

Greentree Transportation Company Occupational Accident Enrollment Form

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



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|---|---|
| Individual Driver Information: (please print) | |
| Name: _____ | CDL Number: _____ |
| Address: _____ | Number of Years Experience: _____ |
| City: _____ State _____ Zip _____ | Contracted By (Name of Company): <u>Greentree Transportation.</u> |
| Social Security Number: _____ | Effective Date of Contract: _____ |
| Date of Birth: _____ | Address: <u>100 Industry Drive</u> |
| Male: <input type="checkbox"/> Female: <input type="checkbox"/> | City: <u>Pittsburgh</u> State <u>PA</u> Zip <u>15275</u> |
| Home Telephone Number: _____ | Motor Carrier Phone Number: <u>(800) 233-3262</u> |
| Cell Phone Number: _____ | Motor Carrier Fax Number: <u>(412) 490-2805</u> |
| E-mail Address: _____ | Motor Carrier E-mail Address: _____ |
| Beneficiary: _____ | |
| Relationship to Beneficiary: _____ | |

| | |
|--|--|
| General Information: | |
| Are you an Owner/Operator? <input type="checkbox"/> If yes, is the Certificate of Title in your name? _____ Yes ___ No ___ If no, are you a: | |
| Co-Owner <input type="checkbox"/> | Leased Driver <input type="checkbox"/> Contract Driver <input type="checkbox"/> Team Driver <input type="checkbox"/> Employee <input type="checkbox"/> |
| Do you drive for another person? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Do you load/unload? | Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what is the average weight you lift: _____ |
| Do you attach and detach the trailer? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Do you tarp? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| What type of transmission do you drive? | Automatic <input type="checkbox"/> Shift <input type="checkbox"/> |
| Do you drive? | Long Haul (> 200 miles/trip) <input type="checkbox"/> Short Haul (< 200 miles/trip) <input type="checkbox"/> |
| What other duties do you perform? _____ | |
| _____ | |
| Are you covered under any medical plan? Yes <input type="checkbox"/> No <input type="checkbox"/> 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: _____