**Zurich American Insurance Company**

1299 Zurich Way

Schaumburg, Illinois 60196

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| **APPLICANT INFORMATION** |
| Applicant's Legal Name:       |  | Tax ID #:       |
| Street Address:       | City:       | State:       | Zip Code:       |
| Mailing Address:       | City:       | State:       | Zip Code:       |
| Telephone:       |  | Website:       |
| Contact Person:       | Email:       |
| Are Subsidiaries/Affiliates to be covered? [ ]  Yes [ ]  No If Yes, please provide a list of complete names and addresses of all to be covered.Number of years in business:      Public or Privately Owned:      Describe the Applicant’s Business Model:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Does the Applicant contract with business entities?      Does the Applicant contract with independent contractors?      Number of independent contractors:       12 month independent contractor projection:      Number of employee[s]:      Number of non-driving employees:       |
| **Please select BENEFIT OPTIONS** (All Coverages/ Benefits are subject to terms, conditions and exclusions in Policy and riders)**:** |
| **Occupational Accident**: |
| Accidental Death & Dismemberment Benefit **\***: | [ ]  $150,000 | [ ]  $200,000 | [ ]  $250,000 | [ ]  Other $      |
| **\*** Death benefits are paid in a partial lump sum and the balance payable to surviving dependents, if any. |
| Accident Medical Expense **Maximum Benefit Amount**: | [ ]  $1,000,000  | [ ]  Other $      |
| Accident Medical Expense **Maximum Benefit Period**: | [ ]  104 Weeks | [ ]  Other       weeks |
| Temporary Total Disability **Maximum Weekly Benefit Amount**:  | [ ] $300 | [ ] $500 |  |
| Temporary Total Disability **Maximum Benefit Period**: |  [ ] $400[ ]  104 Weeks | [ ]  Other      [ ]  Other       weeks |
| Continuous Total Disability Benefit Coverage: | Included, unless otherwise indicated | [ ]  Exclude |
| **Non-Occupational Accident Benefits** (exclude unless otherwise indicated): [ ]  Include |
| Other Options: (Excluded unless otherwise indicated by marking the box below) |
| Smartphone/Tablet Benefit | [ ]  |
| Enhanced Wage Benefit Replacement Option | [ ]  |
| After School Care Benefit  | [ ]   |
| Carjacking Benefit  | [ ]   |
| Coma Benefit  | [ ]   |
| Day Care Benefit  | [ ]   |
| Felonious Assault Benefit  | [ ]   |
| Seat Belt Benefit  | [ ]   |
| Sexual Assault Benefit  | [ ]   |
| Vehicle Modification Benefit  | [ ]   |
| Critical Burn Benefit | [ ]   |
| Passenger Accident Benefit Rider | [ ]   |
| Other Benefits and Amounts Requested  | [ ]  Explain: |
| **INSURANCE BROKER INFORMATION** |
| Name:       | Agency:        |
| Address:       | City:       | State:       | Zip Code:       |
| Telephone:       |  | Email:       |
| Standard Commission: [ ]  Yes [ ]  No [ ]  Other      % Name of Licensed Agent:       |

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| **INSURANCE INFORMATION** |
| 1. What lines of insurance do you require independent contractors to have when operating on your **Platform**?
2. Who is the workers' compensation insurance carrier for employee exposure?

 Please indicate the retention or deductible amount: $     1. Is there a business auto policy? [ ]  Yes [ ]  No
2. Is there a previous or current occupational accident policy? [ ]  Yes [ ]  No
3. Please attach current policy and claim runs for the past three (3) years and complete the table below:
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|  |
|  | Coverage Period | Insurance Company | Premium | Total Losses | Monthly Rate | # Insured Persons |  |
|  |       to       |       | $      | $      | $      |       |  |
|  |       to       |       | $      | $      | $      |       |  |
|  |       to       |       | $      | $      | $      |       |  |
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| **Operations Information** |
| Attach a listing of the current independent contractors by state of residence.Has there been any litigation/ class action against the Applicant?       If yes, provide case information.Have there been any unemployment claims? [ ]  Yes [ ]  NoHave there been any Department of Labor complaints? [ ]  Yes [ ]  NoPlease provide detailed list of all claims and complaints.  |
| **Equipment** **(if applicable):**  |
| Vehicles Used: | Car | Bike | Walking | Sprinter Van | StraightTruck | Other |  |  |
| % of total: |      % |      % |      % |      % |      % |      % |  |  |
|  |  |  |  |  |  |  |  |  |
| Other Equipment used by Independent Contractor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Equipment Policyholder provides to Independent Contractor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|   |  |  |  |  |
| **Independent Contractor Information** |
| 1. Provide the minimum age standard for independent contractors:
2. Does the Applicant issue 1099s to independent contractors?
3. Do you allow the independent contractor to utilize technology platforms offering a similar service? [ ]  Yes [ ]  No
4. Are physicals done by doctors?  [ ]  Yes [ ]  No
5. Are independent contractors allowed to choose their own sequence or method in which assignments are performed?

[ ]  Yes [ ]  No1. If required, what uniforms or identification badges does the Applicant require of independent contractors?
2. Are independent contractors allowed to reject or refuse an assignment? [ ]  Yes [ ]  No
3. Describe how the independent contractor is compensated:
4. Can an independent contractor accept tips? [ ]  Yes [ ]  No
5. What are the average earning per assignment, net of any fees?
6. What are the average weekly earnings per independent contractor?
7. Does the Applicant set the rate of pay for the independent contractor? [ ]  Yes [ ]  No
8. Does the Applicant pay or reimburse the independent contractor for any expense? [ ]  Yes [ ]  No
9. What charges, fees, or commissions does the Applicant charge the independent contractor?
10. What training or orientation does the Applicant provide to the independent contractor?
11. Does the Applicant provide light or restricted duty for independent contractors? [ ]  Yes [ ]  No
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| **Services Provided and Performance of Services** |
| 1. Describe in detail the services being performed by independent contractors: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_1. On what basis are independent contractors compensated? Per hour:       Per task:       Per mile:

Per trip:       Other:      1. What are the physical demands associated with the services: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Do independent contractors use casual labor or helpers? [ ]  Yes [ ]  No If Yes, please describe:
3. Do the independent contractors use subcontractors?
4. Assignments completed by independent contractors       in past       years
5. Average number of assignments per independent contractors/ per week       in past       years
6. Median time duration of assignments in the last three years: Year 1       Year 2       Year 3
7. When is someone considered under dispatch or on an assignment?
8. How do the independent contractors identify that an assignment has been completed?
9. What restrictions are there, if any, on the amount of hours/ numbers or assignments an independent contractor can perform on the platform in a given day?
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| Attachments Required:Please provide an addendum with the number of assignments completed and the number of active independent contractors by month, for each of the last 24 months.Please provide a copy of any insurance enrollment forms.Please supply a copy of any agreements between the Applicant and independent contractors.Please supply a copy of any agreements between the Applicant, their independent contractors, and any third party customers.Please provide a current certificate of insurance that the Applicant provides on behalf of independent contractors.Please provide a list of any additional locations where the Applicant is located.  |

The applicant hereby applies for Occupational Accident Insurance and:

1. Represents that the answers included in this Application for Occupational Accident Insurance coverage have been reviewed and are true and complete; and
2. Understands and agrees that the insurance applied for shall not become effective until the Application for Occupational Accident Insurance coverage is approved by the **Company** and the initial premium deposit is received; and
3. Agrees that if the insurance applied for is approved by the **Company,** the applicant will pay all premiums due after the effective date of the insurance.

This application shall be made part of the **Policy**, if issued.

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

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| Completed by:       | Title:       |

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| Signature:  | Date:       |