



Atlantic Specialty Insurance Company

DRIVER ENROLLMENT AND BENEFICIARY FORM FOR CONTRIBUTORY BLANKET OCCUPATIONAL ACCIDENT INSURANCE FOR CERTAIN MEMBERS OF THE NATIONAL INDEPENDENT TRUCKERS AND CONTRACTORS ASSOCIATION, INC. (NITACA) INSURANCE ADMINISTERED BY HOME OF OWNER-OPERATOR PRODUCTS & SERVICES (HOOPS) Policy #: 216-002-512

You must be a member of NITACA and an eligible Owner-Operator or a Contract Driver for an Owner-Operator or Owner to apply for this Contributory Blanket Occupational Accident Insurance coverage.
This form must be legible, complete, signed and dated before it can be processed and coverage can be put into effect.*

Individual Driver Information: (please print)

Name: _____	MC/DOT Number: _____
Address: _____	CDL Number: _____
City: _____	CDL State: _____ CDL Exp. Date: _____
State: _____ Zip: _____	Number of Years of Experience: _____
Date of Birth: _____	Contracted By (Name of Co.): _____
Home Telephone Number: _____	Address: _____
Cell Phone Number: _____	City: _____
E-mail Address: _____	State: _____ Zip: _____
Beneficiary: _____	Effective Date of Contract: _____
Relationship to Beneficiary: _____	Motor Carrier Phone Number: _____
Address of Beneficiary: _____	Motor Carrier Fax Number: _____
_____	Motor Carrier E-mail Address: _____
Are you covered under any medical plan? Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
If yes, please provide name of carrier: _____	

General Information:

Please indicate your status:

- I am an **Owner-Operator** with written proof that I own or lease a power unit (*power unit must not be leased from a motor carrier whose authority you are operating under*): a) leased to a Motor Carrier **OR** b) operating under my own authority **OR**

- I am a **Contract Driver*** operating the power unit of an Owner-Operator or Owner (*and I receive a Form 1099*)

*You are not eligible for coverage unless the equipment you are operating is owned or leased by an Owner-Operator or Owner. The Owner's power unit must be owned or leased by a corporation or limited liability company where the Owner is the principal shareholder or member. See Policy for full definition.

Type of equipment you use: Intermodal Standard Box Dry Van Reefer Flatbed Tanker Dump
 Auto Hauler Other Describe: _____

Years of experience operating the indicated equipment: _____

Do you haul any Oversize or Overweight loads, or pull any double trailers? Yes No If so, which? _____

Do you load/unload? Yes No If yes, what is the average weight you lift? _____

Do you attach and detach the trailer? Yes No Do you tarp? Yes No Do you strap? Yes No
 What do you haul? _____

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

I hereby authorize my Insurance Agent to bill the following selected party for my Occupational Accident coverage and remit these funds to Broker 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. I agree that I will forward any amount due to the Broker upon demand, for any insurance at any time my account remains unpaid.

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

1. The Contributory Blanket Occupational Accident coverage provided is not a contract for Statutory Workers' Compensation Insurance and neither the carrier above nor I become participants in the Workers' Compensation system by purchasing this insurance.
2. I certify to the best of my knowledge and belief that all information on this form is complete and truthful.
3. I am an active dues paying member of the National Independent Truckers and Contractors Association, Inc. (NITACA).
4. I am 18 years of age or older and I am a professional truck driver.
5. I am an independent contractor and receive a 1099 tax form, not a W-2 tax form for an employee.

By my signature below, I, the undersigned also 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 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.

FRAUD WARNING

Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or a 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**IF THE INFORMATION YOU HAVE PROVIDED IS FRAUDULENT,
 WE MAY HAVE 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 and the Broker.

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:** _____

Broker Use Only

Reviewed and Approved by:
 Broker Signature: _____ Date: _____

Occupational Accident Insurance 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	<input type="checkbox"/>	M
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: _____