



Great American Insurance Company  
 580 Walnut Street  
 Cincinnati, OH 45202  
 800.643.7882

Agency Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone Number \_\_\_\_\_

## OCCUPATIONAL ACCIDENT INSURANCE INDIVIDUAL OWNER-OPERATOR APPLICATION

### 1. SCHEDULE OF BENEFITS: PLAN S75D (Eligibility limited to drivers between their 65th and 75th birthdays)

NOTE: If you are beyond your 70th birthday all benefit and incurral periods listed below will be reduced to max of 52 weeks

DESCRIPTION OF BENEFITS	OCCUPATIONAL	NON-OCCUPATIONAL
<b>ACCIDENTAL DEATH (MAXIMUM SURVIVOR'S BENEFIT (LUMP SUM)</b>	\$250,000 PRINCIPAL SUM (\$50,000 + \$1000 PER MONTH UP TO 200 MTHS)	\$15,000 PRINCIPAL SUM (\$500 PER MONTH UP TO 30 MTHS)
<b>ACCIDENTAL DISMEMBERMENT INCLUDING PARALYSIS, AND SEVERE BURN BENEFITS INCURRAL PERIOD</b>	AGE 65 TO 70TH BIRTHDAY: 104 WEEKS/ AGE 70 TO 75TH BIRTHDAY: 52 WEEKS	<b>52 WEEKS</b>
<b>ACCIDENTAL MEDICAL EXPENSE</b>	\$1,000,000 MAXIMUM BENEFIT AMOUNT	\$10,000 MAXIMUM BENEFIT AMOUNT
ACCIDENTAL DENTAL BENEFIT DEDUCTIBLE	\$1000 PER INJURY/\$10,000 LIFETIME 0	NOT COVERED 0
INCURRAL PERIOD	AGE 65 TO 70TH BIRTHDAY: 104 WEEKS/ AGE 70 TO 75TH BIRTHDAY: 52 WEEKS	<b>52 WEEKS</b>
<b>TEMPORARY TOTAL DISABILITY</b>	\$500 MAX/\$150 MIN PER WEEK	NOT COVERED
WAITING PERIOD	7 DAYS	
DURATION-MAXIMUM BENEFIT PERIOD	104 WEEKS	
<b>CONTINUOUS TOTAL DISABILITY</b>	NOT COVERED	NOT COVERED
WAITING PERIOD		
DURATION-MAXIMUM BENEFIT PERIOD		
<b>CERTIFICATE AGGREGATE AND COMBINED SINGLE LIMIT ANY ONE ACCIDENT</b>	<b>\$1,000,000</b>	

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: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

D.O.B.: \_\_\_\_\_ Home ph: \_\_\_\_\_ Beneficiary name: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Please attach your current long form DOT Physical and CDL MVR to this application. Documents older than 6 months prior to the date of this application may be rejected.**

**NOTE: If you are beyond your 70th birthday all benefit and incurral periods listed on the prior page will be reduced to a maximum of 52 weeks.**

**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 75th 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 \_\_\_\_\_

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