REQUESTED EFFECTIVE DATE: _____

INDEPENDENT CONTRACTOR/OWNER OPERATOR WORKER'S COMPENSATION APPLICATION

To be completed for each DRIVER. Submission must include current Long Form DOT Physical and MVR.

MOTOR CARRIER INFORMATION

Approved Motor Carrier Name:			
Mailing Address:	City:	State:	Zip:
FEIN #:	DOT #:	MC #:	
Phone:	Fax:	Website:	
Contact Person:	Direct Phone:	E-Mail:	

I AM NOT AN EMPLOYEE OF THE APPROVED MOTOR CARRIER.

APPLICATION: I hereby apply to AETS to be included as an Independent Contract Driver (hereinafter referred to as an "ICD") under the contact management program and be qualified to receive all the benefits provided by the program. Along with this application I hereby provide all necessary documentation related to my status as an independent contractor/owner operator. Provided that the ICD has submitted all necessary documentation, the applicable insurance coverage will be effective on the date that the signed application is received and approved by AETS. AETS shall notify the ICD in writing of his acceptance into the program.

INDEPENDENT CONTACTOR ACKNOWLEDGMENT: I represent that I am an independent contractor. Independent contractor is hereby defined, for the purpose of this agreement, as someone who is professionally competent in his/her field and engages in work for hire in his/her field. AETS serves the right to terminate the ICD for any reason including but not limited to: failure to comply with the Department of Transportation (DOT) rules, requirements and regulations and or the approved motor carrier's minimum contract standards etc.

CLAIM JURISDICTION: This policy was procured and governed under the laws of the state of hire. I accept, as exclusive remedy, the jurisdiction of the Worker's Compensation laws for the state in which I have been contracted. I understand that actual lost time benefits received will be determined at the time of the claim and benefits will be based upon the previous twelve (12) months actual personal income generated as an ICD and verified by receipt of a copy of my most recent 1040, 1099 or CPA prepared profit and loss statement. By signing, I hereby authorize AETS to obtain a copy of necessary DOT credentials including but not limited to MVR, Long Form DOT Physical examination records, background screen and drug test as well as weekly settlement information. I further understand that if I withdraw from the AETS Group Purchase Program for any reason, I must re-apply and meet underwriting standards in effect at the time prior to acceptance.

POWER OF ATTORNEY: I hereby appoint AETS as my attorney in fact with regard to this insurance. This power of attorney gives AETS the authority to designate, select, change, increase, decrease, or otherwise modify, on my behalf, insurance coverage, limits, and deductibles. I further give AETS the authorization to cancel my insurance coverage in the event that my contract with the contracted trucking company is terminated for any reason or if I discontinue driving or I have failed to pay the required premium. I hereby authorize the motor carrier listed above to release a copy of my current motor vehicle report to AETS or its agents for underwriting purposes.

I hereby authorize the approved motor carrier listed above to release a copy of my current Long From DOT Physical examination, driving record as well as settlement information to AETS for underwriting purposes.

TRUCK OWNER INFORMATION

Truck Owner/Fleet Owner Name:		DBA:	
Mailing Address:	City:	State:	Zip:
Phone:	Cell or Fax:	E-Mail:	

CERTIFICATION: I am an Independent Contract Driver contracted and dispatched in the state of (state of hire) and I elect to receive Worker's Compensation benefits as authorized by this state's Worker's Compensation Law. I understand that the coverage I am applying for only applies while I am contracted with an approved motor carrier as an ICD and operating under the authority of an approved motor carrier. **I further represent that I hold a current Class A Commercial Driver's License and I am compliant with U.S. DOT Regulation 391.11 as it relates to driver qualifications including subparts G and E. I understand that the insurance company relies on this information in the approval process and has the right to deny coverage should it be determined that this statement is not true and correct.**

DRIVER INFORMATION

Driver Name:	DOB:	Social Security #:	
Mailing Address:	City:	State:	Zip:
Phone:	Cell or Fax #:	E-Mail:	
CDL: ☐ Class A ☐ Class B	License #:	CDL State:	Years of US OTR Driving Experience:
Height: ' "	Weight: lbs.	Driver Wages Reported as: ☐ 1099 ☐ W2	State Contracted/Hired out of:

Current Status: ☐ Owner/Operator ☐ Fleet Owner ☐ Fleet Driver ☐ Company Driver

Current Trailer Type: ☐ Van ☐ Flatbed ☐ Tanker ☐ Mover ☐ Other:

Estimated Personal Annual Income (Less Business Expense and Fuel Charges): $ For current year: 20

Have you ever had back surgery or suffered from chronic back pain? ☐ Yes ☐ No
If yes, please provide details on a separate page.

Are you Diabetic or Insulin Dependent? ☐ Yes ☐ No
If yes, please provide details on a separate page.

Have you previously filed a Worker's Comp Claim? ☐ Yes ☐ No
If yes, please provide details: *(Attach a separate page if necessary.)*

I understand that the cost of this total program includes insurance coverage with a service fee. I also understand and agree, that coverage will not be effective until approved by AETS.

DRIVER SIGNATURE: _____ **DATE:** _____

My signature above authorizes a faxed, or a signed digital copy of this application to be deemed as and have the same legal state as the original.
ANY PERSON WHO KNOWINGLY AND/OR 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 CRIME.
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