Complete the following for a quote on your Worker's Compensation Insurance:

Contact Name for inspections: _____
Contact Name for Accounting Records: _____
Contact Name for Claims Information: _____

# of Years in Business: _____

Type of Entity (Circle One): Individual Corporation Partnership S Corp LLC

Federal ID Number: _____

Location(s):
_____
_____
_____

Effective Date Requested: _____

Limits of Liability : 100,000 Each Accident 500,000 Each Accident
500,000 Disease – Policy Limit OR 500,000 Disease – Policy Limit
100,000 Disease – Each Employee 500,000 Disease Each Employee

States you conduct business in: _____

Full Time Employees: _____ # Part Time Employees: _____

Total Payroll of those employees: _____

# of All other employees & salesperson, drivers: _____
Payroll of those Employees: _____

Experience Modification Factor: _____ if available will show on current declarations page

Individuals Included or Excluded PLEASE LIST EACH PERSON:
Partners, Officers, Relatives to be included or excluded (Payroll to be included must be part of rating information section

State:_____ Location: _____
Name: _____ Date of Birth:_____
Title: _____ Percent of Ownership:_____
Duties: _____ Included or Excluded (circle one)
Class Code: _____ Payroll amount for this person:_____

State: _____ Location: _____
Name: _____ Date of Birth: _____
Title: _____ Percent of Ownership: _____
Duties: _____ Included or Excluded (circle one)
Class Code: _____ Payroll amount for this person: _____

Please attach any additional individuals to this sheet with the above information.

Prior Carrier Information along with Loss History – Provide information for the past 5 years and use the remarks section for loss details

Year Company Annual Premium MOD Claims Amt Paid Reserve

_____
_____
_____
_____

Nature of Business/Description of Operations

Give Comments and descriptions of business operations and products:

_____
_____

Circle Yes or No for the following:

1. Is there a safety program in operation? Yes No
2. Is applicant engage in any other type of business? Yes No
3. Are sub contractors used? (If Yes, Give % of work subcontracted) Yes No %_____
4. Any group transportation provided? Yes No
5. Any employees under 16 or over 60 years of age? Yes No
6. Any Seasonal Employees? Yes No
7. Is there any volunteer or donated labor? Yes No
8. Any employees with physical handicaps? Yes No
9. Do Employees travel out of state? Yes No
10. Are physicals required after offers of employment are made? Yes No
11. Any other insurance with this company? Yes No
12. Any prior coverage declined/cancelled/non renewed in the last three years? Yes No
    If Yes explain_____
13. Are Employee Health Plans Provided? Yes No
14. Do you lease employees to or from other employers? Yes No
15. Any tax liens or bankruptcy within the last 5 years? Yes No
16. Any undisputed and unpaid workers compensation premium due from you or any commonly managed or owned enterprises? Yes No
    If Yes, Explain including entity names and policy number:

Please complete this form and return with the following:

1. **5 years of Loss Runs**