



**INDEPENDENT CONTRACTOR/OWNER OPERATOR
APPLICATION
American Emerald Transportation Services (AETS)
TO BE COMPLETED By EACH DRIVER,
TRUCK OWNER OR FLEET OWNER**

(Truck Owner / Fleet Owner Name) _____ (DBA) _____

(Mailing Address) _____ (City) _____ (State) _____ (Zip) _____ (Phone) _____

Certification: I am an independent contract driver contracted and dispatched in the state of (state of hire) and I elect to receive occupational accident benefits. I understand that the coverage I am applying for only applies while I am contracted with an approved motor carrier as an Independent Contractor Driver (hereinafter referred to as an "ICD") and operating under the authority of an approved motor carrier. **I further represent that I hold a current Class A Commercial Drivers 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 been determined that this statement is not true and correct.**

(Name of Approved Motor Carrier) _____

(Mailing Address) _____ (City) _____ (State) _____ (Zip) _____

I am not an employee of the approved motor carrier.

Application: I hereby apply to AETS to be included as an ICD under the group purchase occupational accident program and be qualified to receive all the benefits provided by the program as evidenced on the certificate of coverage.. 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 and provide a certificate of coverage outlining benefits.

Independent Contractor 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 reserves 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 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 a ICD and verified by receipt of a copy of my most recent 1040, 1099 or a 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, DOT physical examination records, background screen and drug test as well as weekly settlement information. I further understand that if I withdrawal from the AETS Group Purchase Program for any reason, I must re-apply and meet underwriting standards in effect at that time prior to acceptance.

Power of Attorney: I hereby appoint AETS as my attorney in fact with regard to this insurance coverage. 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 motor carrier, truck owner/ fleet owner is terminated for any reason or if I discontinue driving or I have failed to pay any and all costs associated with the AETS Group Purchase Program.

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

Name (Please Print) _____ **Height** _____ **Weight** _____

Street Address _____ **City** _____ **State** _____ **Zip** _____

Phone Number _____ **Email Address** _____ **Date of Birth** _____

Drivers License Number _____ **State** _____ **Total Years of US OTR Driving Experience** _____

Estimated Personal Annual Income (less business expense and fuel charges)

Driver wages reported as: 1099 Yes ___ No ___ *STATE CONTRACTED/HIRED OUT OF: _____

CURRENT STATUS: check one | Owner/Operator ___ | Fleet Owner ___ | Contract Driver ___

CURRENT TRAILER TYPE(s): | Van ___ | Flatbed ___ | Mover ___ | Tanker ___ | Other _____

DO YOU HAVE ANY PHYSICAL DISABILITIES OR LIMITATIONS THAT WOULD RESTRICT OR PREVENT YOU FROM DOING YOUR JOB DUTIES? | Yes ___ | No ___

Driver Signature _____ **Date** _____ **SSN** _____ **Requested Effective Date** _____

My signature above authorizes a faxed copy of this application to be deemed as and have the same legal status as the original. 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 CRIME. (1) Revision Date 1/07/14