Occupational Accident Insurance Protection

PASSENGER ACCIDENT OPTION AVAILABLE

PLANS AVAILABLE FOR:

INDEPENDENT TRUCK OWNER/OPERATORS AND CONTRACT DRIVERS

Administered by:

PALLAY INSURANCE AGENCY

PO Box 727

Mokena, IL 60448

Questions?

Contact Pallay Insurance Agency

Toll-Free Phone: 888-549-8533

E-mail: service@pallayinsurance.com

www.pallayinsurance.com/truckers

DISCLAIMER

This coverage is not workers' compensation or sickness coverage and it does not provide coverage authorized or required under the Workers' Compensation Act. This is not a substitute for workers' compensation coverage.

Underwritten by:

OneBeacon ACCIDENT GROUP

TRUCKERS OCCUPATIONAL ACCIDENT INSURANCE

SUMMARY OF BENEFITS*

OCCUPATIONAL ACCIDENT BENEFITS

	Plan 1	Plan 2	Plan 3
ACCIDENTAL DEATH			
Principal Sum	$50,000	$ 25,000	$25,000
Survivor's Benefit (1% mo.) / up to ...	$200,000	$125,000	$125,000
Accident Commencement Period	365 days	365 days	365 days
ACCIDENTAL DISMEMBERMENT			
% of Principal Sum of ...	$250,000	$150,000	$150,000
Paralysis Benefit / up to ...	$250,000	$150,000	$150,000
Accident Commencement Period	365 days	365 days	365 days
TEMPORARY TOTAL DISABILITY			
Disability Commencement Period	90 days	90 days	90 days
Waiting Period	7 days	7 days	7 days
Benefit Percentage	70%AWE	70%AWE	70%AWE
Maximum Weekly Benefit Amount	$500	$400	$400
Maximum Benefit Period	104 wks	52 wks	52 wks
CONTINUOUS TOTAL DISABILITY			
Waiting Period	104 wks	52 wks	52 wks
Benefit Percentage	70%AWE	70%AWE	70%AWE
Maximum Weekly Benefit Amount	$500	$400	$400
Maximum Benefit Amount	$400,000	$300,000	$200,000
Maximum Benefit Period	to age 70	to age 70	to age 70
ACCIDENT MEDICAL EXPENSE			
Medical Commencement Period	90 days	90 days	90 days
Deductible Amount	$0	$0	$0
Maximum Benefit Period	104 wks	52 wks	52 wks
Dental Maximum per Accident	$1,000	$1,000	$1,000
Maximum Benefit Amt per Accident	$1,000,000	$500,000	$300,000
Lifetime Maximum Benefit	$1,000,000	$500,000	$300,000

NON-OCCUPATIONAL ACCIDENT BENEFITS

	Plan 1	Plan 2	Plan 3
ACCIDENTAL DEATH			
Principal Sum	$15,000	$15,000	$15,000
Accident Commencement Period	365 days	365 days	365 days
ACCIDENTAL DISMEMBERMENT			
% of Principal Sum of ...	$15,000	$15,000	$15,000
Accident Commencement Period	365 days	365 days	365 days
ACCIDENT MEDICAL EXPENSE			
Medical Commencement Period	90 days	90 days	90 days
Deductible Amount	$0	$0	$0
Maximum Benefit Period	52 wks	52 wks	52 wks
Dental Maximum per Accident	$1,000	$1,000	$1,000
Maximum Benefit Amt per Accident	$5,000	$5,000	$5,000
Lifetime Maximum Benefit	$10,000	$10,000	$10,000

LIMITS OF LIABILITY

	Plan 1	Plan 2	Plan 3
OCCUPATIONAL COVERAGE:			
Combined Single Limit	$1,000,000	$500,000	$300,000
Aggregate Limit of Liability (applicable to all covered losses with respect to any one accident)	$2,000,000	$1,000,000	$600,000
NON-OCCUPATIONAL COVERAGE			
Combined Single Limit	$15,000	$15,000	$15,000
Aggregate Limit of Liability (applicable to all covered losses with respect to any one accident)	$30,000	$30,000	$30,000

Travel Assistance Services, ID Theft Management Service and a Discount Prescription Drug Card are included with all plans.

MONTHLY RATE PER DRIVER: PLAN 1: $146.00 PLAN 2: $136.00 PLAN 3: $125.00

*Amounts may be subject to a reduction schedule based on age at date of loss.

PASSENGER ACCIDENT OPTION

BENEFITS*

ACCIDENTAL DEATH	
Principal Sum	$100,000
Accident Commencement Period	365 days
ACCIDENTAL DISMEMBERMENT	
% of Principal Sum of ...	$100,000
Paralysis Benefit / up to ...	$100,000
Accident Commencement Period	365 days

ACCIDENT MEDICAL EXPENSE	
Medical Commencement Period	90 days
Deductible Amount	$50
Maximum Benefit Period	52 wks
Dental Maximum per Accident	$1,000
Maximum Benefit Amt per Accident	$100,000
Lifetime Maximum Benefit	$100,000

LIMITS OF LIABILITY

PASSENGER ACCIDENT COVERAGE:	
Combined Single Limit	$100,000
Aggregate Limit of Liability (applicable to all covered losses with respect to any one accident)	$200,000

RATE PER DRIVER TO INCLUDE PASSENGER ACCIDENT OPTION: $120.00 annual premium

*Amounts may be subject to a reduction schedule based on age at date of loss.

EXCLUSIONS: Coverage not available to drivers hauling or involved in following operations: Hazardous materials or waste; logging and lumbering operations; moving and storage operations; sand, gravel or any type of aggregate haulers; bulk carrier or tank operations; couriers, messengers or livery; PEO's, driver leasing or temporary services.

Coverage is not available in all states.

This brochure is for marketing purposes only. For further details, please review the policy forms and declarations. All coverages are subject to policy terms and conditions and the policy will govern in all matters. The OneBeacon Occupational Accident Policy is underwritten by a OneBeacon insurance company whose principal executive office is located at 150 Royall Street, Canton, MA 02021. OneBeacon Services is a wholly owned entity of OneBeacon Insurance. Services may be provided by third parties.

TRUCKERS OCCUPATIONAL ACCIDENT INSURANCE

ENROLLMENT FORM

REQUESTED EFFECTIVE DATE: _____

This form must be completed, signed and dated before it can be processed and coverage can be put into effect.

Individual Driver Information: (please print)

Name: _____

Address: _____

City: _____

State: _____ Zip: _____

Social Security Number: _____

Date of Birth: _____

Home Telephone Number: _____

Cell Phone Number: _____

E-mail Address: _____

Beneficiary: _____

Relationship to Beneficiary: _____

Address of Beneficiary: _____

_____

MC Number: _____

CDL Number: _____

Number of Years Experience: _____

Contracted By (Name of Company): _____

_____

Address: _____

City: _____

State: _____ Zip: _____

Effective Date of Contract: _____

Motor Carrier Phone Number: _____

Motor Carrier Fax Number: _____

Motor Carrier E-mail Address: _____

_____

General Information:

Are you an Owner/Operator: a) with your own authority? Yes ❑ No ❑ b) leased to a Motor Carrier? Yes ❑ No ❑

If no to both of the above, are you a: Co-Driver ❑ Contract Driver (and you receive a Form 1099) ❑

Are you a team driver? Yes ❑ No ❑

Trailer type used? Dry Van ❑ Refer ❑ Box ❑ Flat Bed ❑ Dump ❑ Other_____

Years of experience hauling the above type trailer? _____

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

Type of Carriage? Truck Load ❑ LTL ❑ (Less than Truckload)

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? _____

What other duties do you perform? _____

Are you covered under any medical plan? Yes ❑ No ❑

If yes, please provide name of carrier: _____

(Continued on next page)

I hereby authorize the Program Administrator to bill the following selected party for my Occupational Accident coverage:

❑ 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 Program Administrator upon demand, for any insurance at any time my account remains unpaid.

I understand and hereby state:

1. The Occupational Accident coverage provided is not a contract for Statutory Workers' Compensation Insurance and neither the carrier 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 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 OneBeacon America Insurance Company, or the Program Administrator or its designated representative. A photographic copy of this authorization shall be as valid as the original.
4. I am 23 years of age or older.
5. I am an independent contractor and receive a 1099 tax form, not a W-2 tax form for an employee. Or I am an employee, and I receive a W-2 form, but I am exempt from Workers' Compensation insurance; I understand that my employer and I must sign a certificate of exemption form to substantiate this.

PARTICIPATION IN TRUST

I understand and acknowledge that by enrolling for insurance coverage I will become a Participant in the Independent Contractor Trust and that I must abide by the terms and conditions of the Trust. A copy of the Trust Agreement will be provided at the Enrollee's request. Please write to: OneBeacon Insurance Group at 201 Old Country Road, Melville, NY 11747, Attn: John Ruvolo.

FRAUD STATEMENT

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 fines and confinement in prison.

**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 you have provided, you are giving us authority to examine the records that are maintained by the motor carrier and the Program Administrator.

PLEASE INDICATE WHICH PLAN YOU ARE ENROLLING IN:

➤ ***OCC/ACC PLAN:*** ❑ **Plan 1 @ $146.00 mo.** ❑ **Plan 2 @ $136.00 mo.** ❑ **Plan 3 @ $125.00 mo.**

➤ ***PASSENGER ACCIDENT OPTION*** ❑ **$120.00, annual premium**

REQUESTED EFFECTIVE DATE: _____

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

Agent/Producer: _____ **Date:** _____

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Program administered by: PALLAY INSURANCE AGENCY

Program underwritten by: OneBeacon ACCIDENT GROUP

Make check payable to submitting agency:

PALLAY INSURANCE AGENCY
PO Box 727
Mokena, IL 60448