PROTECTIVE INSURANCE COMPANY
Work Accident Claims Department
111 Congressional Blvd., Suite 500
Carmel, Indiana 46032
1-800-231-6024

INDEPENDENT CONTRACTOR ACCIDENT INSURANCE

SWORN STATEMENT IN PROOF OF LOSS

Instruction: To receive consideration for benefits, complete and mail this proof to Protective within 90 days of its receipt by you. For quicker claim handling, return this to Protective as soon as possible.

1. Injured Person's Name and Address (No., Street, City, County, State, Zip)	2. Phone ( )	3. Social Sec. No. - -	4. DO NOT COMPLETE THIS PART Sponsor:
5. Terminal Address and Number, if applicable (No., Street, City, County, State, Zip)	6. Last DOT Physical Date / / (Month, Day, Year)	7. Birthdate / / (Month, Day, Year)	
	8. Date of Accident / / (Month, Day, Year)	9. Time of Accident (circle one) _____: _____ a.m. p.m.	

10. Location of Accident — City — County — State

11. Describe in detail how the accident occurred. (Tell what happened and how it happened. Give full details of all factors which led to or contributed to the accident.) Attach additional pages if necessary.

12. At the time of accident were you under Lease to the Sponsor? (circle one) Yes No	13. At the time of accident were you a substitute driver? (circle one) Yes No	14. At the time of accident were you driving for an independent contractor under Lease to the Sponsor? (circle one) Yes No

15. Describe the injury in detail (Amputation, Burn, Cut, Fracture, Etc.) and the part(s) of the body affected (Head, Arm, Circulatory System, etc.) Attach additional pages if necessary.

16. Name, Address and Phone Number of treating doctor. (No., Street, City, County, State, Zip)	17. Name, Address and Phone Number of treating hospital. (No., Street, City, County, State, Zip)

18a. Have you previously sought or received medical treatment for the same or similar injury as the one for which you are making this proof? (circle one) YES NO
If yes, give name and address of treating doctor and hospital.

18b. Last date of previous treatment. / / (Month, Day, Year)	18c. Explain nature and extent of previous treatment, if any.

(over)

19. Did you miss work due to injury? (circle one) Yes No	20. Date you first missed work / / (Month, Day, Year)	21. Have you returned to work part time? (circle one) Yes No	22. Have you returned to work full time? (circle one) Yes No	23. Date returned to work / / (Month, Day, Year)	24. Date expected to return to work / / (Month, Day, Year)

25. Settlements for 3 full months prior to accident. (Indicate month and amount of settlement)

Month 1 _____ Month 2 _____ Month 3 _____

Amount 1 _____ Amount 2 _____ Amount 3 _____

26. If you are currently working for someone other than the Sponsor, indicate name, address, city, county, state and zip code of current employer, contractor or other.

27. Describe type of work you are currently doing, if any.

28. List other companies with which you are insured and benefits you expect to claim as a result of your accident.

	Company	Policy Number	Policy Date	Amount of Benefit (State Weekly or Monthly)
1.				
2.				
3.				

29. Are you receiving, have you filed for, or do you intend to file for Social Security Benefits? (circle one) Yes No	30. Are you receiving, have you filed for, or do you intend to file for No-Fault Benefits? (circle one) Yes No	30. Are you receiving, have you filed for, or do you intend to file for Unemployment Benefits? (circle one) Yes No	30. Are you receiving, have you filed for, or do you intend to file for Workers' Compensation Benefits? (circle one) Yes No
Amount _____	Amount _____	Amount _____	Amount _____
Effective Date _____	Effective Date _____	Effective Date _____	Effective Date _____

PLEASE READ CAREFULLY BEFORE SIGNING!

CERTIFICATION

I certify that the reason I am filing this Proof of Loss is that I have an accidental injury.

I certify that I am an independent contractor in the trucking industry, not the employee of the Sponsor nor of one under contract to the Sponsor, and that I am not eligible for Workers' Compensation Benefits.

I certify that I understand that should I make a claim for or receive Workers' Compensation Benefits due to the accident listed above, I am not entitled to any benefits under this program.

I certify that I understand this to be a formal statement by me regarding my loss and is intended to assist Protective Insurance Company in determining its liability and the extent and amount of benefits to which I am entitled. To that end I have answered all questions in a true and correct fashion to the best of my knowledge and ability.

I certify that no material fact has been withheld or concealed from Protective Insurance Company. Should any omitted material fact come to my attention or should any answer or statement previously made by me be or become incorrect I shall notify Protective Insurance Company promptly. Failure to do so may terminate benefits.

_____ _____ _____

Name (Please Print) | Signature | Date

NOTICE

The furnish of this form or the assistance given by a representative of Protective Insurance Company in preparing this form is not a waiver of its rights or defenses.