



**OCCUPATIONAL ACCIDENT
REQUEST FOR INSURANCE**

Date to Start Occ Acc: _____

Hudson Insurance Company

Under Group Policy Number Standard Long Haul issued to the Trustee of the Group and Blanket Accident & Health Insurance Trust.

Participant: Midwest Affinity Group

Covered Driver: _____
(Name) (Date of Birth)

(Address)

(CDL#/State) (e-mail address)

(Beneficiary Name) (Relationship) (Contact Info)

By signing this Request for Insurance the Independent Contractor agrees to all of the following:

To request coverage for the person listed above. Please check the appropriate box: I am an:

Independent Contractor participating in the Midwest Affinity Group Occupational Accident program performing contracted services pursuant to written agreement.

To make such payments as may be required for the insurance to be provided.

The undersigned wishes to apply for membership in The Advantage Association, LLC, and a Georgia limited liability company. I understand that enrollment in the association is required to be eligible for this policy.

That all of the statements made in this Request are, to the best of my knowledge and belief, true and accurate.

EFFECTIVE DATE OF INSURANCE:

The Effective Date of Insurance is the date shown in the Schedule of Benefits in each person's Certificate of Insurance provided this request has been approved by Hudson Insurance Company and its Underwriting Manager, and the proper premium has been paid.

AMOUNTS OF INSURANCE REQUESTED for: Independent Contractor (as scheduled above): Will be listed on the Benefit Schedule upon binding.

I hereby request enrollment for the Occupational Accident policy set forth above. I understand and acknowledge that I am an **INDEPENDENT CONTRACTOR**, and that as such, the cost of this insurance is my sole obligation and responsibility. In enrolling for this insurance coverage, I hereby acknowledge and agree that I meet the eligibility requirements of this policy, and that I am not an employee of any company for which I perform services. I further understand and acknowledge that this is **NOT WORKERS' COMPENSATION INSURANCE**.

Signed _____
(Signature of Covered Driver)

Date _____