

**INDEPENDENT  
TRUCK OWNER/OPERATORS  
AND CONTRACT DRIVERS**

**OCCUPATIONAL  
ACCIDENT  
INSURANCE  
PROTECTION**



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](mailto:service@pallayinsurance.com)  
[www.pallayinsurance.com/truckers](http://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

<b>OCCUPATIONAL ACCIDENT BENEFITS</b>				<b>NON-OCCUPATIONAL ACCIDENT BENEFITS</b>			
	Plan 1	Plan 2	Plan 3		Plan 1	Plan 2	Plan 3
<b>ACCIDENTAL DEATH</b>				<b>ACCIDENTAL DEATH</b>			
Principal Sum	\$50,000	\$ 25,000	\$25,000	Principal Sum	\$15,000	\$15,000	\$15,000
Survivor's Benefit (1% mo.) / up to ...	\$200,000	\$125,000	\$125,000	Accident Commencement Period	365 days	365 days	365 days
Accident Commencement Period	365 days	365 days	365 days	<b>ACCIDENTAL DISMEMBERMENT</b>			
<b>ACCIDENTAL DISMEMBERMENT</b>				<b>ACCIDENTAL DISMEMBERMENT</b>			
% of Principal Sum of ...	\$250,000	\$150,000	\$150,000	% of Principal Sum of ...	\$15,000	\$15,000	\$15,000
Paralysis Benefit / up to ...	\$250,000	\$150,000	\$150,000	Accident Commencement Period	365 days	365 days	365 days
Accident Commencement Period	365 days	365 days	365 days	<b>ACCIDENT MEDICAL EXPENSE</b>			
<b>TEMPORARY TOTAL DISABILITY</b>				<b>ACCIDENT MEDICAL EXPENSE</b>			
Disability Commencement Period	90 days	90 days	90 days	Medical Commencement Period	90 days	90 days	90 days
Waiting Period	7 days	7 days	7 days	Deductible Amount	\$0	\$0	\$0
Benefit Percentage	70%AWE	70%AWE	70%AWE	Maximum Benefit Period	52 wks	52 wks	52 wks
Maximum Weekly Benefit Amount	\$500	\$400	\$400	Dental Maximum per Accident	\$1,000	\$1,000	\$1,000
Maximum Benefit Period	104 wks	52 wks	52 wks	Maximum Benefit Amt per Accident	\$5,000	\$5,000	\$5,000
<b>CONTINUOUS TOTAL DISABILITY</b>				Lifetime Maximum Benefit	\$10,000	\$10,000	\$10,000
Waiting Period	104 wks	52 wks	52 wks	<b>LIMITS OF LIABILITY</b>			
Benefit Percentage	70%AWE	70%AWE	70%AWE		Plan 1	Plan 2	Plan 3
Maximum Weekly Benefit Amount	\$500	\$400	\$400	<b>OCCUPATIONAL COVERAGE:</b>			
Maximum Benefit Amount	\$400,000	\$300,000	\$200,000	Combined Single Limit	\$1,000,000	\$500,000	\$300,000
Maximum Benefit Period	to age 70	to age 70	to age 70	Aggregate Limit of Liability	\$2,000,000	\$1,000,000	\$600,000
<b>ACCIDENT MEDICAL EXPENSE</b>				(applicable to all covered losses with respect to any one accident)			
Medical Commencement Period	90 days	90 days	90 days	<b>NON-OCCUPATIONAL COVERAGE</b>			
Deductible Amount	\$0	\$0	\$0	Combined Single Limit	\$15,000	\$15,000	\$15,000
Maximum Benefit Period	104 wks	52 wks	52 wks	Aggregate Limit of Liability	\$30,000	\$30,000	\$30,000
Dental Maximum per Accident	\$1,000	\$1,000	\$1,000	(applicable to all covered losses with respect to any one accident)			
Maximum Benefit Amt per Accident	\$1,000,000	\$500,000	\$300,000				
Lifetime Maximum Benefit	\$1,000,000	\$500,000	\$300,000				

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

<b>MONTHLY RATE PER DRIVER:</b>	<b><u>PLAN 1: \$146.00</u></b>	<b><u>PLAN 2: \$136.00</u></b>	<b><u>PLAN 3: \$125.00</u></b>
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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. The OneBeacon Occupational Accident Policy is underwritten by OneBeacon America 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

*This form must be complete, 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: _____ _____
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**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                       Employee Driver

(and you receive a Form 1099)                      (and you receive a Form W-2)

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: \_\_\_\_\_

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 America Insurance Company 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:

Plan 1 @ \$146.00

Plan 2 @ \$136.00

Plan 3 @ \$125.00

**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: PALLAY INSURANCE AGENCY

Mail to: PO Box 727  
Mokena, IL 60448