WORKERS COMPENSATION NSURANCE QUESTIONNAIRE

Required by law if incorporated

Date___________

Business Name: ____

Contact Name: ____

Phone #: ___________________________ Fax#:__________________________________

Mailing Address ____
____

Location Address ____
____

□ Individual Sole Proprietor Partnership Corporation Other:___________

Describe the nature of your operations____
____

Do you currently have insurance:

Carrier: _____________________________________

Policy #: _____________________________________

Expiration Date: ______________________________

Year Business Started________ Years of experience in this business ______

Federal ID #: ___________________________

Annual Payrolls:

Sales People $____________ # of Employees:____________

Clerical $____________ # of Employees:____________

Other $____________ # of Employees:____________

Other $____________ # of Employees:____________

Owners/Executive Officers are to be:

INCLUDED with the workers compensation coverage.

EXCLUDED from the workers compensation coverage.

List all Owners/Executive Officers and their percentage of ownership:

____
____
____
____