

American Transport, Inc.  
Occupational Accident Enrollment Form

Occupational Accident Policy No.: OCA3809907  
Contingent Liability Policy No.: GLO3809908



Individual Driver Information: (please print)

Name: \_\_\_\_\_ CDL Number: \_\_\_\_\_  
 Address: \_\_\_\_\_ Number of Years Experience: \_\_\_\_\_  
 City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Contracted By (Name of Company): American Transport, Inc.  
 Social Security Number: \_\_\_\_\_ Effective Date of Contract: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Address: 100 Industry Drive  
 Male:  Female:  City: Pittsburgh State PA Zip 15275  
 Home Telephone Number: \_\_\_\_\_ Motor Carrier Phone Number: (800) 284-1902  
 Cell Phone Number: \_\_\_\_\_ Motor Carrier Fax Number: (412) 490-6155  
 E-mail Address: \_\_\_\_\_ Motor Carrier E-mail Address: \_\_\_\_\_  
 Beneficiary: \_\_\_\_\_  
 Relationship to Beneficiary: \_\_\_\_\_

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:

- 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.**
- I certify to the best of my knowledge and belief that all information on this form is complete and truthful.**
- 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.**
- I am an independent contractor paid by a 1099 tax form not as a W-2 employee.**
- 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: \_\_\_\_\_