Base Agency

PARTICIPANT APPLICATION

Participant Request for Occupational Accident Insurance

Request Effect Date
1st of THIS or NEXT Month: _____

Sponsor
(Name of business on Account App): _____

Participant Information:

First Name: _____ Last Name: _____ DOB: _____ SS#: _____

Street:_____ City: _____ State: ___ Zip: _____

Email: _____ Phone: _____ DL#: _____

What is the Name of Your Business: _____

I Understand that policy info is sent via Text/Email

Beneficiary Designation for Accidental Death Benefit:

Name:_____ Phone:_____ DOB:_____ Relationship:_____

Workers' Compensation Insurance Rejection Acknowledgement

I hereby declare and state that:
1. I am not an employee or eligible for Workers' Compensation from the Participant sponsor. I request coverage under the Participant Sponsor's group Occupational Accident policy; and
2. I qualify for coverage under the Eligible Class as checked above; and
3. I grant permission to the Participant Sponsor to deduct such payments as may be required for the insurance provided by this policy: and
4. I understand this insurance will become effective the date this Request For Insurance has been received and approved.
5. I am joining this Professional Association
6. I request coverage to be bound under the Participant Sponsor's Occupational Accident policy. I am electing to exclude myself from Workers' Compensation coverage as permissible under the laws of my state.
7. I hereby grant a limited power-of-attorney to Association with the authority to initiate cancellation of my Occupational Accident coverage effective the same date I am no longer eligible under this Program; and
8. I hereby understand and agree that eligibility for this program is limited to Independent Contractors, as defined by law, and Participants who are not employees and further agree to the terms outlined in the above items.
9. The beneficiary designation above shall void and supersede any previous designation by me. I reserve the right to change the beneficiary shown above by completing and submitting a signed Change of Beneficiary Form.
10. I understand that the insurance as applied for is based upon my written statements and answers to the above questions.
11. I attest that all statements made in this Request for Insurance are true and accurate to the best of my knowledge. It is my right as an Independent Contractor and as a sole proprietor or executive officer of my Company to exercise my option to not buy Workers' Compensation insurance on myself. I am choosing not to purchase Workers' Compensation. I am electing to buy Occupational Accident Insurance. I understand that Occupational Accident insurance is not Workers' Compensation insurance and provides different benefits than Workers' Compensation.

I VERIFY THAT I HAVE READ THIS AGREEMENT AND THAT I UNDERSTAND WHAT I AM PURCHASING:

Applicant's Signature: _____ **Date:** _____