FAX TO 888-388-5622
Questions: 888-368-6492

WORKERS' COMP QUESTIONNAIRE

First Name:____________________________ Last Name:_____________________________
Complete Business Name____
Mailing Address:____
Phone Number:_______________________ Fax Number: _______________________________
Federal Tax Id:________________________ Years in Business______________

Circle One: Individual Partnership Corporation S. Corp Other____________

Current Worker's Comp Carrier:________________________
Workers' Comp Expiration Date:_______________________

Business Locations: Hours of Operation

1)____ ___________

2)____ ___________

Type of operation (circle all that apply) Repair Auto Body Tire Sales
Gas Car Wash "C" Store
Transmission Towing

Protection Devices (circle all that apply) Surveillance Cameras Panic Button
Bullet Proof Glass

# of Full Time Employees:______________ # of Part Time Employees______________

Estimated Annual Payroll: _____________ Class Code _______________________
Estimated Annual Payroll: _____________ Class Code _______________________

Name of Officers /Owners to be included or excluded:

	Name	Include/ Exclude	Title/ Relationship	Ownership %	Duties
1)	____________________	________	_____	_________	_______________
2)	____________________	________	_____	_________	_______________

Have you had any claims in the past 3 years? (circle one) Yes No

Do you provide Group Health Insurance for your employees? (circle one) Yes No
If yes, name of health care provider____________________
% of employees participating_____ %of employer contribution____________

Signature: ______________________ Date:______________________

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