TRANSGUARD GENERAL AGENCY, INC.

NAIT ASSOCIATION PROGRAM INSURANCE APPLICATION

Applicant Name: ☐ Mr. ☐ Mrs. ☐ Ms. _____ _____ _____
Last First Middle

Address: _____ _____ _____ _____ _____
Street/PO Box Apt City State Zip

Social Security #:_____ Date of Birth:_____ Phone:_____

CDL #: _____ CDL State: _____

What do you haul? _____

You are an/a: ☐ Owner Operator ☐ Fleet Owner ☐ Fleet Driver If a Fleet Driver, please identify the fleet owner you drive for: _____

_____

Insurance services provided by TransGuard General Agency, Inc. ("TGA"); In California, doing business as TransGuard General Insurance Agency; In Utah, doing business as TransGuard General Insurance Agency, Inc. If you need coverage that is not addressed in this application, please contact TransGuard General Agency, Inc. at (800) 821-8014 for assistance.

OCCUPATIONAL ACCIDENT

Do you want to purchase Occupational Accident coverage for yourself? ☐ **Yes*** ☐ **No**

***If yes, please complete the following information:**

How is your income reported: ☐ 1099 ☐ W-2_____ **Height:**_____Feet _____Inches **Weight:**_____

Please name a beneficiary for the payment of accidental death benefits. (Accidental death benefits are payable to your surviving spouse or dependent children, subject to the terms and conditions of this coverage. The beneficiary designation requested only applies when benefits are payable and you do not have a spouse or dependent children surviving.)

Name of Beneficiary	Address (Street/City/State/Zip)	Relationship

Have you been injured in a work-related accident during the past 36 months? ☐ Yes ☐ No

Date of Accident/Injury: _____

Explanation of Accident/Injury: _____

_____

Treatment Received: _____

Have you received medical treatment for a health-related condition in the past 36 months? ☐ Yes ☐ No

Describe health related condition and treatment received: _____

_____

Are you presently taking any prescription medications? ☐ Yes ☐ No

List medications and what conditions they are used to treat: _____

_____

Do you have any health restrictions or limitations on the type of work you can perform? ☐ Yes ☐ No

Describe restrictions and limitations: _____

_____

Do you have a disability rating? ☐ Yes* ☐ No

*If yes, give percentage: ___ % Disabled area: _____

What caused the disability? _____

When this coverage is provided, you will be insured under the Occupational Accident plan elected by your motor carrier as satisfying their coverage requirements or the plan you elect if billed direct pay. You are also selecting Non-Occupational Accident Coverage with this purchase if your motor carrier requires such coverage on the date of application. If Occupational Accident Coverage for a Helper/Co-driver/Spouse or Partner is needed, a separate supplemental application must be completed. Contact TransGuard General Agency, Inc. for assistance.

OCCUPATIONAL COMPENSATION

Do you want to purchase coverage for your casuals/helpers? ☐ Yes ☐ No

Do you have any permanent helpers? ☐ Yes* ☐ No

***If yes, how many?** _____

Do you have any W-2 paid employees? ☐ Yes* ☐ No

***If yes, how many?** _____

COMMERCIAL BUSINESS AUTO

Equipment #1:

Do you want to purchase Non-Trucking Liability? ☐ Yes ☐ No Limit: ☐ $500,000 ☐ $1,000,000

Do you want to purchase Physical Damage Coverage? ☐ Yes ☐ No

Which Comprehensive/Collision Deductible? ☐ $250 ☐ $500 ☐ $1000 ☐ $2500

Stated Amount: $_____

☐ Tractor ☐ Trailer ☐ Other: _____

_____ _____ _____

Year Manufacturer/Model/Gross Weight VIN#

_____ _____

Loss Payee (lien holder/lessor) Loss Payee Address

Equipment #2:

Do you want to purchase Non-Trucking Liability? ☐ Yes ☐ No Limit: ☐ $500,000 ☐ $1,000,000

Do you want to purchase Physical Damage Coverage? ☐ Yes ☐ No

Which Comprehensive/Collision Deductible? ☐ $250 ☐ $500 ☐ $1000 ☐ $2500

Stated Amount: $_____

☐ Tractor ☐ Trailer ☐ Other: _____

_____ _____ _____

Year Manufacturer/Model/Gross Weight VIN#

_____ _____

Loss Payee (lien holder/lessor) Loss Payee Address

If you answered yes, to wanting to purchase Non-Trucking Liability or Physical Damage Coverage, please answer the questions below:

Do you run under your own authority? ☐ Yes ☐ No

Do you use your vehicle for training? ☐ Yes ☐ No

Do you haul for more than one motor carrier? ☐ Yes ☐ No

If yes, who are the motor carriers? _____

Do you use your tractor as your primary personal vehicle? ☐ Yes ☐ No

NAIT MEMBERSHIP:

I understand that I must be a member of the National Association of Independent Truckers ("NAIT") in order to participate in its insurance programs. If I am not currently a member, I will apply for membership. I may become and remain a member of NAIT without the purchase of NAIT sponsored insurance.

POLICY TERMS AND CONDITIONS

Coverage applied for under the NAIT insurance program is subject to all the terms, conditions and limitations of the policy providing the coverage requested.

PAYMENT TERMS: I understand that the cost of this insurance is my sole obligation and responsibility, and I agree that I will pay upon demand or at any time my account remains unpaid, any amount due and owing. I also understand that if my insurance is canceled my deposit premium will be used to cover my outstanding premium. If the motor carrier to whom I am under contract has agreed to settlement deduction arrangements for the payment of premium, I hereby APPOINT that motor carrier as my agent for receipt of NAIT Program billing notices and AUTHORIZE them to make deductions from my

POLICY TERMS AND CONDITIONS (CONTINUED)

account equal to the cost of NAIT membership dues, benefits and insurance premiums and to remit same as required on my behalf. I also authorize the motor carrier named on page 4 of this application or on my Evidence of Coverage, if changed, to remit any deposit of premium and/ or membership dues required for participation in NAIT's insurance programs. Deposit premium is fully refundable upon termination of coverage if my account is current and in good standing. I understand there is a one-month deposit charge for NAIT membership dues and a one month deposit premium charge for all insurance coverages, except Workers' Compensation. For Workers' Compensation, a state mandated minimum charge, per policy, is applicable.

AGREEMENTS

I certify that I am DOT qualified and that I have complied with all applicable DOT requirements. I am not now, nor will I become, an employee of any motor carrier while any insurance provided through an NAIT program is in force. I authorize the release to TGA, its affiliated insurers and their representatives, if necessary: 1) all insurance documents related to me and/or my insured equipment; 2) my current Motor Vehicle Report (MVR) and/or my drivers' MVR, including updates as needed; 3) applicable medical records; 4) any test results in accordance with DOT regulations; 5) a copy of my current equipment lease agreement(s), if any; and 6) a copy of my independent contractor agreement with my motor carrier. I understand this information may be used for purposes of evaluating my application for insurance. I authorize my motor carrier to request cancellation of my coverage whose premium is paid by settlement deduction arrangements when I am no longer under contract to that motor carrier. I understand NAIT, as group policyholder, has authority to execute and cancel all group coverage. I accept and acknowledge that NAIT, as group policyholder, has elected Uninsured Motorist limits of $25,000 per person/$50,000 per occurrence, the minimum established by the state of Illinois, to apply to the group policy when Non-Trucking Liability coverage is elected. I knowingly reject statutory Workers' Compensation coverage when opting for Occupational Accident coverage, if required by state law. I understand Occupational Compensation coverage is not Workers' Compensation coverage and is not a substitute for statutory Workers' Compensation coverage.

***Applicable To Occupational Accident coverage only*:** I further understand and agree that as an independent contractor and in choosing this Occupational Accident coverage, I am not able to file nor otherwise assert any claim for statutory Workers' Compensation benefits against my motor carrier and/or any insurers or other companies related to such entities. I further agree to indemnify and forever hold harmless NAIT, my motor carrier, and/or any insurers or other companies related to any of the foregoing entities of and from any and all claims that may be made by me or by anyone else on my behalf for statutory Workers' Compensation benefits.

A credit report or other investigative report about me may be requested in connection with this application for insurance and subsequent renewals. Any information about me or which I have provided about anyone will be treated confidentially. However, this information, as well as other non-public personal or privileged information subsequently collected, may, under certain circumstances, be disclosed without prior authorization to non-affiliated third parties. Information may be shared with affiliated companies for such purposes as claims handling, servicing, underwriting and insurance marketing. I have the right to see personal information collected about me, and I have the right to correct any information which may be wrong. A description of TGA's information practices, and my rights regarding information TGA collects may be obtained by contacting TGA.

I certify the information that I have provided in this application is true, complete and accurately recorded to the best of my knowledge and belief. I understand this information will be used to apply for insurance coverage on my behalf. If approved, this application will be attached to and made a part of each policy providing the coverage requested. I certify that I have fulfilled all requirements to work legally in the U.S. by 1) being a U.S. citizen and/or 2) being in full compliance with all Federal laws and/or regulations regarding work eligibility. **I understand that the giving of any inaccurate, false, or misleading information on this application may result in rejection of this application and the denial of benefits under any and all insurance coverage for which I have applied.**

FRAUD WARNINGS

Fraud Warning applicable to residents of all states except those listed below and Nebraska: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

ADDITIONAL STATE SPECIFIC FRAUD LANGUAGE

IN ARKANSAS, LOUISIANA AND MARYLAND - 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.

IN CALIFORNIA - For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

INITIAL/DATE:_____

ADDITIONAL STATE SPECIFIC FRAUD LANGUAGE (CONTINUED)

IN COLORADO - It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

IN DISTRICT OF COLUMBIA – **Warning**: 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 FLORIDA - Any person who knowingly and with intent in injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

IN HAWAII - For your protection, Hawaii law requires you to be informed that any person who presents a fraudulent claim for payment of a loss or benefit is guilty of a crime punishable by fines or imprisonment, or both.

IN KENTUCKY – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

IN MAINE - It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

IN NEW JERSEY - Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties

IN NEW MEXICO - 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 civil fines and criminal penalties.

IN NEW YORK - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the value of the subject motor vehicle or stated claim for each violation.

IN OHIO - Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

IN OKLAHOMA - **Warning** – Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

IN OREGON - Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance or statement of claim containing any materially false information may be subject to prosecution for insurance fraud.

IN PENNSYLVANIA – Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and payment of a fine of up to $15,000.

IN TENNESSEE, VIRGINIA AND WASHINGTON - It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

I UNDERSTAND AND AGREE THAT COVERAGE REQUESTED IN THIS APPLICATION WILL NOT BE AFFORDED UNTIL THIS APPLICATION IS SUBMITTED AND I AM APPROVED. I CERTIFY AND REPRESENT THAT I HAVE READ AND UNDERSTAND THIS APPLICATION USING TRANSLATION SERVICES AS NEEDED AND THAT THE INFORMATION I HAVE PROVIDED AND THE REPRESENTATIONS I HAVE MADE HEREIN ARE TRUE AND CORRECT.

APPLICANT SIGNATURE _____ DATE _____

MOTOR CARRIER NAME/TERMINAL LOCATION _____ UNIT NUMBER _____