GREAT AMERICAN SPIRIT INSURANCE COMPANY PASSENGER AUTHORIZATION APPLICATION

The list of benefits is only a brief description of the actual coverages. Certain exclusions and limitations do apply. For complete details please refer to your policy. In the event of any conflict between the information listed here and the actual policy, the insurance policy will govern in all cases.

Social Security Retirement Age (SSRA) will vary depending upon the Insured Person's date of birth. If the Insured Person reaches his/her SSRA before satisfying the waiting period, he/she may not qualify for Continuous Total Disability Benefits.

Please print: Name:______________________________

Male:______Female:_____ Street Address:______________________City:______________

State:______________________Zip:_________ Social Security Number:______________

Date of Birth:______________________E-mail Address: ______________

Home Telephone Number:______________________Cell Telephone Number: ______________

Name of Beneficiary:______________________Relationship of Beneficiary: ______________

CDL Number:______________________Number of Years Experience: __________

Contracted by (Name of Company):______________________Effective Date of Contract: __________

Street Address:______________________City:______________

State:__________Zip:______________

Policyholder Telephone Number:______________________Fax Number: ______________

Policyholder E-Mail Address: ______________________

Are you an Owner-Operator? Yes__________No _________If yes, is the Certificate of Title in your name? Yes______No _____

If no, are you a: Co-Owner__________Co-Driver_________Team Driver_________Contract Driver __________.

Scheduled Co-Driver______________Fleet Driver_________Leased Driver __________

Authorized Passenger______________Casual Laborer_________or Other _________ Paid by: 1099 ☐ W-2 ☐

For all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of committing a fraudulent insurance act, which is a crime.

For residents of Arkansas, Louisiana, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I understand and hereby acknowledge the following:

1. This coverage is not Workers' Compensation Insurance or for any other purpose except occupational accidents (unless non- occupational benefits apply). I nor the Policyholder above can become participants in the Workers' Compensation system by purchasing this insurance;
2. This is a limited benefit policy. It does not provide comprehensive health insurance coverage. It does not satisfy the requirements of minimum essential coverage under the Affordable Care Act or its equivalent;
3. This policy does not cover pre-existing conditions, unless otherwise endorsed;
4. To the best of my knowledge and belief, all information I have provided is true and complete. I understand my information is protected by privacy laws and will be released only in accordance with these laws;
5. I certify that I meet the eligibility requirements under the Policy. I understand that if I am not eligible, no benefits will be paid and this coverage will be cancelled. I further understand that coverage terminates on the date the policy is terminated, or I am no longer under contract with the above mentioned policyholder, or my premium is not paid;
6. I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility,
7. 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 Great American Spirit Insurance Company, the Policyholder or the Policyholder's designee. A photographic copy of this authorization shall be as valid as the original
8. I understand that coverage becomes effective when this application has been received and approved by Great American Spirit Insurance Company or its authorized agent.

I accept the insurance elected above voluntarily. If at a later date I wish to participate in a coverage I have not elected, I understand that my coverage is subject to the terms and conditions of the policy and acceptance by the Insurance Company. I understand I may be required to provide evidence of insurability at my own expense. If premiums are to be paid by payroll / account deduction, I authorize the necessary amount from my earnings/checking or savings account to be deducted.

Applicant's Signature______________________________

Date Signed ______________________________

Passenger Authorization Form

Motor Carrier: OAKLEY TRUCKING, INC. 3400 Gribble St. North Little Rock, Ar. 72114

- Passengers must be at least 7 years of age.
- Lawful children or stepchildren, between 7 – 18 years old, may be granted passenger authority.
- Only one passenger at a time is permitted in the tractor.
- Persons holding a passenger authority are not permitted to assist with loading or unloading, or the handling of any form of cargo or equipment.
- Drivers requesting passenger authority must complete a request form and submit the form to the Oakley Trucking Safety Department.
- After receiving and approving the request form, the Oakley Trucking Safety Department will send written authorization to carry the designated passenger. No passenger may ride in the tractor until written authorization is received by the driver. Passenger authority applies not only when the tractor is under dispatch but at ***all other times*** as well.
- To receive passenger authority, the driver and/or tractor owner must also enroll in the Passenger Accident Policy facilitated by Oakley Trucking established by Great American Insurance Group.

IC Name: ______________________________ Unit #____________

Address: ____

City: __________________________ State: _______ Zip Code: __________

This coverage does not authorize the passenger to operate the unit at any time. Passenger must be at least 7 years of age.

IC Signature: ______________________________________ Date: __________

I, the Passenger, hereby release and acquit and forever discharge the Motor Carrier, and all other persons from any claims, demands, and damages of any kind, known or unknown, resulting in personal injury, death, or property damage arising from any accident or incident while an occupant in any vehicle owned or under contract to driver. I, the Passenger, understand and agree that any benefits provided by the Passenger Accident Policy will be paid directly to me or my estate unless I designate otherwise at the time coverage is issued.

Passenger Name: ______________________________ AGE: __________

Address: ____

City: __________________________ State: ______ Zip Code: __________

Beneficiary Name: ______________________ Relationship: ______________

Beneficiary Address: ______________________________________

Signature of Passenger: ______________________________________

(Signature of Parent or Guardian in the event of a minor child)

Effective Date: ________________ Expiration Date: ____________________

Oakley Trucking Official authorizing Passenger:____________________________Date:__________