# Atlantic Specialty Insurance Company

**Plymouth, Minnesota**

## TRANSPORTATION PROVIDER ENROLLMENT FORM

OCCUPATIONAL ACCIDENT INSURANCE
Policy Number 216-002-058

I confirm that my name, address, city, state, Zip code, email, and phone number provided to Uber are accurate.

**FRAUD WARNINGS**

Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

FLORIDA: 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.

LOUISIANA: 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 fines and confinement in prison.

MARYLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

OHIO: Any person who with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**In providing this information, I understand and hereby state that:**

1. to the best of my knowledge and belief, all information on this Form is complete and truthful;
2. this coverage is not a contract for Statutory Workers' Compensation Insurance; and
3. if, based on the information supplied in this Form, I am not eligible for coverage, premium will be refunded and no claims will be payable.

By enrolling for coverage, I 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 records, to furnish such information or copies of records to Atlantic Specialty Insurance Company. A photographic copy of this authorization shall be as valid as the original.

**IF THE INFORMATION PROVIDED IN THIS FORM IS FRAUDULENT, THE INSURER HAS THE RIGHT TO RETURN PREMIUM AND CANCEL COVERAGE.**

In order to verify the information provided in this Form, I give the Insurer authority to examine the records that are maintained by any Platform Operator(s), any Transportation Network Company or any On-Demand Company with whom I have a contract.

I certify that I am an Independent Contractor and receive a 1099 tax form.

I understand that by purchasing this coverage I will become a Participant in the On-Demand Companies' Group Insurance Trust. A copy of the Trust Agreement will be provided by the Program Administrator upon my written request. Please write to:

On-Demand Companies' Group Insurance Trust Administrator
c/o Affinity Insurance Services, Inc.
4th Floor
900 Stewart Avenue
Garden City, NY 11530

**I understand that I am covered under this insurance only while Online for the following Platform Operator: Raiser LLC and its affiliates.**

**Payment Authorization**: I authorize Raiser LLC and its affiliates, with whom I have a contract, to take deductions every trip, equal to my premiums, from my settlement account on my behalf, and to remit these funds to Atlantic Specialty Insurance Company. I also authorize Raiser LLC and its affiliates to update the above information on this Enrollment Form which I subsequently provide to them, if applicable.

I UNDERSTAND THAT THE COST OF THE INSURANCE IS MY SOLE OBLIGATION AND RESPONSIBILITY, regardless of the above arrangement of premium payment. I agree that I will forward any amount due and owing to Atlantic Specialty Insurance Company, upon demand, for any insurance at any time my account remains unpaid.