CHUBB

ACE American Insurance Company
(A Stock Company)
Philadelphia, PA 19106

APPLICATION FOR OCCUPATIONAL ACCIDENT INSURANCE

Application is hereby made for Occupational Accident Insurance based on the following statements and representations.

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE.

Drivers' Name: _____ Unit Number: _____
First Name *MI* *Last*

Mailing Address_____

City_____State_____Zip_____

Billing Address (if different from above)_____

Telephone No._____Sex_____Marital Status_____

Date of Birth		Drivers License Number		State	

Motor Carrier Name: _____ Federal ID#: _____

City_____State_____Zip_____

Telephone No._____Contact_____

Email Address_____

Vehicle Make		Model		Year	

List the Commodity(s) you primarily haul for the motor carrier? _____

Identify the type of Trailer used to perform your contractual obligations on behalf of the motor carrier using percentage(s):

Dry Van_____% Refrigerated_____% Box_____% Flat Bed_____% Dump_____% Tanker_____% Auto_____%

If the type of trailer is not listed above, please specify and provide a percentage(s)_____

Requested Effective Date: _____

Beneficiary of Accidental Death Benefit:_____

Relationship to applicant:_____

Premium Rate:

If the vehicle you are driving is:	The premium is:
Dry Van or Refrigerated Trailers:	$138.00 per month
Flat Beds, Aggregate, Redi-Mix, or Dump Truck Haulers:	$159.00 per month
Tankers, Automobile Carriers, or other classification of Haulers subject to the Insurance Company's approval:	$175.00 per month

The Applicant agrees to pay, in advance, the required Premium for the coverage.

Coverage is issued according to plan specifications and rates in effect at the time of enrollment.

Payment Method
Pick ONE from the following three ways to pay:

1. ☐ Credit Card Automatic Payments - By signing the above authorization, I authorize Univantage Insurance Solutions Inc to initiate a credit card transaction for the payment of my premium and, for future premium payments on a recurring basis on the credit card listed below. I further agree to make all present and future payments under this recurring charge authorization according to my credit card statement. I understand my insurance will be cancelled, if my credit card is declined or if I contest any recurring charge made under this authorization. All charges will show on your credit card statement as Univantage Insurance Solutions Inc.

Card #: _____ Expiration Date: _____
(month/ year)

Billing Address:
Street: _____
State/Province: _____ Postal/Zip Code: _____ Country: _____
Name as it appears on card: _____ Signature: _____

2. ☐ Automatic Withdrawals from Checking Account — By signing this form, I hereby authorize Univantage Insurance Solutions Inc to initiate debit entries to the checking account at the depository financial institution indicated below, for the payment of my premium and for future premium payments on a recurring basis. All such transactions to my checking account will comply with the laws of the United States of America. I understand my insurance will be cancelled if the checking account indicated below does not have sufficient funds to pay the applicable premium or if I contest any recurring debit made under this authorization. All recurring debits will show on your bank statement as Univantage Insurance Solutions Inc.

Bank Routing Number: _____	Bank Account Number: _____	
X_____	_____	_____
Signature	Date	Phone Number

3. ☐ Motor Carrier Remittance – I authorize the Motor Carrier named herein to deduct the required premium from my earnings.

By signing this Application the driver applicant agrees to all of the following conditions:

1. **To be covered under the above specified policy**
2. **I am over the age of 17 and under the age of 70.**
3. **I own or lease a motor vehicle to a motor carrier that I personally operate under a fully executed written agreement with the motor carrier that states I am an independent contractor;**
4. **I am not an employee of the motor carrier or any other individual that has a written agreement with the motor carrier;**
5. **I will provide the motor carrier a copy of my current workers' compensation coverage waiver and proof that I am covered by Occupational Accident related insurance as soon as possible.**
6. **That all of the statements made in this Application are, to the best of my knowledge and belief, true and accurate.**

I understand my information is protected by privacy laws and will be released only in accordance with these laws.

It is a crime to provide false or misleading information to an Insurer for the purpose of defrauding the Insurer or any other person. Penalties include imprisonment and/or fines. In addition, an Insurer may deny insurance benefits if false information materially related to a claim was provided by the Applicant.

Signed by:_____Date:_____

THE POLICY PROVIDES LIMITED BENEFITS. REVIEW YOUR POLICY CAREFULLY.

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The following is for use by ACE American Insurance Company or its Underwriting Manager only.

Approved By: _____ Date_____
(Authorized signature)