OneBeacon
INSURANCE GROUP

ENROLLMENT FORM

NON-TRUCKING LIABILITY INSURANCE COVERAGE
FOR
INDEPENDENT CONTRACTOR DRIVER MEMBERS OF NATIONAL INDEPENDENT TRUCKERS AND CONTRACTORS ASSOCIATION, INC. (NITACA)

POLICY NUMBER: 794-000-291

ADMINISTERED BY
HOME OF OWNER-OPERATOR PRODUCTS & SERVICES (HOOPS)

Return completed and signed form to your Insurance Agent or the Administrator.

You must be a member of the above Association to be eligible to apply for this coverage.
This coverage will only be in effect when you are under Permanent Lease to a Motor Carrier.

ENROLLEE INFORMATION FEIN #:_____

Name: _____ DBA:_____

Mailing Address: _____

City: _____ County: _____ State: _____ Zip Code: _____

Phone Number: Main: _____ Alternate:_____

Email Address: _____

Business Type: ☐ Individual ☐ Corporation ☐ Partnership Years in Business:_____

YOUR OPERATION

Permanently leased to: _____ MC Number:_____

Address: _____ City: _____ State:_____ Zip:_____

Primary commodity hauled: _____

Average one-way haul (miles): _____

VEHICLES

#	Year	Make	Owned or Leased	Tractor or Trailer	Trailer Type	Weight Class	VIN	Reg. State
1								
2								
3								

Attach more pages as necessary.

DRIVERS

Name	DOB	CDL Number	State

Attach more pages as necessary.

COVERAGE:

- **Non-Trucking Liability Coverage - as provided by the above referenced Policy**

Do you certify you **have had**: No DWIs in last 5 years? Yes ☐ No ☐ No license suspensions in last 3 years? Yes ☐ No ☐
No more than 3 moving violations in last 3 years, with no more than 2 in last 12 months? Yes ☐ No ☐
No more than 1 preventable accident in last 3 years? Yes ☐ No ☐ No felony convictions? Yes ☐ No ☐

IMPORTANT NOTICE

Any person who knowingly and with intent to defraud any insurance company or another person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects the person to criminal and (**NY**: substantial) civil penalties. (Not applicable in **CO**, **DC**, **FL**, **HI**, **MA**, **NE**, **OH**, **OK**, **OR**, **VT** or **WA**; in **LA**, **ME**, **TN** and **VA**, insurance benefits may also be denied.)

In **Colorado**, it is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement of award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

In the **District of Columbia**, WARNING: 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.

In **Florida**, 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.

In **Hawaii**, for your protection, the law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

In **Kansas**, any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

In **Massachusetts**, **Nebraska**, **Oregon** and **Vermont**, any person who knowingly and with intent to defraud any insurance company or another person, files an application for insurance or statement of claim, containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, may be committing a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

In **Minnesota**, any person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

In **Ohio**, any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deception statement is guilty of insurance fraud.

In **Oklahoma**, WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

In **Washington**, it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

AUTHORIZATIONS AND SIGNATURE:

In providing this information, I, the undersigned, understand and hereby state that:

1. to the best of my knowledge and belief, all information on this Form is complete and truthful; and
2. if, based on the information supplied in this Form, I am not eligible for coverage, premium will be refunded and no claims will be payable.

By my signature below, I, the undersigned, also authorize the motor carrier named above, 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 records, to furnish such information or copies of records to Atlantic Specialty Insurance Company. A photographic copy of this authorization shall be as valid as the original.

Payment Authorization:

I hereby authorize my Insurance Agent to bill the following selected party for my Non-Trucking Liability coverage and remit these funds to Administrator for payment to Atlantic Specialty Insurance Company on my behalf:

☐ Self ☐ Motor Carrier, as listed on the front of this Form

☐ Other: _____

Name

_____

Street/PO Box

_____

City State Zip

I UNDERSTAND THAT THE COST OF THE INSURANCE IS MY SOLE OBLIGATION AND RESPONSIBILITY, regardless of the above arrangement of premium payment. I agree that I will forward any amount due and owing to Atlantic Specialty Insurance Company, upon demand, for any insurance at any time my account remains unpaid.

IF THE INFORMATION PROVIDED IN THIS FORM IS FRAUDULENT,
THE INSURER HAS THE RIGHT TO RETURN PREMIUM AND CANCEL COVERAGE.

In order to verify the information provided in this Form, I, the undersigned, give the Insurer authority to examine the records that are maintained by the motor carrier named above and the Administrator.

By signing below, I affirm knowledge of and adherence to current D.O.T. safety regulations, and hereby apply for insurance with respect to the coverage stated on this Enrollment Form.

By signing below, I authorize and accept, as if I had made the election, the selection/rejection made by the above named Association, for Uninsured Motorists, Underinsured Motorists, and/or No-Fault (PIP & Medical Payments) insurance.

By affixing a check mark in the red box next to “Enrollee’s Signature” and typing my name in the “Enrollee Signature” field and typing the date in the “Date” field, I acknowledge I am electronically signing this form. Furthermore in order to conduct business with Atlantic Specialty Insurance Company, I agree that my electronic signature serves with the same force as my signature affixed by hand.

☐ **Enrollee's Signature:** _____ **Date:** _____

Administrator Use Only

Reviewed and Approved by:

Administrator Signature: _____ Date: _____

Note: This Non-Trucking Liability Insurance coverage is provided through the National Independent Truckers and Contractors Association, Inc. (NITACA), and underwritten by Atlantic Specialty Insurance Company, an insurance company subsidiary of Intact Insurance Group USA LLC (formerly OneBeacon Insurance Group LLC.) for members of NITACA. NITACA has entered into endorsement agreements with the insurer for which it receives compensation which is used to defray costs and provide membership services and benefits.

NATIONAL INDEPENDENT TRUCKERS AND CONTRACTORS ASSOCIATION, INC. ("NITACA") MEMBERSHIP ENROLLMENT APPLICATION

Please Print Clearly

Name:_____
Last First Middle ☐ M ☐ F

Address:_____

City:_____State:_____Zip:_____

Phone:_____ Email:_____ Last four of social security number:_____

By signing this Membership Enrollment Application, Member agrees to abide by the Bylaws of NITACA, as amended from time to time. NITACA reserves the right to change the membership dues. Membership in NITACA is non-transferable and only one membership in NITACA is allowed per eligible person. You may cancel your membership and obtain a full refund of any membership dues paid within thirty (30) days from the date you join NITACA by sending a cancellation letter and a request for refund with your name and membership number to Member Services. NITACA bylaws are available upon request. Nothing herein creates the relationship of employer-employee between a Member and NITACA.

Members of NITACA have access to certain benefits and/or products offered by NITACA or sponsored by NITACA. Benefits and/or products are offered at the sole discretion of NITACA and may vary by availability, vendor or the member's state of residence. NITACA may change vendors or immediately terminate the benefits and/or products offered without prior notice to members. Termination of membership in NITACA for failure to pay dues or for any other cause will result in the loss of such benefits and/or products. By signing this Form, you authorize NITACA to share your information with such third-party vendors on an as needed basis only.

Proxy: By signing this application I understand that I am enrolling as a member in NITACA. I appoint the Secretary of NITACA in office at any particular time as my proxy to receive notice of and attend all meetings of the members and vote on my behalf and to otherwise act for me in the same manner and with the same effect as if I were personally present. This proxy shall be valid until revoked at any time prior to voting at any meeting by executing and delivering a written notice of revocation to the Secretary of NITACA, by executing and delivering a subsequently dated proxy to the Secretary of NITACA or by voting in person.

Payment of Dues: The monthly membership dues are $3.00 per member. I understand that the cost of this membership is my sole obligation.

Selection of Uninsured Motorist/Underinsured Motorists Coverage by NITACA: By signing this membership form I acknowledge that if I decide to purchase the Non-Trucking Liability Insurance through NITACA, I authorize NITACA to make the selection for the Uninsured Motorists, Underinsured Motorists, and/or No-Fault (PIP& Medical Payments) insurance.

I hereby state that I certify to the best of my knowledge and belief that all information on this form is complete and truthful and I am 18 years of age or older and I am a professional driver. Membership in NITACA begins the first of the month in which the membership enrollment form is indicated by Association Administrator below.

By affixing a check mark in the red check box below and typing my name in the "Signature" field and typing the "Date" in the date field, I acknowledge that I am electronically signing this form. Furthermore in order to conduct business with NITACA, I agree that my electronic signature serves with the same force as my signature affixed by hand.

☐ **SIGNATURE:** _____ **Date:** _____

For Association Administrator Use Only

Signature of Association Administrator: _____

Membership effective date (month/day/year):_____ Membership effective month: _____

For NITACA Use Only

Date Received: _____**Approved By:** _____**Member Number:**_____