

INDEPENDENT CONTRACTOR OCCUPATIONAL ACCIDENT ENROLLMENT FORM

INSURED PERSON INFORMATION:

Last Name First Name M.I.

Street

City State Zip

Contact Telephone Number(s)

Date of Birth Last 4 SSN

Email address

Beneficiary Last First Name M.I.
Name

Beneficiary Address

Relationship or

Check box to have death benefits paid to my Estate

Start Date Driver Number

Contractor Leased to: _____

Location/Terminal: _____



Insurance | Risk Management | Consulting

kc_trans_admin@ajg.com

CERTIFICATION

I certify that all information in this Enrollment Form and other enrollment documents is true and correct to the best of my knowledge. I hereby request occupational accident coverage under the insurance program ("Occupational Accident Program") developed by Gallagher Transportation Services ("Gallagher"). I verify that I am the independent contractor/driver named on this Enrollment Form who is under contract to the facilitating motor carrier on the date of this Enrollment Form. I verify that I am also an independent contractor/driver under contract to the facilitating motor carrier and understand that I am covered only while under contract with the facilitating motor carrier. I have designated the noted beneficiary in the event of my death.

I certify that I am under the age of 75 as of the date set forth below my signature.

I understand and acknowledge that Arthur J. Gallagher Risk Management Services, Inc. ("AJG") is the insurance agent with limited authority to procure the insurance coverage referenced in this Enrollment Form. I also acknowledge that I have not sought or received insurance advice from Gallagher or AJG on the referenced insurance coverage as it applies to me and/or my business needs. I further understand and acknowledge that compensation for the services described above is part of the cost of the insurance coverage and not separately charged to me.

In accordance with my independent contractor operating agreement, and as an addendum thereto, I authorize the facilitating motor carrier to periodically deduct my insurance costs. If such settlements (or other monies due me) are not sufficient to cover the insurance costs, I will remit by certified check or money order the outstanding insurance cost to Gallagher Transportation Services, 4622 Pennsylvania Ave, Suite 920, Kansas City, MO 64112 within a ten (10) day period. Otherwise, I understand the insurance underwriters may cancel this insurance coverage in accordance with policy terms and conditions. I also understand coverage will not automatically be reinstated if cancellation is processed. I have read, understand and agree to the terms and conditions on the reverse side of this Enrollment Form.

I agree that a photographic, facsimile or electronically signed copy of the authorization is as valid as the original.

By signing below, I acknowledge that I may receive my Occupational Accident Confirmation of Coverage electronically in lieu of it being mailed to my residence. If I would prefer to receive a paper copy, I will contact Gallagher Transportation Services at 800.455.6959 and request a copy.

Signed: _____

Date: _____

TERMS AND CONDITIONS - Please read carefully

It is further understood and agreed:

1. Not Statutory Workers' Compensation & Employers' Liability: This coverage is NOT a statutory Workers' Compensation and Employers' Liability policy, and the benefits under this coverage do not necessarily equal the benefits which an individual might be eligible for under statutory Workers' Compensation. However, you agree that in the event of an occupational accident, you will look to the occupational accident coverage described herein in lieu of seeking Workers' Compensation coverage.

2. Assignment of Benefits: In the event benefits are paid from the statutory Workers' Compensation and Employers' Liability Policy of the facilitating motor carrier or any similar policy becomes liable for such benefits, the benefits which an Insured Person is entitled to under this policy will be automatically assigned to the facilitating motor carrier. In such event, you agree to the immediate assignment to the facilitating motor carrier of all benefits which you receive or would otherwise be payable to you or any third party under the Occupational Accident Program.

3. Cost and Consent to Cost Change: You understand that the insurance cost shown may include taxes, fees and administrative expenses which you accept and acknowledge as part of the insurance cost. The insurance underwriters reserve the right to change the rate by giving written notice to you.

4. Evidence of Coverage: Your state of principal operations could require you to purchase Statutory Workers' Compensation, otherwise, the facilitating motor carrier will accept coverage under the Occupational Accident Program. If you do not participate in the Occupational Accident Program, you are required to have on file a certificate of insurance for Statutory Workers' Compensation or when allowed by law, an Occupational Accident Certificate. Your insurance agent should provide this information to the facilitating motor carrier.

You will be enrolled in the facilitated occupational accident program until you provide proof of appropriate coverage. At that time you will receive an adjustment in any costs charged to you.

5. Termination: In the event your independent contractor operating agreement with the facilitating motor carrier is terminated for any reason by either party, the occupational accident coverage will be cancelled effective the date of the contract termination or the earliest date thereafter allowed by law. You should make arrangements to replace coverage immediately.

6. Terms & Conditions: Coverage will be subject to all policy terms, conditions and exclusions as detailed in the Evidence of Insurance. The Insured Person must be under age 75 to enroll in the Occupational Accident Program.

7. Authorization of Settlement Deduction: You authorize the facilitating motor carrier to deduct from your settlement checks, funds, accruals or other compensation, on a periodic basis (e.g. weekly or monthly) in amounts sufficient to pay the insurance costs and hereby instruct it to forward such funds to Gallagher by the 15th of each month. Your cost (as described in "Cost and Consent to Cost Change") will be deducted from your settlement check. If your settlement check is not enough to cover your insurance cost, you will be asked to forward a check or money order made payable to Gallagher Transportation Services, 4622 Pennsylvania Ave, Suite 920, Kansas City, MO 64112 immediately, or the coverage will be cancelled, in accordance with policy terms and conditions.

8. Effective Date: Coverage shall become effective on the date your Enrollment Form is accepted by Gallagher.

**PLEASE READ ALL INFORMATION
CAREFULLY BEFORE SIGNING THE
APPLICATION ON THE REVERSE SIDE**



Insurance | Risk Management | Consulting

Please email all applications to Gallagher Transportation at kc_trans_admin@ajg.com