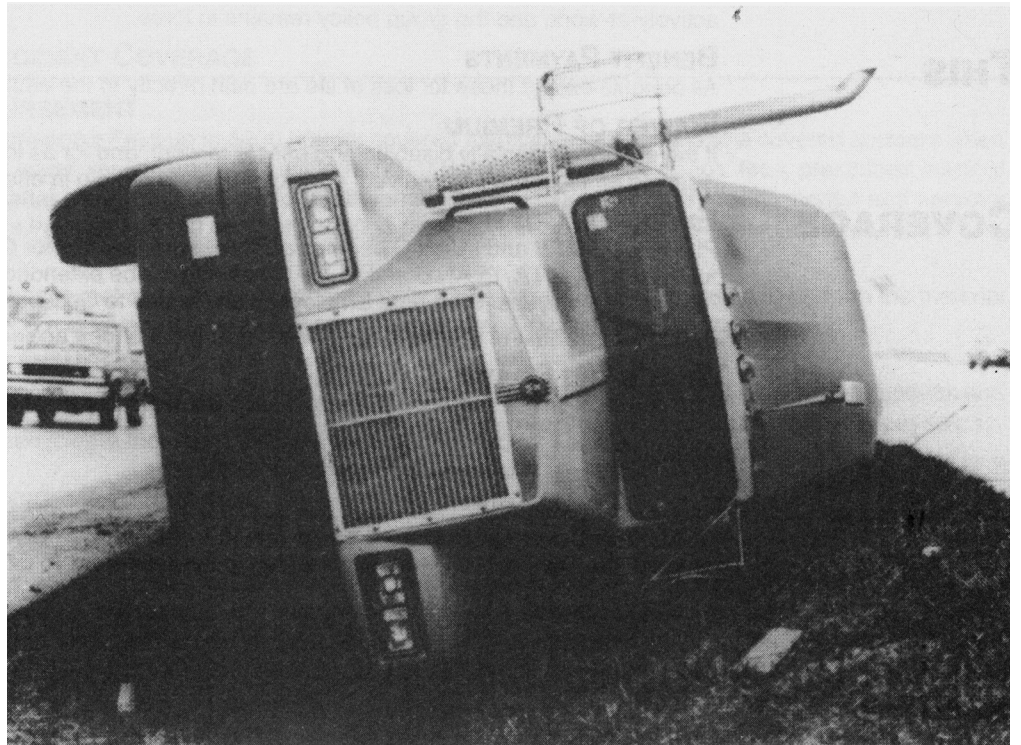


ACCIDENTS CAN HAPPEN ON OR OFF THE ROAD.



BE SURE YOU'RE PROTECTED!

TAPP

TRUCKERS ACCIDENT PROTECTION PLAN

IMPORTANT NOTICE: THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY AND, IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

IMPORTANT

ELIGIBILITY

If your company: has 1-25 employees; is a motor carrier; has been in business for at least one year; has elected to non-subscribe to the Texas Workers' Compensation system; **and your company is not:** a seasonal agricultural hauler; a company hauling toxic waste, explosive or hazardous material, nor logging; you are eligible to participate in this program. Your active full-time employees (working a minimum of 20 hours a week) and part-time employees (working between 5-20 hours per week), age 18 and under 70, are eligible for coverage.

Special considerations may be given for companies with more than 25 employees. Please contact George W. Evans & Associates, Inc. if you have inquires regarding this issue.

FACTS

EFFECTIVE DATE

Your group coverage will begin as soon as your application is received and approved, and the first premium payment is made. An employee must be actively-at-work on that date for his coverage to be effective. If an employee is not actively-at-work, coverage will go into effect on the day after he returns to work for one full day.

ABOUT

RENEWAL GUARANTEES

Coverage will stay in effect for each employee until age 70, provided premiums are paid when due, they remain actively-at-work, and the group policy remains in force.

THIS

BENEFIT PAYMENTS

All benefits except those for loss of life are paid directly to the employee.

WAIVER OF PREMIUM

If the employee is totally disabled and unable to work, and for as long as that total disability lasts, premium for the disabled employee will be waived, and coverage will remain in effect.

COVERAGE

EXTENT OF COVERAGE

The TAPP PLAN benefits as shown are payable for Occupational Accidents.

The aggregate limit of liability for all losses arising out of one accident is \$2,000,000.

WHAT'S THE COST?

Your premium amount depends on the Medical Plan Limit, Deductible, and the make-up of your eligible employees in the following classifications:

Class I - Clerical/Administrative/Management employees

Class II - Mechanics/Warehouse employees

Class III - Drivers

HOW TO APPLY?

Only licensed agents may submit business.

1. Make sure your group is eligible for coverage. Call your General Agent if there is a question.
2. Select the Medical and Dental Expense Reimbursement amount you want (\$300,000 or \$500,000).
3. Complete the Application for Group Accident Insurance, and employee census form. (This data should include the employee's name, SS#, DOB, DOH, occupation and indicate full-time or part-time status.)
4. Include a check for the first month's premium made payable to: NORTH AMERICAN BENEFITS COMPANY. Be sure to include the correct administrative fee for the mode of payment you select as well as the one-time policy setup fee. Both charges are indicated on the application.
5. Premium is based on the number of full-time and part-time employees actively at work on the effective day of the policy.
6. Application must be received by the General Agent prior to the effective date.
7. Do not cancel or change any existing coverage until you are notified in writing that we have accepted the group for coverage. In some cases we may require further information from you.

EXCLUSIONS - THE FOLLOWING IS A BRIEF OVERVIEW OF THE PROGRAM'S EXCLUSIONS. FULL DETAILS ARE PROVIDED IN THE POLICY.

No benefits are payable for any losses due to:

- 1) suicide or any self-inflicted injury;
- 2) committing an assault or felony, or being engaged in an illegal occupation;
- 3) war or act of war, whether declared or undeclared;
- 4) participation in armed services of any country or participation in any riot, rebellion, insurrection;
- 5) disease, bodily or mental infirmity, nervous or emotional disorders;
- 6) hernia or hemorrhoids;
- 7) ptomaine or bacterial infection;
- 8) owned aircraft, unless covered; operating an aircraft under certain circumstances;
- 9) intoxication or influence of alcohol;
- 10) narcotics, barbiturates, or other drugs unless prescribed by a doctor;
- 11) organized competitive athletic events;
- 12) race or speed contests;
- 13) commutation to and from work.

Benefits are not payable for:

- 1) charges for care provided by a family member;
- 2) any loss for which Workers' Compensation benefits are payable;
- 3) any charges for care or treatment which is not considered medically necessary, or is experimental in nature.

Losses due to re-injury or a degenerative condition are limited. Only the first \$10,000 of benefits payable will be covered (combination of medical and disability benefits payable), unless the insured has been covered for 24 months, or has gone without treatment for the condition for 12 consecutive months. The terms "re-injury" and "degenerative" are defined in the policy.

Charges are limited for ambulance services, manipulation therapy, and mental or nervous conditions.

This brochure is a brief description of the TAPP Plan. It is not an insurance contract. Additional conditions and limitations may apply. If a conflict arises between this brochure and the issued policy, the policy will govern.

TAPP PLAN OCCUPATIONAL ACCIDENT COVERAGE

MEDICAL AND DENTAL EXPENSE REIMBURSEMENT

- \$1,000 or \$2,500 Deductible Per Person, Per Occurrence
- Pays up to \$300,000 or \$500,000 (depending on plan chosen) for covered medical expenses due to a covered accident when incurred within 104 weeks of the accident
- Pays usual, reasonable and customary charges for covered physicians' fees, prescribed medical and/or surgical services and supplies, and hospital charges
- Benefits for ambulance service, extended care facility, mental and nervous conditions and chiropractic treatment are limited
- Pays up to \$400 per tooth, \$5,000 per injury for covered dental expenses.

DISABILITY INCOME INSURANCE

- Pays a maximum of \$500 per week for up to 104 weeks, not to exceed 70% of base salary
- Payable if worker is unable to perform the material and substantial duties of his own occupation due to a covered accident
- Payments begin after 7-day waiting period.

ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

- \$100,000 payable for covered loss of life
- \$100,000 payable for covered loss or loss of use of both hands, feet, sight in both eyes, speech and hearing
- \$50,000 payable for covered loss or loss of use of one limb, sight in one eye, speech or hearing
- Additional benefits payable for covered losses of fingers or toes.

MONTHLY RATE PER INSURED

	<i>Full-Time Employee</i>				<i>Part-Time Employee</i>			
	\$1,000 Deductible		\$2,500 Deductible		\$1,000 Deductible		\$2,500 Deductible	
Medical Plan Limit	\$300,000	\$500,000	\$300,000	\$500,000	\$300,000	\$500,000	\$300,000	\$500,000
CL I	\$24.00	\$27.00	\$18.00	\$21.00	\$14.00	\$16.00	\$11.00	\$13.00
CL II	\$79.00	\$82.00	\$70.00	\$73.00	\$48.00	\$51.00	\$43.00	\$45.00
CL III	\$135.00	\$138.00	\$105.00	\$108.00	\$85.00	\$88.00	\$66.00	\$68.00

There is a one-time policy setup fee and a billing fee by premium payment mode. See application for amounts.

TAPP Truckers' Accident Protection Plan

New Business Case Transmittal

Company Name: _____

Company Address: _____

City: _____ TX: _____ Zip: _____

Contact Person: _____ Phone: (____) _____

Email: _____

Broker/Agent's Name: _____ Commission %: _____

Address: _____ Tax ID# _____

Email: _____

Broker/Agent's Name: _____ Commission %: _____

Address: _____ Tax ID# _____

Email: _____

General Agent's Name: _____ Commission %: _____

Address: _____ Tax ID# _____

Email: _____

Effective Date: _____ Date Submitted _____

Special Instructions: _____

Included Are:

- ____ Employer Application *Employer Must Be In Business at Least 1 Year*
____ Broker/Agent Licensing
____ (Electronic Bank Draft) ACH Debit Application
____ Premium Check amount of \$ _____ Check # _____ Premium Without Fee \$ _____

Mail All Completed Enrollment Material to: 5904 Dolores • Houston, TX 77057-5604
Call with questions: (800) 580-3826 • (713) 780-1116 • Fax: (713) 782-1113 or email
michelle@gwevans.com or lucy@gwevans.com

Administered by: NORTH AMERICAN BENEFITS COMPANY (NABCO)
530 East Swedesford Road, Wayne, PA 19087 • (800) 994-GAPP (4277)

TAPP -

TRUCKERS'

ACCIDENT

PROTECTION

PLAN

APPLICATION

FOR

COVERAGE

Requested Plan Effective Date: _____
 Name of Employer (full corporate name under which business operates): _____

Mailing Address: _____

Street Address: _____

City/Town: _____ County: _____ State: _____ Zip: _____

Phone Number: _____

Email: _____

SIC Code Assigned: _____

The applicant must be engaged in the business of trucking. Coverage for other industries is available through the Company's Group Accident Protection Plan (GAPP) program.

Describe Nature of Business *IN DETAIL*: _____

Goods Hauled: _____

Number of Years in Business: _____

Are any of the truckers to be insured independent contractors? Yes No How many? _____

Are the independent contractors directly contracted to the employer applicant? Yes No

TAPP Plan Selections			
Medical Plan Limit:	<input type="checkbox"/> \$300,000	<input type="checkbox"/> \$500,000	
Medical Expense Deductible:	<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$2,500	

Class	Number of Employees	Rate Per Employee	Class Total
Full-Time			
I	_____	X _____	= _____
II	_____	X _____	= _____
III	_____	X _____	= _____
Part-Time			
I	_____	X _____	= _____
II	_____	X _____	= _____
III	_____	X _____	= _____

Please check only for the (Electronic) Bank Draft/ACH Debit Payment Option. (If yes, ACH Debit Form/Application must be completed.)

Choose One: \$20 Monthly*
 \$35 Quarterly*
 \$50 Semi-Annually*

Subtotal: \$ _____
Total Premium: \$ _____
Billing Fee:* \$ _____
One Time Issue Fee: \$50.00
Total to be Submitted: \$ _____

Subject TXDOT regulations? Yes No Permit No: _____
 (Complete Census including each employee's name, SS#, DOB, DOH, occupation and full-time or part-time status must be attached.)

THE INFORMATION ABOVE ACCURATELY REPRESENTS THE TAPP PROGRAM DESIGN FOR WHICH WE ARE APPLYING. THE REQUIRED EMPLOYEE INFORMATION IS ACCURATELY SHOWN ON THE ATTACHED TAPP CENSUS FORM WHICH REQUIRES INFORMATION ON ALL EMPLOYEES.

Employer Authorized Signature _____ Date _____

Broker or Agent Name (Please Print) _____

Broker or Agent Signature _____ Date _____

PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM. THE COMPANY CANNOT ISSUE A POLICY UNLESS THE REVERSE SIDE OF THIS FORM HAS BEEN COMPLETED.

**EMPLOYER CERTIFICATION - THE COMPANY CANNOT ISSUE A POLICY
UNLESS THIS SECTION OF THE APPLICATION IS COMPLETED.**

We the undersigned Employer, hereby certify the following:

1. We are applying to BCS Insurance Company (the Company) for Accident Insurance. We fully acknowledge and understand that acceptance of this request is subject to all of the Company's requirements and verification of quoted premium. The insurance applied for shall not be effective until the application has been approved and accepted by the Company in writing and the Coverage Effective Date has been assigned. A Policy and Schedule of Benefits will be issued.
2. We understand that 100% of all eligible employees must be covered and that this will be verified using quarterly employment tax statements.
3. In order for employee insurance to take effect, each employee must satisfy the eligibility requirements of the Policy.
4. We agree to pay the required premiums to the Company when due.
5. We have reviewed the sales material and the application. These materials, taken together, describe the coverage terms, conditions, limitations, and exclusions of the Accident Insurance for which we are applying, all of which have been explained to us by the broker/agent whose signature appears below.
6. We understand the coverage terms, conditions, limitations, and exclusions of the Accident Insurance for which we are applying.
7. WE ACKNOWLEDGE AND FULLY UNDERSTAND EACH OF THE FOLLOWING ITEMS:
 - a. The coverage for which application is being made does not insure any casualty or general liability risk of the Employer. This coverage is not intended to nor will it provide the Employer with any protection or defense against any suit which may be brought by an employee or anyone else.
 - b. Neither the Company nor the undersigned broker/agent has represented the coverage as anything other than a program of coverage which offers no indemnity for the Employers' liability.
 - c. THIS IS NOT A PROGRAM OF WORKERS' COMPENSATION INSURANCE. WE DO NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS COVERAGE. AND IF WE ARE A NON-SUBSCRIBER, WE LOSE CERTAIN COMMON LAW DEFENSES TO SUIT AS WELL AS CERTAIN LIMITATIONS ON LIABILITY THAT WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. WE MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.
8. I am authorized by the Employer to review and to sign this Certification.
9. BCS Insurance Company and its representative are authorized to contact me by mail or telephone to discuss this certification.
THE COMPANY CANNOT ISSUE A POLICY UNLESS THIS SECTION OF THE APPLICATION IS COMPLETED.

Employer Authorized Signature

Date

Broker or Agent Name (Please Print)

Broker or Agent Signature

Date

PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM. THE COMPANY CANNOT ISSUE A POLICY UNLESS THE REVERSE SIDE OF THIS FORM HAS BEEN COMPLETED.

Mail Application and Premium Quotation Form to:
George W. Evans & Associates, Inc.
5904 Dolores, Houston, TX 77057-5604



BCS Insurance Company, Oakbrook Terrace, IL

TEXASWORKS
TAPPWORKS

OWNER WAIVER

I (WE) THE SOLE PROPRIETOR OR PARTNERS HAVE ELECTED NOT TO CARRY ANY COVERAGE UNDER THIS TEXAS GROUP ACCIDENT POLICY. PLEASE PROVIDE THE NAME OF YOUR CURRENT CARRIER AND POLICY NUMBER BELOW.

<u>Name/Title</u>	<u>Social Security #</u>	<u>Signature (s)</u>	<u>Your Current Carrier/Policy #</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(TAPP) TRUCKERS' ACCIDENT PROTECTION PLAN

Employer: _____ Date: _____

	NAME	S.S.#	Date of Birth	Date of Hire	*F/P	OCCUPATION
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						

* Full-time / Part-time Employee Status (Indicate by F or P)

UNDERWRITTEN BY

BCS Insurance Company is rated in the "A" (Excellent) category by the A.M. Best Company. Licensed in all states, BCS is a company known for excellence in product development and special risk underwriting with more than 50 years of experience in the group market.

ARRANGED BY

GEORGE W. EVANS & ASSOCIATES, INC.
5904 Dolores
Houston, TX 77057-5604
713-780-1116
800-580-3826

ADMINISTERED BY

NORTH AMERICAN BENEFITS COMPANY (NABCO)

North American Benefits Company is dedicated to providing individuals with quality insurance coverages at economical costs and has made a commitment to the trucking industry.

MARKETED BY

**North American Benefits Company
Agreement for Electronic Funds Transfer**

I authorize North American Benefits Company, hereinafter called THE COMPANY, to automatically deduct monthly premium payments through an Automated Clearing House (ACH) Debit transaction from the bank account listed below on the 5th of every month. Should the 5th of the month fall on a weekend or bank holiday, the ACH Debit will be processed on the next following bank business day. This agreement will remain in effect until I give written notice to change financial institutions, terminate service, or until THE COMPANY notifies me that this service has been terminated.

Please Print

Policy Name (no abbreviations): _____

Mailing Address: _____

City, State, Zip: _____

Phone: _____ Email: _____

INSTRUCTIONS FOR ELECTRONIC FUNDS TRANSFER (EFT)

Fill in complete banking information where indicated. If routing number is unknown, please contact your bank. Without the Routing Number, **the automatic debit cannot be processed.**

Check One: New EFT Debit: Change Existing EFT Debit: (Policy Number: _____)

Bank Name	Account Name (as it appears on the account)
Bank Account Number	Type of Account Checking: <input type="checkbox"/> Savings: <input type="checkbox"/>
Bank ABA Routing Number	Bank Address

VOIDED CHECK (Forms submitted without a voided check will not be accepted and will be returned.)

I hereby authorize THE COMPANY and the financial institution to electronically debit premium payments from my designated account. If THE COMPANY is notified of any failed transactions, THE COMPANY will automatically process a second ACH Debit for my premium payment. **If a failed transaction occurs more than once THE COMPANY will automatically terminate agreement.**

Authorized Name (Print)	Date
Authorized Signature	

THE REVERSE SIDE OF THIS FORM MUST BE COMPLETED WITH INITIAL EMPLOYEE INFORMATION

