupational accidents (unless non-occupational benefits apply). This policy does not cover disease unless otherwise endorsed.

The list of benefits is only a brief description of the actual coverages. Certain exclusions and limitations do apply. For complete details please refer to your policy. In the event of any conflict between the information listed here and the actual policy, the insurance policy will govern in all cases.

2. Driver and beneficiary information: Indicate type of driver:

Owner-operator ☐ Co-driver ☐ Contract-driver ☐ Scheduled co-driver ☐ Fleet driver ☐ Team driver ☐

Other, including an authorized passenger (applicable on plans B or D only) ☐ _____

Paid by 1099 ☐ W-2 ☐ CDL number: _____ Contracted by: _____

Unit number/vehicle identification number _____

Name: _____

D.O.B.: _____ Home phone number: _____ Beneficiary name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

History: Please explain all yes answers on a separate sheet of paper

Have you been injured in a work-related accident during the past 36 months? ..... Yes ☐ No ☐

Have you received medical treatment for a health-related condition in the past 36 months? ..... Yes ☐ No ☐

Are you presently under a physicians care or taking any prescription medications? ..... Yes ☐ No ☐

Do you have any health restrictions or limitations on the type of work you can perform? ..... Yes ☐ No ☐

Do you load or unload? ..... Yes ☐ No ☐

Do you have a disability rating? ..... Yes ☐ No ☐

If yes, please provide % of disability and area affected on a separate sheet of paper

I accept ☐ **reject** ☐ the occupational accident insurance offered by the above listed motor carrier. I understand that coverage becomes effective when this application has been received and approved by Great American Insurance Company or its authorized agent. I understand that i will no longer be eligible for coverage upon my 65th birthday and that coverage will therefore cease. I further understand that coverage terminates on the date the policy is terminated; or i am no longer under contract with the above mentioned motor carrier; or my premium is not paid. I also understand that coverage may be available on an individual policy subject to underwriting guidelines in effect at termination of the above policy.

Driver signature _____ Date: _____

Medical Information Authorization: I hereby 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 nay records, including any medical history for the above named person to furnish such information or copies of records to the insurance companies association or its representatives. A photographic copy of this authorization shall be as valued as the original.

Driver Signature _____ Date: _____

Form AR-A	ARKANSAS WORKERS' COMPENSATION COMMISSION	A
Ark. Code Ann. § 11-9-102(9)(D), 11-9-402 Revised: 1-1-2001	324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	

APPLICATION FOR CERTIFICATE OF NON-COVERAGE

Please note prior to completing this Application:

1. Arkansas law requires workers' compensation insurance for every employment:
   (a) in the state in which three or more employees are regularly employed by the same employer;
   (b) in which two (2) or more employees are employed by any person engaged in building or building repair work;
   (c) in which one (1) or more employees are employed by a contractor who subcontracts any part of his contract;
   (d) in which one (1) or more employees are employed by a subcontractor.
2. There are some exceptions to this requirement. Contact your insurance agent or the Workers' Compensation Commission for an explanation.
3. Exclusion of business arrangements or professions from the definition of "employee" under law does not affect the coverage rights of employees of the person(s) listed below.
4. It is a felony for prime contractors to compel sole proprietors or partnerships to pay or contribute to workers' compensation insurance coverage of that sole proprietor or partnership when presented with a Certification of Non-Coverage by the sole proprietor or partnership.
5. It is a felony for prime contractors or employers to compel sole proprietors, partnerships or "employees" to obtain a Certificate of Non-Coverage when the sole proprietor, partnership or employee does not desire to do so.
6. Sole proprietors or partners of a partnership who devote full time to the proprietorship or partnership are presumed to be "employees" for workers' compensation purposes and subject to coverage for themselves UNLESS they obtain a Certificate of Non-Coverage.
7. Address below must be applicant's OWN business or home address, NOT address of company to whom the applicant is contracting or for whom the applicant is doing a project.

Company Name (list ALL names under which you yourself conduct business):_____

_____

Address of YOUR Company or Home:_____

_____

Name of Party Applying (please print; attach additional sheets if necessary):

_____

_____	___-___-___	_____	_____
(Printed Name)	Social Security No.	Signature	Date
_____	___-___-___	_____	_____
(Printed Name)	Social Security No.	Signature	Date

1. ❑ Yes ❑ No Does the business employ others in addition to the parties listed above?
2. ❑ Yes ❑ No Have any partners determined they wish to remain under workers' compensation coverage?
3. ❑ Yes ❑ No Is the company or are the companies incorporated?
4. If you or any of your employees are covered under a workers' compensation policy, please list:

Insurance Company:_____ Policy No.:_____

If answers to any questions above are "yes," provide the application to your insurance agent for further processing during the writing of your workers' compensation insurance policy. The agent is to provide the following information, then forward the Application to the Arkansas Workers' Compensation Commission at the address below:

Agent's Name _____

Agent's Address_____

(City) _____ (State) _____ (Zip Code) _____

Agent's Signature_____

If answers to ALL questions above are "no", submit Form A to the Coverage/Compliance Section, Arkansas Workers' Compensation Commission, P.O. Box 950, Little Rock, Arkansas 72203-0950 or deliver to 324 Spring St., Little Rock, Arkansas 72201. Your Application will be processed and action communicated back to you within ten (10) working days.

SEE IMPORTANT INFORMATION ON OTHER SIDE

AWCC Form A
(Application for Certificate of Non-Coverage)

Form A is not used by corporations or corporate officers to be excluded. Exclusion of corporate officers is handled directly by the agent/carrier.

If the answer is yes to Question 1 on **Form A**, the application for non-coverage will be rejected unless:

1. The AWCC has **Form I** (insurance coverage card) for the employment from a carrier; or

2. The agent furnishes a copy of the declarations page or the National Council on Compensation Insurance application for proof of workers' compensation coverage; or

3. The applicant has furnished proof that coverage is not required.

Help with Form A is available from the AWCC Compliance Section. General information is available from the AWCC Support Services Division. (1-800-622-4472 or 501-682-3930)

Ark. Code Ann. §11-9-106(a): Any person or entity who willfully and knowingly makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme, or artifice for the purpose of: obtaining any benefit or payment; defeating or wrongfully increasing or wrongfully decreasing any claim for benefit or payment; or obtaining or avoiding workers' compensation coverage or avoiding payment of the proper insurance premium, or who aids and abets for any of said purposes, under this chapter shall be guilty of a Class D felony. Fifty percent (50%) of any criminal fine imposed and collected under .... this section shall be paid and allocated in accordance with applicable law to the Death and Permanent Total Disability Trust Fund administered by the Workers' Compensation Commission.

Illinois Workers Compensation
Coverage Election/Rejection Form

If you are a sole proprietor or partner, you **must** check off one and only one box in either section Aor B.

A. Acceptance of Coverage under the Illinois Workers Compensation Act.

If you choose to be covered under the Illinois Workers Compensation Act, you are required to provide evidence and a copy of a Workers Compensation policy indicating that you have purchased coverage and have elected to include yourself as a covered person on that policy. Should you fail to provide such evidence of WC coverage, an additional premium charge will be made to you, based upon the classification applicable to your activities, using a standard payroll amount for each such sole proprietor/partner, as outlined in the Workers Compensation manual applicable to Illinois.

As provided under the terms of the Illinois Workers Compensation Act, (305/3) I am exercising my right to be covered for accidental injuries, including death resulting therefrom, sustained by me and arising out of, and in the course of employment, in accordance with the provisions of the Illinois Workers Compensation Act.

[ ] I Elect To Be Covered Under The Illinois Workers Compensation Act.

B. Waiver of Rights Under the Illinois Workers Compensation Act

As provided under the terms of the Illinois Workers Compensation Act, (305/3) I am waiving my right to be covered for accidental injuries, including death resulting therefrom, sustained by me and arising out of, and in the course of employment, in accordance with the Illinois Workers Compensation Act.

[ ] I Elect Not To Be Covered Under The Illinois Workers Compensation Act. (305/2(c)).

Name:_____

Title:_____ **SSN/CDL:**_____

Policy Number:_____ **Policy Expiration Date:**_____

_____ _____

Driver Signature **Date**

Countersigned by:_____ _____

Authorized Agent **Date**