As a member of NASTC you have access to a special program of Occupational Accident Coverage designed for the American Trucker

NASTC Members
Occupational Accident Benefit Plan

Available to Owner Operators/Independent Drivers/Fleets/Employees (Tx) to age 75

MEDICAL BENEFITS	**NASTC MEMBERS**
Deductible Choices	**$0** / $500 / $1000
Per Person	$1,000,000 / $2,000,000
Per Occurrence	$1,000,000 / $2,000,000
Accidental Death	$250,000 Lump Sum
Accidental Dismemberment	$250,000 Maximum

DISABILITY BENEFITS	
Disability Payments 70% of Income	110 weeks $700
Continuous Total Disability	to full retirement age or SSI benefit

ADDITIONAL BENEFITS	
Occupational Disease	Policy Limits
Cumulative Trauma	Policy Limits
Waiver of Subrogation	Included
Dental	Policy limits
Chiro	10 visits
Hernia	Policy Limits
Ambulance	Policy Limits
Coverage Age Limit	75

OFF JOB BENEFITS	
Accidental Medical	$10,000 $500 Deductible
Accidental D&D	$10,000 $500 Deductible

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE

Not available in NY, CA, MD, KY, IL, PR, VI

Certain Underwriters at Lloyd's of London

NASTC APPLICATION OCCUPATIONAL ACCIDENT INSURANCE Independent Contractor/Owner Operator

Requested Plan Effective Date:_____

Name of Applicant _____

Check One: Corporation ☐ Partnership ☐ IC ☐ Tax ID # _____SS# _____

Mailing Address: _____ City ____ _____ _____ State:_ _____ Zip: _____

Physical Address: _____ City_____ State:_____ Zip: _____

Phone #: _____ Email Address: _____

CDL#: _____ Contracted by (Authority): _____

Years in Business: _____ Tractor Make & Model: _____

Radius of Operation: _____ Loading/Unloading %_____ Strapping/Tarping % _____

Cargo: _____ Trailer Type: _____

Does applicant perform any work at heights over 15 ft.? _____ If Yes, please explain:_____
Do you handle, store or engage in transport of hazardous materials, including but not limited to explosive, caustic, poisonous, or flammable materials? _____If yes please explain, separate worksheet might be needed.

_____

Are all drivers contract labor? _____ (Please complete separate application for additional driver.)
Do you have Prior Coverage? _____ Previous Insurance Carrier? _____
Do you have 3 years of loss runs or a loss runs letter? _____ (Please submit)
Does the applicant have a Safety Program? _____ Do you conduct random and post-accident drug tests? _____

Chose Plan:

Deductible Amount: $0☐ $500☐ $1,000☐

Choose Weekly Accident Indemnity Benefit Amount: **70%** of weekly earnings up to **[$700]** _____

_____	_____	_____
Applicant Authorized Signature	Printed	Date
_____	_____	_____
NASTC Agent Signature	Printed	Date

Beneficiary Designation & Independent Contractor Acknowledgement

Driver Name: _____

Beneficiary Designation for benefits to be paid in the event of your death:

Beneficiary Name_____ Relationship _____

Beneficiary Name _____ Relationship _____

I AM NOT BEING OFFERED A POLICY OF WORKERS' COMPENSATION INSURANCE, THE LESSOR/COMPANY DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PROVIDING THIS COVERAGE.

Initial Each

1. ___ I understand that this coverage is only available for Independent Contractors.
2. ___ I hereby certify that I am an Independent Contractor and not an Employee of any carrier or company. Should any court or entity of any jurisdiction determine that I am in fact, an employee, I agree to reimburse for all premiums paid on my behalf and relinquish any claim to recover under this policy.
3. ___ I hereby relinquish my right in any state venue to represent myself as an employee of any entity.
4. ___ I understand that Texas law will govern all disputes under this contract of insurance and that all disputes must be brought in Harris County, Texas.
5. ___ The coverage for which application is being made does not include any legal, general liability or casualty risk.
6. ___ Neither the Company nor the undersigned broker/agent has represented the coverage as anything other than a benefit which offers no indemnity.

By my signature below, I attest that I have read and understand the statements in this document and agree to immediate notification in the event my status changes to an Employee.

I understand that a facsimile or emailed copy of my signature will serve as an original.

Print Name: _____ Date of Signature_____

Signature of Independent Contractor: _____

Address: _____ Email: _____

Last four digits of social security number _____ Date of Birth: _____

Administrator for Occupational Accident Coverage: *ASSURANCE RESOURCES, INC 888-266-6401 P O BOX 84525, PEARLAND, TX 77584*