



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

TRUCKING PROGRAM

Agency Name _____
 Address _____
 Telephone Number _____

OCCUPATIONAL ACCIDENT INSURANCE INDIVIDUAL OWNER-OPERATOR APPLICATION

1. SCHEDULE OF BENEFITS : PLAN D

DESCRIPTION OF BENEFITS	OCCUPATIONAL	NON-OCCUPATIONAL	PASSENGER
ACCIDENTAL DEATH (MAXIMUM) SURVIVOR'S BENEFIT (LUMP SUM)	\$250,000 PRINCIPAL SUM (\$50,000+\$1000/MTH UP TO 200 MTHS)	\$15,000 PRINCIPAL SUM (\$500 PER MONTH UP TO 30 MTHS)	\$50,000 PRINCIPAL SUM (\$12,500+\$500/MTH UP TO 25 MTHS)
ACCIDENTAL DISMEMBERMENT INCLUDING PARALYSIS, AND SEVERE BURN BENEFITS INCURRAL PERIOD	104 WEEKS	104 WEEKS	104 WEEKS
ACCIDENTAL MEDICAL EXPENSE ACCIDENTAL DENTAL BENEFIT	\$1,000,000 MAXIMUM BENEFIT AMOUNT \$1000 PER INJURY/ \$10,000 LIFETIME	\$10,000 MAXIMUM BENEFIT AMOUNT NOT COVERED	\$50,000 MAXIMUM BENEFIT NOT COVERED
DEDUCTIBLE INCURRAL PERIOD RIDER LIMIT FOR: HERNIA OR HEMORRHOID OR OCCUPATIONAL DISEASE OR OCCUPATIONAL CUMULATIVE TRAUMA MAX BENEFIT PERIOD	0 104 WEEKS \$7,500 PER ACCIDENT OR INJURY SUBJECT TO A \$15,000 LIFETIME MAXIMUM 10 WEEKS	0 104 WEEKS NOT COVERED	\$100 104 WEEKS NOT COVERED
TEMPORARY TOTAL DISABILITY WAITING PERIOD DURATION-MAXIMUM BENEFIT PERIOD RIDER LIMIT FOR: HERNIA OR HEMORRHOID OR OCCUPATIONAL DISEASE OR OCCUPATIONAL CUMULATIVE TRAUMA MAX BENEFIT PERIOD	\$700 MAX/\$200 MIN PER WEEK 7 DAYS 104 WEEKS 10 WEEKS	NOT COVERED	NOT COVERED
CONTINUOUS TOTAL DISABILITY WAITING PERIOD DURATION-MAXIMUM BENEFIT PERIOD	\$700 MAX/\$200 MIN PER WEEK 104 WEEKS TO AGE 70	NOT COVERED	NOT COVERED
CERTIFICATE 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 any 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: _____

FLORIDA STATUTE 817.234(1)(b)

“Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.”

NEW MEXICO STATUTE 59A-16C-8

“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 civil fines and criminal penalties.”

Agent Printed Name: _____

Agent License Number: _____

Agent State: _____

Agent Signature: _____