



ZURICH

DRIVER INFORMATION SHEET

Individual Driver Information: (please print) Name: _____ Address: _____ City: _____ State _____ Zip _____ Social Security Number: _____ Date of Birth: _____ Male: <input type="checkbox"/> Female: <input type="checkbox"/> Home Telephone Number: _____ Cell Phone Number: _____ E-mail Address: _____ Beneficiary: _____ Relationship to Beneficiary: _____	CDL Number: _____ Number of Years Experience: _____ Contracted By (Name of Company): _____ Effective Date of Contract: _____ Address: _____ City: _____ State _____ Zip _____ Motor Carrier Phone Number: _____ Motor Carrier Fax Number: _____ Motor Carrier E-mail Address: _____
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General Information:

Are you an Owner/Operator? If yes, is the Certificate of Title in your name? _____ Yes ___ No ___ If no, are you a:
 Co-Owner Leased Driver Contract Driver Team Driver Employee

Do you drive for another person? Yes No
 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
 What type of transmission do you drive? Automatic Shift
 Do you drive? Long Haul (> 200 miles/trip) Short Haul (< 200 miles/trip)

What other duties do you perform? _____

Are you covered under any medical plan? Yes No If yes, please state: _____

As a participant in the Zurich American Occupational Accident Program, I understand and hereby state:

1. The Occupational Accident coverage provided is not a contract for Statutory Workers' Compensation Insurance and neither my 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 Zurich American Insurance Company, the motor carrier or the motor carrier's designee. A photographic copy of this authorization shall be as valid as the original.
4. I am an independent contractor paid by a 1099 tax form not as a W-2 employee.
5. I authorize the above named motor carrier with whom I have a contract, to take monthly deductions, equal to my premiums plus administrative and other related expenses as more specifically explained in the lease agreement, from my settlement account.

Drivers Signature: _____

Date: _____

Motor Carrier Representative: _____

Phone/Fax Number: _____

