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 D2

DESCRIPTION OF BENEFITS	OCCUPATIONAL	NON-OCCUPATIONAL	PASSENGER
ACCIDENTAL DEATH (MAXIMUM) SURVIVOR'S BENEFIT (LUMP SUM) **ACCIDENTAL DISMEMBERMENT** INCLUDING PARALYSIS, AND SEVERE BURN BENEFITS INCURRAL PERIOD	$300,000 PRINCIPAL SUM ($50,000+$2000/MTH UP TO 125 MTHS) 104 WEEKS	$15,000 PRINCIPAL SUM ($500 PER MONTH UP TO 30 MTHS) 104 WEEKS	$50,000 PRINCIPAL SUM ($25,000+$1000/MTH UP TO 25 MTHS) 104 WEEKS
ACCIDENTAL MEDICAL EXPENSE ACCIDENTAL DENTAL BENEFIT DEDUCTIBLE INCURRAL PERIOD **RIDER LIMIT FOR:** HERNIA OR HEMORRHOID OR OCCUPATIONAL DISEASE OR OCCUPATIONAL CUMULATIVE TRAUMA MAX BENEFIT PERIOD	$1,000,000 MAXIMUM BENEFIT AMOUNT $1000 PER INJURY/ $10,000 LIFETIME 0 104 WEEKS $7,500 PER ACCIDENT OR INJURY SUBJECT TO A $15,000 LIFETIME MAXIMUM 10 WEEKS	$10,000 MAXIMUM BENEFIT AMOUNT NOT COVERED 0 104 WEEKS NOT COVERED	$50,000 MAXIMUM BENEFIT 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 UP TO SOCIAL SECURITY RETIREMENT AGE	NOT COVERED	NOT COVERED
CERTIFICATE AGGREGATE AND COMBINED SINGLE LIMIT ANY ONE ACCIDENT	**$2,000,000**		

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: _____

Address:_____ City: _____ State: _____Zip:_____

Date of birth: _____ Home phone number:_____

Beneficiary name: _____Relationship: _____

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 fi les 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 benefi t or knowingly presents false information
in an application for insurance is guilty of a crime and may be subject to civil fi nes and criminal penalties."
OHIO INSURANCE CODE 3999.21
"Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application
or fi les a claim containing a false or deceptive statement is guilty of insurance fraud."