MEMBERSHIP REGISTRATION FOR NORTHAMERICAN TRANSPORTATION ASSOCIATION

In applying for membership with ***NorthAmerican Transportation Association Inc. (NTA Inc.)*** for the procurement of any of the association's programs, I or We, are desirous of becoming a member of NTA and understand that the membership in NTA Inc. is limited to and made up entirely of separate transportation related companies consisting of at least one owner. NTA offers its members a free subscription to NTA's "**High-Way Hi-Lites,**" an electronic weekly newsletter & "**10-4 Magazine",** a monthly electronic magazine.

We understand and agree that we must have on file a current credit card and/or electronic check payment form (ACH) at all times. We understand that some benefits or services are for MEMBERS ONLY. To help new member companies establish a credit line, we understand that all accounts are reported to our in-house credit bureau on a monthly basis.

THIS FORM MUST BE SIGNED by an authorized representative from each company and returned with the applicable fees to NTA Inc. before any services or benefits can be started. Please keep copies of this form for your record keeping as proof of your association membership with NTA Inc.

Please email all forms to: INFO@NTASSOC.COM, or use our online form interface at WWW.NTASSOC.COM/JOIN-THE-NTA

PLEASE PRINT Date _____ **NTA ID #** _____

Name of Company/Individual _____

Mailing Address _____

Physical Address _____

City/State _____ Zipcode _____

US DOT# _____ #PIN # or SS# _____

Phone: _____ FAX: _____

Email address _____ Web site _____

Total number of employees you will enroll _____

Total number of Independent Contractors you have to enroll _____

By clicking this check-box you acknowledge by typing your name below you are legally signing this document. ☐

Print Name

FOR OFFICE USE ONLY

DATE:_____ CHECK # _____ CASH _____

HH_____ CM _____ QB _____

AMT REC'D _____ RE: _____

NTA Membership Dues Rate Schedule for Motor Carriers & Independent Contractors

Dues include a Free subscription to Hi-Way Hi-Lites (association electronic newsletter)and a Free subscription to 10-4 Magazine

No of Drivers	Membership Fee Schedule for Motor Carriers is based on the number of drivers reported x 12 months
1	$100.00 per year for each Independent Contractor.
	Motor Carrier Schedule
2 to 10	$4.50 per driver x 12 months = Annual Fee
11 to 20	$4.00 per driver x 12 months = Annual Fee
21 to 50	$3.50 per driver x 12 months = Annual Fee
51 to 100	$3.00 per driver x 12 months = Annual Fee
101 to 200	$2.50 per driver x 12 months = Annual Fee
201 to 500	$2.00 per driver x 12 months = Annual Fee
501 & Over	$1.50 per driver x 12 months = Annual Fee
	Must be secured by either a credit card or an electronic check payment authorization.
	Membership is Non-Refundable

Rev: 1/1/2018

Initial Box to designate type of payment.
ALL Payments must be made no later than the 16th of each month.

☐ Automatic ACH deduction.
☐ Automatic Credit Card.
☐ Will pay on-line as shown on Invoice.
☐ Will pay by check.

Electronic Check/ Credit Card Authorization Form

Please complete the information in the box below to authorize an electronic check payment (ACH-debit).

Name on Check (Last, First): _____

Address:

_____

Type of Account: ☐ Checking ☐ Savings

Bank Routing Number: _____

Bank Account Number: _____

Amount Authorized: _____

Email Address for electronic receipt (optional): _____

By clicking this check-box you acknowledge by typing your name above you are legally signing this document: ☐

Please complete the information in the box below to authorize a credit card transaction.

Card Holder Name: _____

Card Address:

_____

Amount Authorized: _____

Card Type: ☐ Visa ☐ Master-card ☐ Discover-card Expiration Date: _____/_____

Card Number: _____ 3-digit security code: _____

E-mail Address for electronic receipt (optional): _____

By clicking this check-box you acknowledge by typing your name above you are legally signing this document: ☐

Workers' Compensation Loss History Affidavit

Must be completed. NO PREVIOUS WORKERS' COMPENSATION COVERAGE- ☐ Check here

I, _____, do hereby certify and swear that
(name of owner or officer)

_____
(company name)

_____
(dba)

has incurred _____ injuries within the last 36 months. Please list the injuries and the costs incurred in the table below for the last 36 months.

Year	Employee	Cost	Injury	Status

Note: If there have been no injuries, write (None) in the table above.

Explanation: Why can't loss runs be provided or if an individual claim amount exceeds $15,000.00

If you have had Workers' Comp Coverage through another company within the last 36 months list company(s) below and attach loss runs from that company(s).

Company Name: _____

Signed by: _____ Date: _____

Title/Position: Owner

Note: This affidavit must be submitted with the New Client Profile Sheets when loss runs are not available.

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 with the purpose of avoiding or reducing the amount of premiums for workers' compensation coverage or crucial information pertinant to the computation and application of an experience rating modification factor, is guilty of a felony of the third degree or as otherwise punishable by law.

IGI rev.2/05

Occupational Accident Plan Disclosure

Each Motor Carrier with a FMCSA MC number and each Independent Contractor (IC) is considered to be a separate company. This is based on certain States that have the "A, B, C Rule" plus Dept. of Labor (DOL) & Internal Revenue Service (IRS) regulations and each entity is required to submit an NTA Membership application to gain access to our Master Policy.

Important: NTA dues will be billed by NorthAmerican Transportation Association and Insurance premiums will be billed by NTA Administrative Services. NTA uses Intuit QuickBooks as its billing protocol. Be advised that any business with NTA is a credit account reported to a division of Equifax. See website for the required document forms. On ALL forms "Your printed name constitutes your Signature."

Membership is necessary to prove that the individual to be covered is in reality an Independent Contractor in the eyes of the Dept. of Labor (DOL) and the various State courts using the "A, B, C Rule" i.e., California and to gain access to our Benefits and Services.

Membership for a Motor Carrier is based on the number of drivers shown on their last MCS-150 filing. Membership for Independent Contractors starts at $100 for the sole proprietor. Memberships are paid annually and are not refundable. ***Please be sure to insert the individual's SS# where it calls for the PIN#.***

This Plan Disclosure Form MUST be signed & Submitted by the party who is responsible for premium payment.

Please note that coverage always starts on the 1st of each month. There is no prorating. Policy is issued to the individual. Coverages starting after the 1st of the month must be accompanied by two months premiums, as the premiums must be paid in advance two (2) weeks before the premium is due.

Once a Certificate/Policy is issued the premium is considered earned. These Plans are considered long term coverages; therefore, **a 30 day Written Notice of Cancellation is required**. Please read Section II of your policy "Effective Dates and Termination Dates" for more specific information of your rights and responsibilities.

All billing is done on the 15th of each month prior to the premium period and all automatic ACH and/or Credit Card deductions are done on the 16th of each month. There is a $5.00 admin fee added to cover each personal policy issued.

After your coverage is in place, you will have the following options of paying your premiums. 1) pay by ACH deduction ($3.00 fee), 2) pay by credit card (5% charge with a $10 minimum charge applies), or with Approved credit options 3 & 4. 3) pay on-line, and 4) by mail, or 5) fax in your check (save postage-fee same as ACH).

If this meets your needs, please complete the enclosed documentation and either scan and email back or fax back to our secure fax 800-810-6998. No cover sheet is necessary as your fax goes directly to our computer.

Please submit one (1) NTA and (1) Great American application for each individual to be covered. Do not forget to submit your authorization for payment. We cannot process without these completed documents.

If you need a Certificate Holder listed on your Notice of Coverage, please make sure we have the complete information i.e., Name, Address, Tel # and email added to the Great American Application.

If you have any further questions, you may call, email me or go to www.ntassoc.com and review the 12-page brochure in the privacy of your home.

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NOTICE: Credit Card regulations require that you have read this Plan Disclosure and understand by printing and/or signing below you have given your affirmative consent under the ESIGN Act, Sec 101(c)(1) (c) This form MUST be submitted along with your application for coverage.

PRINT NAME

☐ By clicking this check-box you acknowledge by typing your name below you are legally signing this document.

2. DRIVER AND BENEFICIARY INFORMATION

Name: _____ DOB: _____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____ Cell: _____

Beneficiary Name: _____ Relationship: _____

Indicate type of driver: Owner Operator □ Date of Hire: _____

Other, including an authorized passenger □ _____

CDL Number: _____ Unit Number/VIN#: _____

Commodity Hauled: _____

Paid by: 1099 ☐ W-2 ☐ Contracted By: _____

Motor Carrier Name & Address:

_____

Agent Name: _____ Agent Phone: _____

Agent Address: _____

I accept ☐ reject ☐ The Occupational Accident insurance offered by the above listed Policyholder or Participating Motor Carrier. I understand that coverage becomes effective when this application has been received and approved by Great American Insurance Company or its authorized agent. I understand that I will no longer be eligible for coverage upon my 65th birthday and that coverage will therefore cease. I further understand that coverage terminates on the date the policy is terminated; or I am no longer under contract with the above mentioned motor carrier; or my premium is not paid. I also understand that coverage may be available on an individual policy subject to underwriting guidelines in effect at termination of the above policy.

Owner-Operator Signature (Print Name) _____ ☐ By clicking this check-box you acknowledge by typing your name you are legally signing this document. Date _____

Medical Information Authorization: I hereby 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 history for the above named person to furnish such information or copies of records to the insurance companies association or its representatives. A photographic copy of this authorization shall be as valued as the original.

Owner-Operator Signature (Print Name) _____ ☐ By clicking this check-box you acknowledge by typing your name you are legally signing this document. Date _____

FLORIDA STATUTE 817.234(1)(b)
"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 felony of the third degree."

NEW MEXICO STATUTE 59A-16C-8
"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 civil fines and criminal penalties."

OHIO INSURANCE CODE 3999.21
"Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insured, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud."

Great American Insurance Company
301 E. 4th Street Cincinnati, OH 45202-4201 513.369.5000

Agency: HEALTH SPECIAL RISK, INC.
880 Sibley Memorial Highway, Suite 101
Mendota Heights, MN 55118

Policyholder: HEALTH SPECIAL RISK MASTER PROGRAM
880 Sibley Memorial Highway, Suite 101
Mendota Heights, MN 55118

Policy number: OA3940789

Rate Per Driver Per Month: $12**6**.00

OCCUPATIONAL ACCIDENT INSURANCE INDIVIDUAL OWNER-OPERATOR APPLICATION

I. SCHEDULE OF BENEFITS: (FOR OWNER-OPERATORS AGE 23 TO 65)

DESCRIPTION OF BENEFITS	OCCUPATIONAL	NON-OCCUPATIONAL
ACCIDENTAL DEATH AND DISMEMBERMENT MAXIMUM BENEFIT AMOUNT SURVIVOR'S BENEFIT (LUMP SUM) INCURRAL PERIOD ACCIDENTAL DISMEMBERMENT – INCLUDING PARALYSIS AND SEVERE BURN BENEFIT	 $150,000 PRINCIPAL SUM (($25,000 DEATH LUMP SUM) + $1000 PER MONTH UP TO 125 MONTHS) 52 WEEKS INCLUDED IN PRINCIPAL SUM	 $10,000 PRINCIPAL SUM LUMP SUM 52 WEEKS INCLUDED IN PRINCIPAL SUM
ACCIDENTAL MEDICAL EXPENSE COMMENCEMENT PERIOD DEDUCTIBLE INCURRAL PERIOD ACCIDENTAL DENTAL MAXIMUM BENEFIT AMOUNT CHIROPRACTIC CARE, OCCUPATIONAL THERAPY, PHYSICAL THERAPY	$500,000 MAXIMUM BENEFIT AMOUNT 90 DAYS $ 0 104 WEEKS $1,000 PER INJURY/ $10,000 LIFETIME NO SUB-LIMIT APPLIES	$5,000 MAXIMUM BENEFIT AMOUNT 90 DAYS $ 0 52 WEEKS NOT COVERED NO SUB-LIMIT APPLIES
TEMPORARY TOTAL DISABILITY WAITING PERIOD COMMENCEMENT PERIOD DURATION-MAXIMUM BENEFIT PERIOD	*$450 MAX/ $150 MIN PER WEEK 7 DAYS RETROACTIVE 90 DAYS 104 WEEKS *Subject to the lesser of: 70% of Average Weekly Earnings or the Maximum Weekly Benefit Amount shown	NOT COVERED
CONTINUOUS TOTAL DISABILITY WAITING PERIOD DURATION-MAXIMUM BENEFIT PERIOD	*$450 MAX/ $150 MIN PER WEEK 104 WEEKS UP TO SOCIAL SECURITY RETIREMENT AGE** *Subject to the lesser of: 70% of Average Weekly Earnings or the Maximum Weekly Benefit Amount shown	NOT COVERED
ADDITIONAL BENEFIT RIDERS: HERNIA OR HEMORRHOID OR OCCUPATIONAL DISEASE OR CUMULATIVE TRAUMA	$10,000 PER INJURY SUBJECT TO A $40,000 LIFETIME MAXIMUM MAXIMUM BENEFIT PERIOD: 10 WEEKS	
CERTIFICATE COMBINED SINGLE LIMIT ANY ONE ACCIDENT AND AGGREGATE	$500,000	

This coverage is not Workers' Compensation Insurance or for any other purpose except occupational accidents (unless non-occupational benefits apply). This policy does not cover disease unless otherwise endorsed. 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 your date of birth. If you are to reach your SSRA before satisfying the waiting period, you may not qualify for Continuous Total Disability Benefits.