Great American Insurance Company
301 E. 4th Street Cincinnati, OH 45202-4201 513.369.5000

Agency: HEALTH SPECIAL RISK, INC.
880 Sibley Memorial Highway, Suite 101
Mendota Heights, MN 55118

Policyholder: HEALTH SPECIAL RISK MASTER PROGRAM
880 Sibley Memorial Highway, Suite 101
Mendota Heights, MN 55118

Policy number: OA3940789

Rate Per Driver Per Month: $124.00

OCCUPATIONAL ACCIDENT INSURANCE INDIVIDUAL OWNER-OPERATOR APPLICATION

I. SCHEDULE OF BENEFITS: (FOR OWNER-OPERATORS AGE 23 TO 65)

DESCRIPTION OF BENEFITS	OCCUPATIONAL	NON-OCCUPATIONAL
ACCIDENTAL DEATH AND DISMEMBERMENT MAXIMUM BENEFIT AMOUNT SURVIVOR'S BENEFIT (LUMP SUM) INCURRAL PERIOD ACCIDENTAL DISMEMBERMENT – INCLUDING PARALYSIS AND SEVERE BURN BENEFIT	 $150,000 PRINCIPAL SUM (($25,000 DEATH LUMP SUM) + $1000 PER MONTH UP TO 125 MONTHS) 52 WEEKS INCLUDED IN PRINCIPAL SUM	 $10,000 PRINCIPAL SUM LUMP SUM 52 WEEKS INCLUDED IN PRINCIPAL SUM
ACCIDENTAL MEDICAL EXPENSE COMMENCEMENT PERIOD DEDUCTIBLE INCURRAL PERIOD ACCIDENTAL DENTAL MAXIMUM BENEFIT AMOUNT CHIROPRACTIC CARE, OCCUPATIONAL THERAPY, PHYSICAL THERAPY	$500,000 MAXIMUM BENEFIT AMOUNT 90 DAYS $ 0 104 WEEKS $1,000 PER INJURY/ $10,000 LIFETIME NO SUB-LIMIT APPLIES	$5,000 MAXIMUM BENEFIT AMOUNT 90 DAYS $ 0 52 WEEKS NOT COVERED NO SUB-LIMIT APPLIES
TEMPORARY TOTAL DISABILITY WAITING PERIOD COMMENCEMENT PERIOD DURATION-MAXIMUM BENEFIT PERIOD	*$450 MAX/ $150 MIN PER WEEK 7 DAYS RETROACTIVE 90 DAYS 104 WEEKS *Subject to the lesser of: 70% of Average Weekly Earnings or the Maximum Weekly Benefit Amount shown	NOT COVERED
CONTINUOUS TOTAL DISABILITY WAITING PERIOD DURATION-MAXIMUM BENEFIT PERIOD	*$450 MAX/ $150 MIN PER WEEK 104 WEEKS UP TO SOCIAL SECURITY RETIREMENT AGE** *Subject to the lesser of: 70% of Average Weekly Earnings or the Maximum Weekly Benefit Amount shown	NOT COVERED
ADDITIONAL BENEFIT RIDERS: HERNIA OR HEMORRHOID OR OCCUPATIONAL DISEASE OR CUMULATIVE TRAUMA	$10,000 PER INJURY SUBJECT TO A $40,000 LIFETIME MAXIMUM MAXIMUM BENEFIT PERIOD: 10 WEEKS	
CERTIFICATE COMBINED SINGLE LIMIT ANY ONE ACCIDENT AND AGGREGATE	$500,000	

This coverage is not Workers' Compensation Insurance or for any other purpose except occupational accidents (unless non-occupational benefits apply). This policy does not cover disease unless otherwise endorsed. The list of benefits is only a brief description of the actual coverages. Certain exclusions and limitations do apply. For complete details please refer to your policy. In the event of any conflict between the information listed here and the actual policy, the insurance policy will govern in all cases.

*Social Security Retirement Age (SSRA) will vary depending upon your date of birth. If you are to reach your SSRA before satisfying the waiting period, you may not qualify for Continuous Total Disability Benefits.

2. DRIVER AND BENEFICIARY INFORMATION

Name: _____ DOB: _____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____ Cell: _____

Beneficiary Name: _____ Relationship: _____

Indicate type of driver: Owner Operator □ Date of Hire: _____

Other, including an authorized passenger □ _____

CDL Number: _____ Unit Number/VIN#: _____

Commodity Hauled: _____

Paid by: 1099 ☐ W-2 ☐ Contracted By: _____

Motor Carrier Name & Address:

_____

Agent Name: _____ Agent Phone: _____

Agent Address: _____

I accept ☐ reject ☐ The Occupational Accident insurance offered by the above listed Policyholder or Participating Motor Carrier. I understand that coverage becomes effective when this application has been received and approved by Great American Insurance Company or its authorized agent. I understand that I will no longer be eligible for coverage upon my 65th birthday and that coverage will therefore cease. I further understand that coverage terminates on the date the policy is terminated; or I am no longer under contract with the above mentioned motor carrier; or my premium is not paid. I also understand that coverage may be available on an individual policy subject to underwriting guidelines in effect at termination of the above policy.

Owner-Operator Signature _____ Date _____

Medical Information Authorization: I hereby 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 history for the above named person to furnish such information or copies of records to the insurance companies association or its representatives. A photographic copy of this authorization shall be as valued as the original.

Owner-Operator Signature _____ Date _____

FLORIDA STATUTE 817.234(1)(b)
"Any person who knowingly and with intent to 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."

NEW MEXICO STATUTE 59A-16C-8
"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."

OHIO INSURANCE CODE 3999.21
"Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insured, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud."