PASSENGER AUTHORIZATION FORM and APPLICATION FOR PASSENGER ACCIDENT COVERAGE

This letter constitutes authority for _____ to be transported as a
(passenger)
Passenger on Unit # _____ with _____ as the only driver.
(truck) (Garner associate/driver)

This covers the period from _____, 20_____, to _____, 20_____, over routes authorized by **Garner Transportation Group, Inc.**

This does not authorize _____ to operate the unit at any time.
(passenger)

For my own protection, I hereby request coverage for the above named passenger under the Passenger Accident Insurance Policy underwritten by Great American Insurance Group for the period noted above. **I authorize Garner Transportation Group, Inc. to deduct the premium of $25.00 from my settlements.**

I, _____, by my signature hereby release and acquit and forever
(passenger)
discharge **Garner Transportation Group, Inc.** and their agents, representatives and all other persons of any claim, 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 Garner Transportation Group, Inc.

I, _____, hereby request to participate in the Passenger Accident
(passenger)
Insurance Policy underwritten by Great American Insurance Group, under Policy No. OA3941731, Plan Option 2, and understand and agree that any benefits provided by this Policy will be paid directly to me or my designated beneficiary, if any, or to my estate.

Beneficiary:_____ Relationship:_____

_____ _____
Passenger Garner Associate/Driver or Owner/Operator

Date:_____ Date:_____

_____
Authorized by

Date:_____

2. DRIVER AND BENEFICIARY INFORMATION

Name: _____ DOB: _____

Address: _____ City: _____

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

Beneficiary Name: _____ Relationship: _____

Indicate type of driver: Owner Operator ☐ Co-Driver ☐ Contract-Driver ☐ Scheduled Co-Driver ☐ Fleet Driver ☑ Team Driver ☐

Other, including an authorized passenger ☐ _____

CDL Number: _____ Unit Number/VIN# : _____

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

Motor Carrier Name & Address:

_____

Agent Name: _____ Agent Phone: _____

Agent Address: _____

Monthly Plan: I ($13.50) ☐ II ($19.80) ☑ III ($9.00) ☐ Accept Supplemental Accident Benefits ($2.00/month) Yes ☑ No ☐

I accept ☑ **reject** ☐ The Passenger 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 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.

Driver Signature _____ 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.

Driver Signature _____ 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."