INDEPENDENT CONTRACTOR
DRIVER ENROLLMENT FORM
FOR OCCUPATIONAL ACCIDENT
COVERAGE

Insured Person Information:

Last Name *First Name* *M.I.*

Street Address

City *State* *Zip*

Telephone:

Social Security #:

Date of Birth (MM/DD/YYYY):

Sex: ☐ F ☐ M **Marital Status:**

Beneficiary Information

Last Name *First Name* *M.I.*

Street Address

City *State* *Zip*

or Pay to my Estate

Relationship

Contract Effective Date:

Desired Insurance Effective Date:

Contractor Number:

Leased to:

Location Number:

Quasar Risk Advisors
P.O. Box
Land O Lakes, FL 34639
Office - 813-540-6833
Fax - 813-333-2966
generalemailbox@quasar here

Acceptance

I hereby request coverage under the Independent Contractor Program. I verify that I am the independent contractor named on this enrollment form who is under contract to the sponsoring company on the date of this application. I verify that I am also an approved independent contractor under contract to the sponsoring company and understand that I am covered only while contracted for the sponsoring company. I have read and understand the terms and conditions on the reverse side and have designated the noted beneficiary, in the event of my death.

I certify that I am under the age of 75 as of the date set forth below.

I understand and acknowledge that QUASAR RISK ADVISORS is the insurance agent with limited authority to procure the insurance coverage referenced in this enrollment form. I also acknowledge that I have not sought or received insurance advice from QUASAR on the referenced insurance coverage as it applies to me and/or my business needs. I also understand and acknowledge QUASAR RISK ADVISORS uses a third party claims administrator that is authorized to carry out the reasonable and customary duties of a claims administrator for the insurance coverage hereby offered. I further understand and acknowledge that compensation for services rendered for the above are part of the cost of the insurance coverage and not separately charged to me.

In accordance with my lease agreement and as an addendum thereto, I, the Independent Contractor, authorize the sponsoring company to periodically deduct my insurance costs. If such settlements (or other monies due you) are not sufficient to allow deduction of the cost, I will remit by certified check or money order the outstanding insurance cost to Quasar Risk Advisors, PO Box "TBD", Land O Lakes, FL 34639 within a ten (10) day period. Otherwise, I understand the insurance underwriters may cancel this insurance coverage within policy terms and conditions. I also understand coverage will not automatically be reinstated if cancellation is processed.

Signature:

Date:

Terms & Conditions

Please Read Carefully

It is further understood and agreed:

1. Not Statutory Workers' Compensation & Employers' Liability: *This coverage is NOT a statutory Workers' Compensation and Employers' Liability policy* and the benefits under this policy do not necessarily equal the benefits which an individual might be eligible for under statutory Workers' Compensation. However, the Insured Person agrees that in the event of an occupational accident, he will look to this program in lieu of seeking Workers' Compensation coverage.

2. Assignment of Benefits: In the event benefits are paid from the statutory Workers' Compensation and Employers' Liability Policy of the sponsoring company or any similar policy becomes liable for such benefits, the benefits which an Insured Person is entitled to under this policy will be automatically assigned to the sponsoring company. Therefore, in such event the Insured Person hereby agrees to the immediate assignment to the sponsoring company of all benefits which he receives or would otherwise be payable to him or any third party under this program.

3. Cost and Consent to Cost Change: The Insured Person understands that the insurance cost shown may include taxes, fees and administrative expenses which he accepts and acknowledges as part of the insurance cost. The insurance underwriters reserve the right to change the rate by giving written notice to you.

4. Evidence of Coverage: Your state of principal operations could require you to purchase Statutory Workers Compensation; otherwise, the sponsoring company will accept this Independent Contractor Occupational Accident Program. If you do not participate in this Occupational Accident Program, you are required to have on file a certificate of insurance for Statutory Workers' Compensation or when allowed by law, an Occupational Accident Certificate; your insurance agent should provide this information to the sponsoring company.

You will be enrolled in the Independent Contractor Program until you provide proof of appropriate coverage. At that time you will receive an adjustment in any costs charged to you.

5. Termination: In the event the contractor's lease agreement with the sponsoring company is terminated for any reason by either party, the Occupational Accident coverage will be cancelled effective the date of the contract termination or the earliest date thereafter allowed by law. You should make arrangements to replace coverage immediately.

6. Terms & Conditions: Coverage will be subject to all policy terms, conditions and exclusions as detailed in the Evidence of Insurance. The Insured Person must be under age 75 to enroll in the plan.

7. Authorization of Settlement Deduction: You, the Independent Contractor, authorize the sponsoring company to take from your settlement checks, funds, accruals or other compensation, on a periodic basis (e.g. weekly or monthly) in amounts sufficient to pay the cost of premiums and taxes and hereby instruct it to forward direct to Quasar Risk Advisors such amounts by the 15th of each month. Your cost (as described in "Cost and Consent to Rate") will be deducted from your settlement check. If your settlement check is not enough to cover the insurance cost to you, you will be asked to forward a check or money order made payable to Quasar Risk Advisors at the address listed below

immediately, or the coverage will be cancelled, in accordance with policy terms and conditions.

8. Effective Date: Coverage shall become effective on the date your application is accepted by Midlands Management but no sooner than the first day of the month following your completion and signing of this enrollment form.

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