Enrollment and Beneficiary Designation Form

Zurich Transportation Independent Contractor Accident Policy

Zurich American Insurance Company
1299 Zurich Way
Schaumburg, Illinois 60196

POLICYHOLDER NAME:	Effective Date of Your Contract:
Address:	Contact Name:
E-mail Address:	Telephone:
INDIVIDUAL INSURED (ENROLLEE'S) NAME:	FEIN Number:
Address:	Date of Birth:
Home Phone: Cell Phone:	Email Address:
Beneficiary:	Relationship to Beneficiary:
YOU ARE NOT ELIGIBLE FOR COVERAGE IF YOU ARE AN EMPLOYEE OF THIS POLICYHOLDER	
Are you covered under any other medical and/or disability insurance plan? ☐ Yes ☐ No	
If Yes, name of insurance carrier:	

I understand and hereby acknowledge the following:

1. The Occupational Accident coverage provided is not a contract for Statutory Workers' Compensation Insurance and neither I nor the **Policyholder** above can become participants in the Workers' Compensation system by purchasing this insurance;
2. I certify that I work for the **Policyholder** above and meet the eligibility requirements under the **Policy**. I understand that if I am not eligible, no benefits will be paid as no coverage was ever in place and any premium paid will be returned;
3. I certify that I am an independent contractor and receive a 1099 tax form from the **Policyholder**. I further certify that I am not an employee and do not receive a W-2 tax form. I understand coverage will be terminated and no benefits paid if I am an employee of the **Policyholder**;
4. I 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 records to furnish such information or copies of records to the **Company**, the **Policyholder** or the **Policyholder's** designee. A photographic copy of this authorization shall be as valid as the original;
5. I certify to the best of my knowledge and belief that all information on this form is complete and truthful; and
6. I authorize the above-named **Policyholder** with whom I have a contract, to take deductions, equal to my premiums, from my settlement account on my behalf, and to remit these funds to the **Company** or its appointed agent. I understand that the cost of the insurance is my sole obligation and responsibility regardless of the above arrangement.

☐ By checking this box, the enrollee acknowledges that the enrollee is electronically signing this form. Furthermore, in order to conduct business electronically with the **Company**, the enrollee acknowledges that the electronic signature is the same as the handwritten signature for purposes of validity, enforceability, and admissibility.

Enrollee's Signature: _____ Date: _____

Policyholder Representative: _____