# *NEW Non-DOT Indirect Driver Checklist*

**Master IC Name:** ________________________________ **Master IC Driver #:** ______

**Indirect Driver Name:** ____________________________ **Indirect Driver #:** ________

**Business Center:** ____________

**Date:** _______________________
**(mm/dd/yyyy)**

To the Business Center Transportation Purchasing Coordinator:

**When preparing an Indirect Driver packet to be sent to Corporate Safety and Compliance Team, please make sure you follow the checklist. Any items incomplete or missing will result in a delay of driver approval. All Driver Packages MUST BE COMPLETED ON THE COMPUTER WITH THE EXCEPTION OF THE SIGNATURE (HAND WRITTEN WILL NOT BE ACCEPTED), and uploaded on the dxShare North American Safety and Compliance website.**

**A.** **Photo Meeting SOP Criteria Uploaded for Identification Badge**

**B.** **Indirect Driver Information Sheet**

**C.** **Is this Individual a US Citizen?**

**YES**

**NO - Clear Copy of Work Authorization Documents with Expiration Date Required**

***NOTE: In the case of Section C above. If the Indirect Driver has recently become a US Citizen and has not received their new Social Security Card a US Passport will suffice as supporting evidence along with the existing Social Security Card in lieu of the Alien Registration Card. They will still need to submit the New Social Security Card upon receipt.***

**D.** **Social Security Card**

**E.** **Consumer Report Release**

**F.** **Current (w/in 60 days) Motor Vehicle Report meeting Dynamex Contracting Standards**

**G.** **Current (w/in 60 days) Criminal Background Check Report meeting Dynamex Contracting Standards**

H. **If they will be doing IKEA work submit the IKEA Background Request and Consent Form as well as Item E.**

**I.** **Confirmation (w/in 60 days) of Negative Drug Test result**

**J.** **Indirect Driver Has:**

**a.)** **Will be driving Master IC Vehicle and will be covered under Master IC Ins Policy**

**b.) Will be using their own vehicle and provide proof of Insurance by COI or copy of Declarations Page (Policy must have effective date and expiration dates including limits of liability and VIN)**

**c.) INSEL**

**d.) INSEL CGL/CARGO (If Master IC has INSEL CGL/CARGO then the Indirect Driver MUST also enroll**

**K. Vehicle Registration (If using own vehicle or INSEL) – Must Match VIN on COI**

**L. Current State Driver's License**

**M. Deduction Agreement – Must be Signed by Master IC as well**

**N. OAC/Occupational Accident Insurance Enrollment Form – or proof of personal Occupational Accident Insurance coverage N/A**

**O. Covered Under Master IC Workman's Comp N/A**

Dynamex

# Indirect Driver Information Sheet*

Name: ______________________________________________
First Middle Last

Home Phone#: _______________ Cell#: ______________ Email Address: ____________________________

**Current Address: ______________________ ______________________ ____ ________
Street City State Zip

** If at the above address less than three years, list below all residences for the past three years. Attach a separate sheet if necessary.

______________________ ______________________ ____ ________
Street City State Zip

______________________ ______________________ ____ ________
Street City State Zip

Date of Birth: _________________ (mm/dd/yyyy) Social Security No. ____ - ___ - _____

Driver's License Number: _________________________ Driver's License State: ____ DL Exp. Date: _____________

## General

List two (2) people to contact in the event of emergency:

______________________ ______________________ ________
Name Address Phone

______________________ ______________________ ________
Name Address Phone

**Description of Vehicle -** The vehicle(s) which I will use are:

| Year | Make | Model | VIN | Plate # | GVWR | Special Equip (& Box Length) |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |

| **Vehicle Owner** | **Street** | |
|---|---|---|
| | | |
| **City** | **State** | **Zip Code** |
| | | |
| **Insurance Policy Number** | **Expiration Date** | **Limits of Liability** |
| | | |

| Other Comments |
|---|
| |
| |
| |

# Disclosure and Release

**Dynamex Operations East, LLC or Dynamex Operations West, LLC** (depending on the entity with whom you are contracting) (hereinafter "Dynamex") may obtain information about you from a consumer reporting agency in connection with its standard due diligence procedures when contracting with contractors performing services for Dynamex. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living, and which can involve personal interviews with sources. These reports may be obtained at any time after receipt of this authorization and, if you and Dynamex enter into a contract, throughout the validity of your contract. You have the right, upon written request made within a reasonable time after receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report. Please be advised that the nature and scope of the most common form of investigative consumer report obtained in connection with the contracting process is an investigation into your criminal history, education and/or employment history conducted by Accutrace, Inc. P.O. Box 624, Bryn Mawr, PA 19010 ("Accutrace"). You may obtain a copy of the investigative consumer report by contacting Accutrace at 1-888-54 -TRACE or another outside organization. The scope of this notice and authorization is all-encompassing, however, allowing Dynamex to obtain from any outside organization all manner of consumer reports and investigative consumer reports now and, if you enter into a contract with Dynamex, throughout the course of your Contract, is limited to the extent permitted by law. As a result, you should carefully consider whether to exercise your right to request disclosure of the nature and scope of any investigative consumer report.

New York applicants or employees only: You have the right to inspect and receive a copy of any investigative consumer report requested by Dynamex by contacting the consumer reporting agency identified above directly. □

**ACKNOWLEDGMENT AND AUTHORIZATION**

I acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" at any time after receipt of this authorization and, if I enter into a contract with Dynamex, throughout the term of my contract. **I ALSO CONSENT TO MY INFORMATION BEING RELEASED TO CLIENTS OF DYNAMEX THAT REQUIRE ANY CONSUMER REPORT OR INVESTIGATIVE CONSUMER REPORT ABOUT ME, IN ORDER FOR ME TO ACCESS THEIR LOCATION OR CARGO IN THE COURSE OF THE FULFILLMENT OF MY CONTRACT WITH DYNAMEX.** To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by Accutrace, Inc. or another outside organization acting on behalf of Dynamex, and/or Dynamex itself. I agree that a facsimile ("fax") or photographic copy of this Authorization shall be as valid as the original.

Minnesota and Oklahoma applicants or employees only: Please check this box if you would like to receive a copy of a consumer report if one is obtained by Dynamex. □

California applicants or employees only: By signing below, you also acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW. Please check this box if you would like to receive a copy of an investigative consumer report or consumer credit report if one is obtained by Dynamex at no charge whenever you have a right to receive such a copy under California law. □

**<Please Print Clearly>**

Applicant's Name: ______________________________________________

First Middle Initial Last

Maiden Name: ______________________ Nickname(s) Used: ______________________

**Signature:** ______________________________ **Date: ____mm/____dd/______yyyy**

| | | - | | | - | | | | | | | | | | - | | | - | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

**Date of Birth (mm/dd/yyyy)** **Social Security Number**

| | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

**Driver's License Number** **State**

______________________________________________

**Current Address** **City** **ST** **Zip**

**No. of Years at Current Address:** _______

**Previous Addresses within the Past 7 Years (Use back if additional space is needed)**

______________________________________________

**Current Address** **City** **ST** **Zip**

Accutrace, Inc. • P.O. Box 624 • Bryn Mawr, PA 19010 • Phone: 484-381-3200• Toll Free: 888-54 TRACE • www.accu-trace.com

**Fax: 888-658-8608**

# INSEL and Cargo/CGL Program Application

I. **COVERAGE TYPE:** *(Check Desired Coverage)*

a. ☐ INSEL (In-Service Only) Liability Only – Does not include Physical Damage

*INSEL is only available for vehicles weighing less than 10,000 lbs.*

b. ☐ General Liability & Cargo - ***available for vehicles up to 26,000 lbs.***

Choose Limit: ☐ $25,000 ☐ $50,000

Do you do installation? ☐ Yes ☐ No

II. **PERSONAL INFORMATION:** *(Applicant must complete)*

Print Your Name: ______________________________________________
Last First MI

Address: ______________________________________________
Street

______________________________________________
City ST County Zip

Driver's License #: ____________________ DOB: __________ State: _____

Expiration Date: ________________ Driver #: ______

III. **VEHICLE INFORMATION:** *(Applicant must complete)*

List the vehicle(s) to be driven. You may insure more than one vehicle but all vehicles must be scheduled and used in the courier operations (in-service only). Please submit Change Form for each additional vehicle.

Year: _______, Make: ____________________, Model: __________________

VIN: ________________________________, GVWR: ____________

Type: ☐ Automobile ☐ Pickup Truck ☐ Van ☐ Sport Utility

☐ Other (Specify) ________________________

Commodity being delivered: ____________________________________________

*Applicants must sign below to acknowledge application of coverage:*

**I understand & agree the insurance policies requested apply only while on-dispatch only. They do not include coverage for uninsured/underinsured drivers, personal injury protection, physical damage, property, or other coverage's.**

**Signature of Applicant:** ______________________________ **Date:** __________

IV. **PURCHASED TRANSPORTATION COORDINATOR:** *Check the boxes below indicating which documents are included.*
Coverage does not apply until AJG receives all appropriate documents & your office has confirmation of acceptance.

☐ This Completed Application, signed by applicant

(If Master IC or Drive Vendor, must have application for each covered driver.)

☐ Copy of Vehicle Registration/BOS ☐ Current Motor Vehicle Report (MVR)

Business Center #: __________

# INDEPENDENT CONTRACTOR DEDUCTION AGREEMENT

IC NAME: ______________________________________________

| DECS CODE | NAME | GL Code | Deduction Amount | DECS CODE | NAME | GL Code | Deduction Amount |
|---|---|---|---|---|---|---|---|
| **AFR** | AD FEE REV | 401600 | ________ | **LWH** | LEASE WITHHELD | 506216 | ________ |
| **INSEL** | AUTO INSURANCE | 512800 | ________ | **MDU** | MOBL DATA | 514900 | ________ |
| **BKG** | BACKGROUND | 511600 | ________ | **MIK** | MIK (Canada Only) | 514900 | ________ |
| **BIR** | BSH IN RNT | 513900 | ________ | **MIL** | NY VEH MILEAGE | 531900 | ________ |
| **BLD** | BSH DN PMT | 513900 | ________ | **MVR** | MVR (MOTOR VEHICLE REPORT) | 513900 | ________ |
| **BLL** | BUSH LSE PMT | 513900 | ________ | **OAC** | OC ACC INS | 506217 | ________ |
| **BLM** | BUSH LSE MAI | 513900 | ________ | **OAF** | OC ACC FEE | 506217 | ________ |
| **CAS** | CASH CALL | 111200 | ________ | **OVR** | Overcharge | 514900 | ________ |
| **CEL** | CELL PHONE | 514900 | ________ | **PARK** | PARKING RENT | 611450 | ________ |
| **CF1** | CHDSUP 1 | 222000 | ________ | **PGR** | PAGER ONLY (Canada Only) | 514900 | ________ |
| **CF2** | CHDSUP 2 | 222000 | ________ | **PHY** | DOT PHYS | 601570 | ________ |
| **CIC** | CARGO CLAIM | 512110 | ________ | **PL2** | PR LN/ADV2 | 121300 | ________ |
| **CIN** | CARGO CLAIMS COST RECOVERY | 512113 | ________ | **PL3** | PR LN/ADV3 | 121300 | ________ |
| **CLO** | CELL OVERG | 514900 | ________ | **PL4** | PR LN/ADV4 | 121300 | ________ |
| **CSP** | CHILD SUP % | 222000 | ________ | **PLA** | PR LN/ADV | 121300 | ________ |
| **CSU** | CHILD SUPP | 222000 | ________ | **RAD** | RADIO | 514900 | ________ |
| **DEC** | DECALS | 513900 | ________ | **RNT** | RENTAL FEE | 513900 | ________ |
| **DIS** | DISABILITY | 506200 | ________ | **SAT** | Satelite (Canada Only) | 514900 | ________ |
| **DPF** | DRVPRO FEE | 513100 | ________ | **SCA** | SCANNER | 514900 | ________ |
| **DRG** | DRG SCREEN | 601570 | ________ | **SLC** | LOST SCANNER | 514900 | ________ |
| **DVR** | DAILY REV | 401300 | ________ | **SUP** | SUPPLIES | 512200 | ________ |
| **FUX** | Fuel Card (Canada Only) | 513550 | ________ | **TEC** | TECHNOLOGY CHARGE | 514900 | ________ |
| **GAP** | GARN PCT | 222000 | ________ | **TKTS** | TICKETS | 512500 | ________ |
| **GAR** | GARN FLAT | 222000 | ________ | **TOL** | TOLLS | 515200 | ________ |
| **GAS** | GAS CARD | 513550 | ________ | **ORT** | ORIENTATION | 503100 | ________ |
| **GF1** | GARN FLAT1 | 222000 | ________ | **UNI** | UNIFORMS | 515900 | ________ |
| **GR2** | GARN FLAT2 | 222000 | ________ | **UNL** | UNLOAD HLP | 512400 | ________ |
| **GF3** | GARN FLAT3 | 222000 | ________ | **VLL** | VEH INS (Canada Only) | 512800 | ________ |
| **HLP** | HELPER | 503100 | ________ | **VLS** | VEH LEASE | 513900 | ________ |
| **LCE** | LOST CELL | 514900 | ________ | **VMA** | VEH MAINT | 513900 | ________ |
| **LFR** | LS FIN REV | 401500 | ________ | **VMI** | VEH MILEGE | 513900 | ________ |
| **LMD** | LS FIN REV | 514900 | ________ | **VRE** | VEH REPAIR | 513900 | ________ |
| **LRA** | LOST RADIO | 514900 | ________ | **CGL** | COMM GENERAL LIAB INS/CARGO | 512800 | ________ |

**NOTE:** **Neither Dynamex nor its subsidiaries pays for benefits for Independent Contractors. Items listed hereon may include insurances and other programs, the full cost of which are borne by the Independent Contractor and paid for through authorized deductions**

**I authorize the company indicated above to deduct the dollar amounts for the items noted above to be withheld from all contractor settlement payments made to me. I also understand that if I have an Indirect Driver (sub contractor) operating for me, their deductions will be withheld from my settlements as well. I understand that all items purchased are nonreturnable.**

**Contractor Signature:** ______________________________________ **Date:** ______________

**Dynamex Rep Printed Name:** ______________________________________________

**Dynamex Signature:** ______________________________________ **Date:** ______________

**Revision 11/2014**

# Enrollment and Beneficiary Designation Form

**Occupational Accident Insurance**

**Zurich American Insurance Company**
1400 American Lane
Schaumburg, Illinois 60196

☐ Class I (Full Time) ☐ Class II (Part Time)

| **MOTOR CARRIER INFORMATION** (Please print) | |
|---|---|
| Name of Motor Carrier: **DYNAMEX, INC** | Contact Name: |
| Address: 5429 LBJ FREEWAY | Telephone: |
| City: DALLAS State: TX Zip: 75240 | Email Address: |
| Effective Date of Your Contract: | |

| **INDIVIDUAL DRIVER INFORMATION** (Please print) | | | |
|---|---|---|---|
| Name: | | FEIN / SS Number: | ☐ None |
| Address: | | DL Number: | |
| City: | State: Zip: | Number of Years Experience: | |
| Date of Birth: | ☐ Male ☐ Female | Height: | Weight: |
| Home Phone: | Cell Phone: | Email Address: | |
| Beneficiary: | | | |
| Relationship to Beneficiary: | | | |

| **GENERAL INFORMATION** |
|---|
| **YOU ARE NOT ELIGIBLE FOR COVERAGE IF YOU ARE AN EMPLOYEE DRIVER** |
| 1. Do you own and operate your own vehicle? ☐ Yes ☐ No |
| 2. Do you operate a vehicle under a lease to purchase plan? ☐ Yes ☐ No |
| 3. Do you operate a vehicle as a 1099 contract driver, but do not own or lease the vehicle? ☐ Yes ☐ No<br>If Yes, for whom? |
| 4. Do you operate a vehicle as part of a team or as a co-driver? ☐ Yes ☐ No<br>If Yes, with whom? |
| 5. Equipment type: ☐ Box Truck ☐ Tractor-Trailer ☐ Van ☐ Pickup ☐ Car ☐ Sprinter<br>☐ Other, please specify: |
| 6. Have you filed a workers' compensation or occupational accident claim in the past 3 years? ☐ Yes ☐ No<br>If Yes, please explain: |
| 7. Are you covered under any other medical and/or disability insurance plan? ☐ Yes ☐ No |
| If Yes, name of insurance carrier: |
| 8. Are you a full or part time driver? ☐ Full ☐ Part |

**INSURANCE FRAUD WARNING**
**Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading, is guilty of insurance fraud and is subject to criminal and/or civil penalties.**

I understand and hereby acknowledge the following:

1. The Occupational Accident coverage provided is not a contract for Statutory Workers' Compensation Insurance and neither I nor the Motor Carrier above can become participants in the Workers' Compensation system by purchasing this insurance;
2. I certify that I am actively at work at least 10 hours per week for the Motor Carrier above and meet the eligibility requirements under the Policy. I understand that if I am not eligible, no benefits will be paid and this coverage will be cancelled and premiums returned;
3. I certify that I am an independent contractor and receive a 1099 tax form. I further certify that I am not an employee and do not receive a W-2 tax form. I understand coverage will be terminated and no benefits paid if I am an employee;
4. 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 Zurich American Insurance Company, the Motor Carrier or the Motor Carrier's designee. A photographic copy of this authorization shall be as valid as the original;
5. I certify to the best of my knowledge and belief that all information on this form is complete and truthful; and
6. I authorize the above named Motor Carrier with whom I have a contract, to take monthly deductions, equal to my premiums, from my settlement account on my behalf, and to remit these funds to Zurich American Insurance Company or its appointed agent. I understand that the cost of the insurance is my sole obligation and responsibility regardless of the above arrangement.

Driver's Signature: ________________________________________ Date: ___________________________

Motor Carrier Representative: Dynamex, Inc.____________________ Phone/Fax Number: _______________

# DYNAMEX – SCHEDULE OF BENEFITS – CLASS I (Full Time)

| | Benefit | Occupational Injuries | Non-Occupational Injuries |
|---|---|---|---|
| ☒ | **Accidental Death Benefit:** | | |
| | Principal Sum* | $50,000 | $10,000 |
| | Commencement Period | 365 days | 365 days |
| ☒ | **Survivor's Benefit:** | | |
| | Principal Sum* | $200,000 | N/A |
| | Monthly Benefit Percentage of Principle Sum | 1% | N/A |
| | Monthly Benefit Amount | $2,000 | N/A |
| ☒ | **Accidental Dismemberment Benefit:** | | |
| | Principal Sum* | $250,000 | $10,000 |
| | Commencement Period | 365 days | 365 days |
| ☒ | **Accidental Paralysis Benefit:** | | |
| | Principal Sum* | $250,000 | $10,000 |
| | Commencement Period | 365 days | 365 days |
| ☒ | **Accident Medical Expense Benefit:** | | |
| | Commencement Period | 90 days | 90 days |
| | Deductible Amount | $0 | $0 |
| | Maximum Benefit Amount | $1,000,000 | $7,500 |
| | Maximum Benefit Period | 104 weeks | 52 weeks |
| | Dental Benefit Maximum | $1,000 | $1,000 |
| | Lifetime Maximum Benefit Amount | $1,000,000 | $15,000 |
| ☒ | **Temporary Total Disability Benefit:** | | |
| | Commencement Period | 90 days | 90 days |
| | Waiting Period | 7 days | 14 days |
| | Benefit Percentage | 70% | 70% |
| | Minimum Weekly Benefit Amount | $200 | $200 |
| | Maximum Weekly Benefit Amount | $600 | $600 |
| | Maximum Benefit Period** | 104 weeks | 13 weeks |
| | **Benefit** | **Occupational Injuries** | **Non-Occupational Injuries** |
| ☒ | **Continuous Total Disability Benefit: ***** | | |
| | Waiting Period | equals Maximum Benefit Period for Temporary Total Disability | N/A |
| | Benefit Percentage | 70% | N/A |
| | Minimum Weekly Benefit Amount | $50 | N/A |
| | Maximum Weekly Benefit Amount | $600 | N/A |
| | Maximum Benefit Amount | $200,000 | N/A |
| | Maximum Benefit Period | Up to age 70, but not beyond full Social Security retirement age | N/A |
| ☒ | **Limits of Liability:** | | |
| | Combined Single Limit of Liability | $1,000,000 | $10,000 |
| | Aggregate Limit of Liability | $2,000,000 | $20,000 |
| | Sub Limits of Liability: | | |
| | Combined Single Limit of Liability for: | | |
| | Pre-Existing Conditions | $10,000 | N/A |
| | Occupational Disease | $50,000 | N/A |
| | Occupational Cumulative Trauma | $50,000 | N/A |

* Starting at age 70, the Principal Sum shall be based on the following schedule:

| Age at Date of Loss | Percent of Principal Sum |
|---|---|
| 70 | 80% |
| 71 | 60% |
| 72 | 40% |
| 73 | 20% |
| 74 | 15% |
| 75 and over | 10% |

** If an Insured Person suffers an Injury at or after age 70, the Maximum Benefit Period shall be one (1) year.

*** If an Insured Person sustains an Injury within six months or less of attaining his or her full Social Security retirement age, as defined by the United States Social Security Administration, the Insured Person does not qualify for the Continuous Total Disability Benefit.

# DYNAMEX – SCHEDULE OF BENEFITS – CLASS II (Part Time)

| | Benefit | Occupational Injuries | Non-Occupational Injuries |
|---|---|---|---|
| ☒ | **Accidental Death Benefit:** | | |
| | Principal Sum* | $25,000 | $10,000 |
| | Commencement Period | 365 days | 365 days |
| ☒ | **Survivor's Benefit:** | | |
| | Principal Sum* | $125,000 | N/A |
| | Monthly Benefit Percentage of Principle Sum | 1% | N/A |
| | Monthly Benefit Amount | $1,250 | N/A |
| ☒ | **Accidental Dismemberment Benefit:** | | |
| | Principal Sum* | $150,000 | $10,000 |
| | Commencement Period | 365 days | 365 days |
| ☒ | **Accidental Paralysis Benefit:** | | |
| | Principal Sum* | $150,000 | $10,000 |
| | Commencement Period | 365 days | 365 days |
| ☒ | **Accident Medical Expense Benefit:** | | |
| | Commencement Period | 90 days | 90 days |
| | Deductible Amount | $0 | $0 |
| | Maximum Benefit Amount | $1,000,000 | $7,500 |
| | Maximum Benefit Period | 104 weeks | 52 weeks |
| | Dental Benefit Maximum | $1,000 | $1,000 |
| | Lifetime Maximum Benefit Amount | $1,000,000 | $15,000 |
| ☒ | **Temporary Total Disability Benefit:** | | |
| | Commencement Period | 90 days | 90 days |
| | Waiting Period | 7 days | 14 days |
| | Benefit Percentage | 70% | 70% |
| | Minimum Weekly Benefit Amount | $125 | $125 |
| | Maximum Weekly Benefit Amount | $400 | $400 |
| | Maximum Benefit Period** | 104 weeks | 13 weeks |
| | **Benefit** | **Occupational Injuries** | **Non-Occupational Injuries** |
| ☒ | **Continuous Total Disability Benefit: ***** | | |
| | Waiting Period | equals Maximum Benefit Period for Temporary Total Disability | N/A |
| | Benefit Percentage | 70% | N/A |
| | Minimum Weekly Benefit Amount | $50 | N/A |
| | Maximum Weekly Benefit Amount | $400 | N/A |
| | Maximum Benefit Amount | $200,000 | N/A |
| | Maximum Benefit Period | Up to age 70, but not beyond full Social Security retirement age | N/A |
| ☒ | **Limits of Liability:** | | |
| | Combined Single Limit of Liability | $1,000,000 | $10,000 |
| | Aggregate Limit of Liability | $2,000,000 | $20,000 |
| | Sub Limits of Liability: | | |
| | Combined Single Limit of Liability for: | | |
| | Pre-Existing Conditions | $10,000 | N/A |
| | Occupational Disease | $50,000 | N/A |
| | Occupational Cumulative Trauma | $50,000 | N/A |

* Starting at age 70, the Principal Sum shall be based on the following schedule:

| Age at Date of Loss | Percent of Principal Sum |
|---|---|
| 70 | 80% |
| 71 | 60% |
| 72 | 40% |
| 73 | 20% |
| 74 | 15% |
| 75 and over | 10% |

** If an Insured Person suffers an Injury at or after age 70, the Maximum Benefit Period shall be one (1) year.

*** If an Insured Person sustains an Injury within six months or less of attaining his or her full Social Security retirement age, as defined by the United States Social Security Administration, the Insured Person does not qualify for the Continuous Total Disability Benefit.