PROSPECTIVE ENROLLEE QUESTIONNAIRE FOR OCCUPATIONAL ACCIDENT COVERAGE

NAME_____

CITY_____STATE_____

DATE OF BIRTH_____GENDER: MALE☐ FEMALE☐

NUMBER OF YEARS EXPERIENCE_____

ARE YOU AN OWNER OPERATOR? YES☐ NO☐ IF YES, IS THE CERTIFICATE OF TITLE IN YOUR NAME? YES☐ NO☐
IF NO, ARE YOU A: CO-OWNER☐ LEASED DRIVER☐ CONTRACT DRIVER☐ TEAM DRIVER☐ EMPLOYEE☐

NUMBER OF AUTO ACCIDENTS WITHIN THE PAST 3 (THREE) YEARS_____

DO YOU DRIVE FOR ANOTHER PERSON? YES☐ NO☐ DO YOU LOAD OR UNLOAD? YES☐ NO☐

DO YOU ATTACH OR DETACH ANY TRAILERS? YES☐ NO☐ DO YOU USE TARPS OR CHAINS? YES☐ NO☐

WHAT TYPE OF TRANSMISSION DO YOU DRIVE? AUTOMATIC☐ MANUAL☐

DO YOU DRIVE: LONG HAUL (>100 MILES PER TRIP)☐ SHORT HAUL (<100 MILES PER TRIP☐

DO YOU HAUL OR DRIVE (CHECK ALL THAT APPLY)? LIVESTOCK☐ TANKER☐ DUMP TRUCKS☐
GARBAGE/REFUSE☐ CHEMICALS☐ INTERMODAL☐ DUMP TRAILERS (SIDE OR END DUMP☐)
FURNITURE MOVING & STORAGE☐ GVW <20,000 LBS.☐ FLATBED☐

****PLEASE ATTACH CURRENT MVR

Excluded/Referral Classes:

- Tanker Units
- Fuel, Gas. Liquefied petroleum, gasses or gasoline
- Ammunition
- Reclamation/repossession
- Remediation
- Recyclables
- Refuse Haulers
- Log/pulpwood transports
- Off-road logging
- Coal Haulers
- Other hazardous chemicals/materials
- Moving & Storage
- Home Delivery
- Livestock

1300 S. Grove Ave. Suite 102, Barrington, IL 60010 * Phone 847-387-6545 * Fax 847-387-6544

2. DRIVER AND BENEFICIARY INFORMATION

Name: _____ DOB: _____

Address: _____ City: _____

State: _____ Zip : _____ Home Phone: _____ Cell: _____

Beneficiary Name: _____ Relationship: _____

Indicate type of driver: Owner Operator ☐ Co-Driver ☐ Contract-Driver ☐ Scheduled Co-Driver ☐ Fleet Driver ☐ Team Driver ☐

Other, including an authorized passenger ☐ _____

CDL Number: _____ Unit Number/VIN# : _____

Paid by: 1099 ☐ W-2 ☐ Contracted By: _____

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 70th 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.

Owner-Operator 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.

Owner-Operator 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."

OHIO INSURANCE CODE 3999.21

"Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insured, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud."