LOTUS BENEFITS CORP.
Info@LotusOccAcc.com
608-618-9199

Driver Form

Owner / Operator Request for Occupational Accident Insurance

PAIC Membership Enrollment

Date: **Participant Sponsor:** *Truckers Insured Program* **Motor Carrier:**

Driver Information

First Name:	**Last Name:**	**DOB:**
DOT #	**SS#**	**DL#**
Steet:	**City:**	**State:**
ZIP:	**Email:**	**Cell Phone:**

Driver Legal Status: ☐ Sole Prop ☐ Partnership ☐ INC ☐ LLC **Business Name:**

Allow Text/Email to provide Quote/Bind/Policy info: X Yes No

Beneficiary Designation- Accidental Death Benefit

Name:	**Phone:**	**DOB:**	**Relationship to Insured:**

Workers' Compensation Insurance Rejection Acknowledgement

I hereby decare and state that:

1. I am not an employee or eligible for Workers' Compensation from the Participant Sponsor. I request coverage under the Participant Sponsor's group Occupational Accident policy; and
2. I qualify for coverage under the Eligible Class as checked above; and
3. I grant permission to the Participant Sponsor to deduct such payments as may be required for the insurance provided by this policy: and
4. I understand this insurance will become effective the date this Request For Insurance has been received and approved by High Point Underwriters.
5. I am joining the Professional Association of Independent Contractors (PAIC); and
6. I request coverage to be bound under the Participant Sponsor's Occupational Accident policy. I am electing to exclude myself from Workers' Compensation coverage as permissible under the laws of my state.
7. I hereby grant a limited power-of-attorney to PAIC with the authority to initiate cancellation of my Occupational Accident coverage effective the same date I am no longer eligible under this Program.; and
8. I hereby understand and agree that eligibility for this program is limited to Independent Contractors, as defined by law, and Owner Operators' who are not employees and I further agree to the terms outlined in the above items.
9. The beneficiary designation above shall void and supersede any previous designation by me. I reserve the right to change the beneficiary shown above by completing and submitting a signed Change of Beneficiary Form.
10. I understand that the insurance as applied for is based upon my written statements and answers to the above questions.
11. I attest that all statements made in this Request for Insurance are true and accurate to the best of my knowledge.

It is my right as an Independent Contractor and as a sole proprietor or executive officer of my Company to exercise my option to not buy Workers' Compensation insurance on myself. I am choosing not to purchase Workers' Compensation. I am electing to buy Occupational Accident Insurance. I understand that Occupational Accident insurance is not Workers' Compensation insurance and provides different benefits than Workers' Compensation.

I VERIFY THAT I HAVE READ THIS AGREEMENT AND THAT I UNDERSTAND WHAT I AM PURCHASING:

Applicant's Signature **Date**