Atlantic Specialty Insurance Company

Canton, Massachusetts

DRIVER ENROLLMENT AND BENEFICIARY FORM

TRUCKERS OCCUPATIONAL ACCIDENT INSURANCE

Load One LLC 216-001-586

Please print:

Name: _____ Male: _____ Female:_____

Street Address: _____ City: _____ State: _____ Zip: _____

Social Security Number: _____ Date of Birth: _____ E-Mail Address:_____

Home Telephone Number: _____Cell Telephone Number: _____

Name of Beneficiary:_____ Relationship of Beneficiary: _____

CDL or Required License Number:_____ Number of Years Experience: _____

Contracted by (Name of Company): _____ Effective Date of Contract: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Motor Carrier Telephone Number: _____ Fax Number: _____

Motor Carrier E-Mail Address: _____

FRAUD STATEMENT

It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

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

1. to the best of my knowledge and belief, all information on this Form is complete and truthful;
2. this coverage is not a contract for Statutory Workers' Compensation Insurance, and neither I nor my carrier become participants in the Workers' Compensation system by purchasing this insurance; and
3. if, based on the information supplied in this Form, I am not eligible for coverage, premium will be refunded and no claims will be payable.

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, the motor carrier or the motor carrier's designee. A photographic copy of this authorization shall be as valid as the original.

IF THE INFORMATION PROVIDED IN THIS FORM IS FRAUDULENT,
THE INSURER HAS 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.

I certify that I am an independent contractor, paid by a 1099 tax form, not as a W-2 employee.

Driver's Signature: _____ Date: _____

Motor Carrier Representative's Signature: _____

Payment Authorization: I authorize the above named motor carrier, with whom I have a contract, to take monthly deductions, equal to my premiums, from my settlement account on my behalf, and to remit these funds to Atlantic Specialty Insurance Company.

I UNDERSTAND THAT THE COST OF THE INSURANCE IS MY SOLE OBLIGATION AND RESPONSIBILITY, regardless of the above arrangement of premium payment. I agree that I will forward any amount due and owing to Atlantic Specialty Insurance Company, upon demand, for any insurance at any time my account remains unpaid.

Signature: _____ Date:_____